IT'S TIME!

THE PATIENT-CENTERED MEDICAL HOME PRACTICE

WORK YOUR WAY DOWN THE TO-DO CHECKLIST

The Patient-Centered Medical Home (PCMH) model enables the healthcare profession to refocus on the importance of primary care, especially when it comes to managing chronic diseases and patient care coordination. The result of this should be a healthcare system that is more satisfactory for:

- Patients, who will be less likely to suffer the unfortunate consequences of unsynchronized care;
- Physicians, who can improve the quality of their patients' experiences, build a more efficient and productive practice, and realize financial benefits in the way of insurer incentives or increased reimbursements;
- Insurers and employers, who may see a reduction in costs around major acute events thanks to PCMH doctors' increased involvement with their patients and with those patients' other healthcare providers.

The more practitioners who get involved in this type of program, the more effective it will be in terms of impacting care for the entire patient population. Interested in turning this vision into a reality at your practice? Get going by following the ideas in this action plan:

Action Item 1: Revise your cultural mindset and practices.

In medical school, students are trained to be independent judges, working solo to assess patients' conditions. But the PCMH model requires a cultural transformation, with physicians adding to their roles as clinician the functions of team manager and coach. In order for PCMH to be effectively adopted, you must guide physician assistants and nurse practitioners as they undertake more patient care responsibilities.

The good news is that these days, a growing number of patients are used to receiving healthcare services first from these professionals – sometimes even exclusively. So, it won't come as a shock to most of them for you to adopt that practice, as well.

The person for whom it may be the biggest adjustment is YOU as you both supervise and collaborate with PAs and NPs to build appropriate courses of treatment and ensure that patients – particularly those with chronic conditions – understand how to follow those plans and adhere to them. New processes and workflows will be part of this picture.

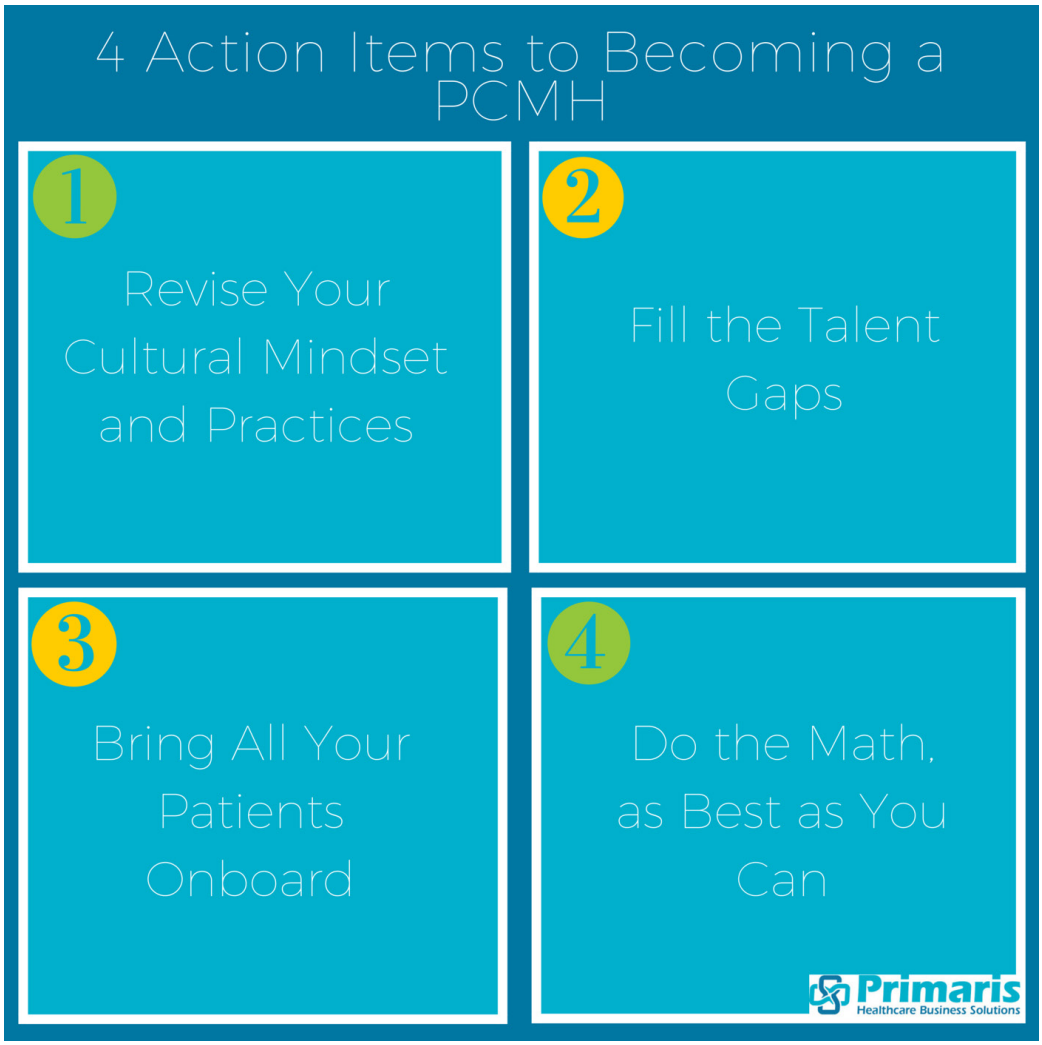
Action Item 2: Fill the talent gaps.

