After PCMH Recognition, Make Changes Stick

BY M. ALEXANDER OTTO

FROM A CONFERENCE ON PRACTICE IMPROVEMENT SPONSORED BY THE SOCIETY OF TEACHERS OF FAMILY MEDICINE

SAN ANTONIO – Earning patient-centered medical home recognition from the National Committee for Quality Assurance can seem an insurmountable challenge.

Cari Miller, the New Jersey Academy of Family Physicians' director of advocacy and program operations, should know. She recently helped 32 primary care practices achieve patient-centered medical home (PCMH) recognition from NCQA.

After talking a few practices off the ledge as they struggled to meet NCQA's nine PCMH standards – and after being a PCMH coach in the past – she has some advice for others seeking recognition:

► **Get it in writing.** The biggest struggle for most was fulfilling the first standard, which requires written policies for patient access and communication, plus data to prove they're followed.

NCQA, for example, wants to ensure patients are seen mostly by their specific primary care provider. The group "is not saying [that has to happen] every single time, and we would recommend that your policy doesn't say that," Ms. Miller said in an interview after her presentation at the conference.

"What we have practitioners do is write a policy that may say 80% of the time patients will be scheduled with their primary care provider, then generate reports that show the patients who called in, [and] the percentage of time they actually saw their specific primary care provider versus another provider within the practice," she said.

► **Open access isn't an informal option.** Along similar lines, to meet NCQA's open access requirement for last-minute patients, "often, practices will say, 'We see [patients] that day, we just fit them in.' " But that's not going to fly with the accreditor. "NCQA is going to say that if you are just fitting people in, that's not meeting the intent," Ms. Miller said at the conference, also sponsored by the American Academy of Family Physicians.

Instead, the group is looking for dedicated, unscheduled slots held open each day for last-minute patients, she said.

"We found we could work with practices to, on average, keep two slots open for every morning and two slots open for every afternoon," Ms. Miller explained. That way, NCQA could see that, "in fact, if somebody called at 9 o'clock in the morning, there is always a 10:15 and 11:15 appointment" available, Ms. Miller said.

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Staff should know what the process is so that there is no variation. "[NCQA is] trying to take the variation out of things," Ms. Miller said.

► **Don't underestimate the power of a "carrot."** Horizon Blue Cross Blue Shield of New Jersey funded the efforts of Ms. Miller and the NJAFP to speed the adoption of the PCMH model in that state. "We really believed there needed to be a really strong carrot" to motivate participation, Ms. Miller said.

The 32 practices she recently coached included large, small, single, and multisite practices. NCQA recognition made them eligible for a $15 per patient per month care-coordination payment for Horizon Blue Cross Blue Shield enrollees with diabetes, plus a portion of any money saved in treating those patients as a result of the PCMH efforts.

The practices all won NCQA's seal of approval by October 2009, after starting the process in March of that year. Most achieved level 1 status, while others achieved level 2 or level 3.

► **Change requires follow-up.** In general, practice transformation is "a 2- to 5-year process," Ms. Miller cautioned. PCMH recognition is just the first step – after that, practices must make sure the changes remain and are effective.

That's not always easy.

For example, when Ms. Miller visited one practice working toward recognition, it was doing a great job logging lab results, a critical PCMH component. But then the logger took a vacation, and no one was designated to take her place. When she returned, she stopped logging results because she felt she had too many other responsibilities.

Ms. Miller revisited the practice and discovered the system had fallen apart. "There was no information on the logs," she said.

Similar things happened in other practices. "One of the fastest things that can go right down the drain is the follow-up, monitoring, and tracking," she said.

The solution is to cross-train staff, let them know why they are being asked to do what they are being asked to do, and check records to ensure they are being kept.

► **Physicians can't do it all themselves.** Although 32 of Ms. Miller's practices passed PCMH muster, 2 did not. The medical assistant at the first practice thought he'd rack up enough points addressing only some of the standards; he let the others slide. The second practice had a problem Ms. Miller saw several times: Physicians had a hard time delegating decision-making responsibilities when they remained accountable for what happened in their practice.

"Some of the real challenges we saw had to do with physicians letting go of some of the work that could be done by others," she said.

The problem is that team-based care is a PCMH foundation concept; NCQA does not want physicians running around trying to do everything themselves, Ms. Miller said.

The 11 physicians in the practices simply weren't on board with the concept, "and it was clearly evident in the documentation they sent NCQA," she said.

One approach is to divide out the tasks that need physician involvement from those that do not.

Nurses, for instance, could give pneumococcal shots to all patients older than 64 years under a standing order. The only thing the doctor would need to do is pull records periodically to make sure the shots are given, at least until they become automatic in the way that blood pressure checks are.

► **You may have more documentation than you think.** In working toward PCMH recognition, Ms. Miller also cautioned not to assume required documentation doesn't exist, especially in larger settings.

For example, one hospital-based residency practice was sure it couldn't meet NCQA's e-prescribing standard. After a little sleuthing, however, Ms. Miller discovered that the hospital pharmacy department had all kinds of e-prescribing practices and documentation in place, including alerts to prevent errors.

"The pharmacy department was able to take care of and coordinate that whole standard for the residency program," Ms. Miller said.

"That was an eye-opener. Do not assume. You need to tell people [what you are doing]," she said. ■

Medicare Launches Physician Compare Web Site

FROM THE CENTERS FOR MEDICARE AND MEDICAID SERVICES

Medicare officials launched a new online tool that allows consumers to locate physicians in their communities and get information about their specialties, degrees, and other training.

The new tool, called Physician Compare, is available online at www.medicare.gov/find-a-doctor. The tool is modeled after the Hospital Compare Web site (www.hospitalcompare.hhs.gov), which allows consumers to compare hospitals based on quality data and patient evaluations. Currently, the Physician Compare Web site contains mostly practice information. However, it does let consumers know if the practice reported quality data to the Centers for Medicare and Medicaid Services under the Physician Quality Reporting System, a voluntary program for reporting quality metrics on Medicare patients. More than 200,000 physicians and other health care providers reported data to the CMS under the voluntary system in 2009.

"The new Physician CTRompare tool begins to fill an important gap in our online tools by providing more information about physicians and other health care workers," Dr. Donald Berwick, CMS administrator, said in a statement. "This helps to pave the way for consumers" to have information about physicians as they do for nursing homes, home health agencies, and health and drug plans, Dr. Berwick noted.

Later this year, officials at the CMS plan to add information to Physician Compare about whether doctors are participating in the voluntary electronic prescribing program. Under the Affordable Care Act, the CMS is required to expand the Web site to include information on quality of care and patient experience data by 2013.

–Mary Ellen Schneider

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