IT'S TIME!

THE ROAD TO BECOMING A PATIENT-CENTERED MEDICAL HOME

This past April the 10,000th medical practice earned recognition by the National Committee for Quality Assurance (NCQA) as a Patient-Centered Medical Home provider. That's a long way away from the 28 practices that could claim that designation back when the program debuted in 2008.

Almost 50,000 clinicians today are certified in this model. While the NCQA is one of the better-known

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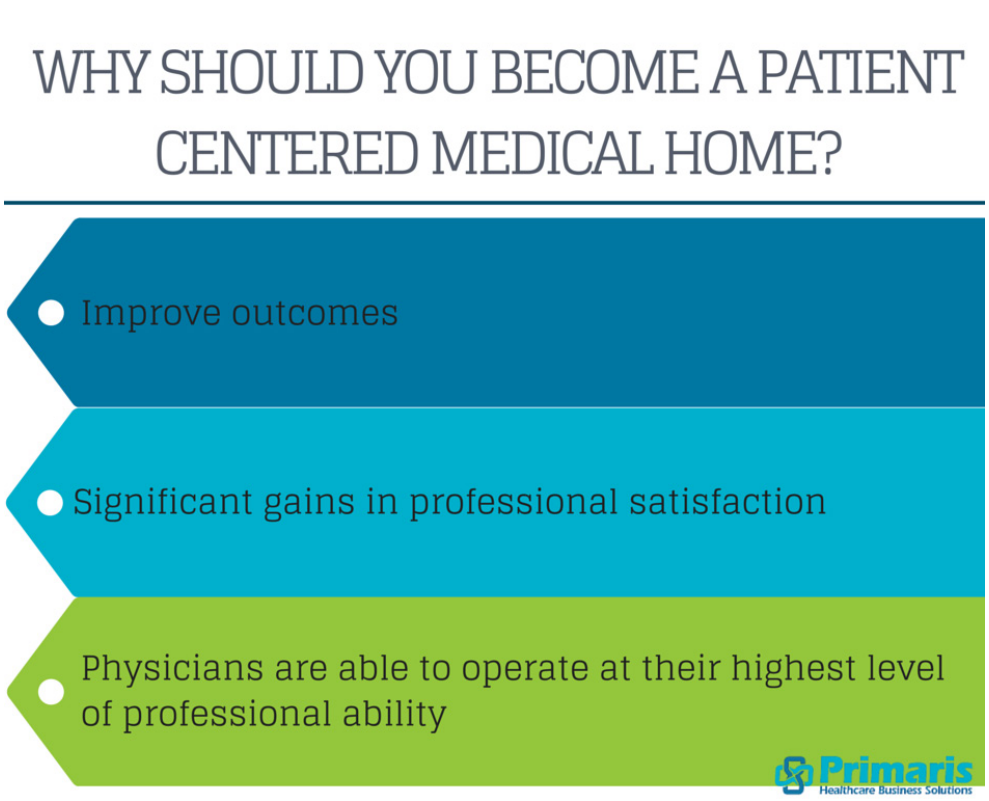
PCMH standards, other organizations also offer paths to PCMH status, such as The Joint Commission. By and large they emphasize the same values: PCMH calls upon primary care physicians to coordinate, communicate and collaborate with all the other parties servicing their patients – specialists, surgeons, hospitals, rehab facilities, home health care operators, pharmacies and more. It also demands more seamless interaction among a practice's internal care teams and with patients to ensure better facilitated and more continuous care.



PCMH came about in response to how very much the world of medicine has changed in the last few decades. Specialty and sub-specialty fields of medical practice have multiplied, new therapeutic and care assistance models have emerged, and more sophisticated home medical equipment has become available right from the neighborhood pharmacy, to name just a few shifts.

While these advances have benefitted patients in many ways, they also have helped create a fragmented system. Too often, primary care doctors don't know that a patient went to see a specialist, was rushed to the emergency room, wound up admitted to a hospital, and spent time in a rehab facility until well after the events have occurred.

That opens the door to potential problems, such as an emergency surgery taking place without the surgeon being fully informed about the status of a patient's chronic condition – and the patient winding back up in the hospital a few weeks later because of complications that result from that lack of knowledge.

PCMH-certified clinicians and practices are vital to reducing the discontinuity that leads to these and other situations that can take a toll both on healthcare system costs and patient quality of treatment. They become the central authority in the web of their patients' healthcare relationships.

By staying apprised of everything that's going on and being involved with the continuum of healthcare relationships that patients have – particularly the elderly or those with chronic conditions – they can play a critical role in keeping individuals from experiencing acute care episodes.

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At the same time as they are helping patients stay healthier and experience a better quality of life, they also are positioning themselves to potentially increase practice revenues. Those providers who embrace PCMH will find that they also have embraced a better way of managing their existing patients, one that frees up time and resources to bring more clients into their practices. Credit that to the PCMH model's team-focused approach to care that emphasizes the roles of nurse practitioners and physician assistants, and to its requirement for digitally managing patient populations.

Not only that, but clinicians also are poised to benefit from an emerging trend that has insurers and even employers offering financial incentives to PCMH-certified practices that prove they can reduce medical costs by lowering the incidents of covered patients going to the hospital as a result of a major acute event.