It is probably wishful thinking to expect that a clinician on his or her own will be able to handle the day-to-day tasks of care coordination with external doctors, hospitals, pharmacies and other healthcare sources along with all their other responsibilities. It is definitely wishful thinking to assume that he or she also happens to have studied business intelligence and data science to support patient analytics tasks or data extraction for reporting purposes.

Yet those skills will need to be represented to assure that PCMH fulfills its potential for clinicians. To that end, physicians may consider giving some existing employees new responsibilities around care coordination, or hiring additional employees to take on those tasks.

Such responsibilities might include reviewing medical records to alert an oncologist, for example, to data that could be of particular importance in the way he or she approaches treating one of your patients who has been diagnosed with cancer, or reconciling medications to ensure that a third-party's prescription doesn't conflict with a drug the patient already is taking.

As for data analytics talent, large practice groups can probably support hiring these higher-priced workers on their own as in-house resources to comb through EMRs and filter patients by condition to defend against poor outcomes or efficiently report performance and quality metrics. But smaller practices may find it best to outsource these services – perhaps even sharing a contract resource with another medical practice.



Action Item 3. Bring all your patients onboard.

PCMH has its most immediate applicability for servicing patients with chronic conditions or those diagnosed with a particular illness for which they are seeing other providers – specialists, therapists, and so on – which requires the highest coordinated care efforts. Nonetheless, it's important to enroll your entire population in the effort.

For one thing, it builds on an IT foundation of having better access to relevant patient information, clinical knowledge and evidence-based guidelines to personalize care for everyone, whether the focus is on proactively keeping a healthy patient well or quickly diagnosing a problem affecting a generally robust individual so that it can be treated efficiently and appropriately.

Of course, it's a doctor's greatest pleasure to see his or her patients stay healthy, but the unfortunate truth is that anyone's health can turn on a dime – particularly in the case of elderly populations – and it is best practice to be prepared for that possibility with the right data and relationships. That includes, for example, being able to provide higher-quality referrals with more complete documentation to specialists, or collaborating with a pharmacist on medication recommendations.

Action Item 4. Do the math, as best as you can.

It's difficult to calculate just how much money clinicians and practices will have to spend in order to become PCMH-tested and certified by an organization such as the National Committee for Quality Assurance (NCQA), with the accompanying potential costs of hiring more staff and investing in more technology, among other factors. The total cost can differ depending on how far along a practice already is in adopting and leveraging technology such as EMR systems, or whether it is part of a larger system that already has data experts available, for example.

But it is possible to get some insight into potential sources of aid in moving to the model, as well as into potential returns-on-investment, to help decide if it's worth participating.

You can explore, for instance, whether the insurance companies with which you do business support the PCMH model with tools, financial incentives, and more. One that does so, for example, is Maryland's

CareFirst BlueCross BlueShied, launched in 2011. In the first complete year of the program, nearly 60 percent of eligible teams of primary care physicians and nurse practitioners that form the basis of the program earned increased reimbursements for their performance, based on savings achieved against projected total care costs for members and quality measures. In the second year, 66 percent of eligible teams earned increased reimbursements.

BlueCross BlueShield of Kansas City also has discussed its work on this front, including providing practices a few dollars per patient in compensation each month for their PCMH work in managing patient care, follow-ups, outcomes and the like.

PCMH works on so many levels: The Patient-Centered Primary Care Collaborative (PCPCC) has provided data on PCMH cost and quality results between 2010 and 2013 pointed out significant reductions in emergency department and urgent care visits; decreased hospital admissions and readmissions; improvements in post-hospitalization follow-ups; better control of chronic disease conditions; and increased primary care visits for plans across the U.S.

Given these benefits, it sounds like it may be time to make PCMH work for your practice, too.

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