Get Started on the Road To Becoming a PCMH Practice

It should be clear to those clinicians and practices interested in becoming a PCMH that getting there takes work – a lot of work. It can take up to two years to build up a practice to the point where it can pass the NCQA's certification requirements, for instance.

But it's equally clear that there are good reasons for clinicians and practices to turn to this model and become

certified by organizations such as the NCQA. How to do so successfully revolves around five key steps:

1. Put in place a comprehensive team approach to caring for patients.
On an internal basis, that means authorizing nurse practitioners and physician assistants in a practice to more fully take on routine patient care services such as follow-ups, under clinicians' overall supervision, of course.

Doing so gives physicians a little more time and flexibility to take on the external team approach requirements of establishing relationships with other parties from whom their patients access healthcare services. You'll need those relationships so that you'll be able to "direct traffic" with those third parties, to ensure that their care efforts are undertaken with consideration to the patient's overall health status, particularly when chronic disease is involved. Building these relationships also assures you that you'll never lose touch in situations where patients may transition across healthcare settings.

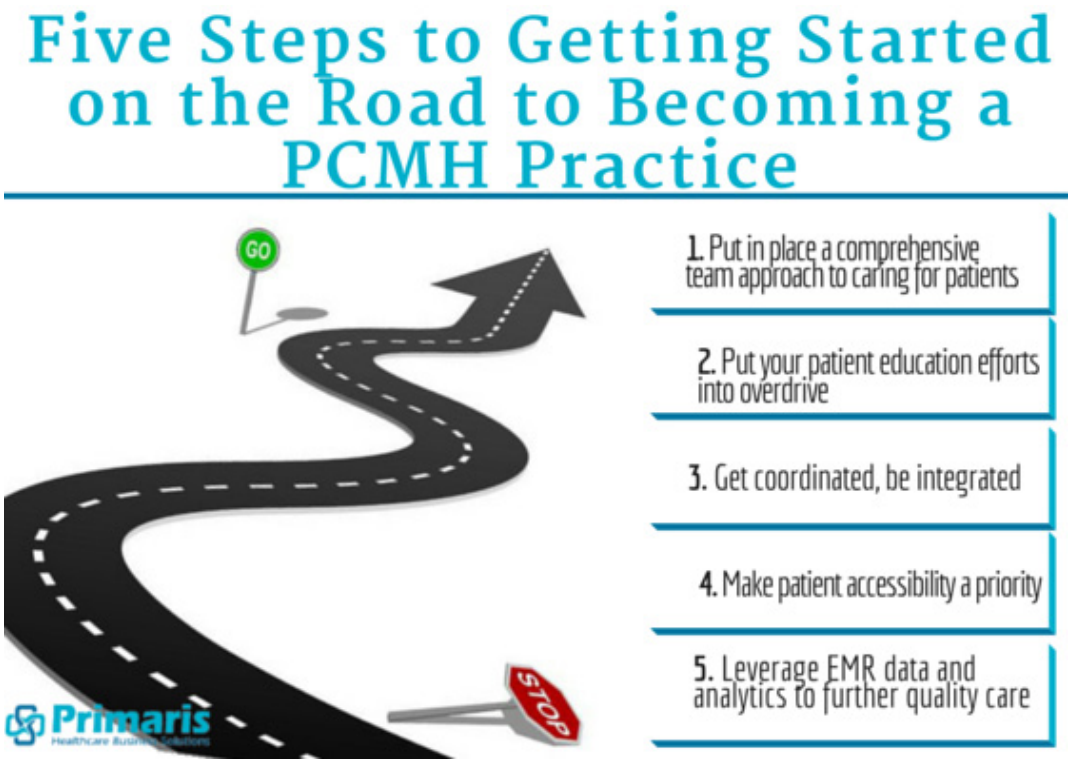
2. Put your patient education efforts into overdrive.
When you think PCMH, think patient-centered. The team approach to caring for patients is one aspect of that, but another equally important one is to give your patients the knowledge they need so that they can self-manage their own care. For generally healthy patients who perhaps are a few pounds overweight, for example, that can take the form of providing them with nutrition information so they can start to eat healthier.

But it's a bigger effort when it comes to equipping patients with chronic conditions to take more responsibility for their own care. You not only need to direct patients with diabetes, for instance, to purchase a finger stick device that they can use at home to measure their blood glucose levels – your team also must be prepared to demonstrate to them how to use it.

You and your staff must make sure such patients understand the importance of washing their hands before doing a test; of never sharing their finger stick lancing devices with others; and of properly disposing of the used lancet. It's also worth discussing with them the possibility

of selecting products that send results wirelessly to your electronic medical records system, so that you can have a continuous record of their status without requiring them to keep a paper-based finger-stick log to present at the next visit.

3. Get coordinated, be integrated.
Building relationships with external providers – from hospitals, to pharmacies, to home healthcare services – is the first step to coordinating patient care across the various elements of the healthcare system. But you'll need to create an infrastructure to support the relationships you're building, too.



Care coordinators and technology – electronic medical records systems among them, of course – are keys to tracking patients as they move across the healthcare inpatient, outpatient and specialty care settings continuum.

Practices will be striving to implement tools that can be used to filter patients by condition to mitigate poor outcomes; that provide real-time notifications when a patient interacts with the healthcare system during care transitions; and that integrate messaging apps so that primary care doctors can see where there are gaps in treatment coverage, among other features.

4. Make patient accessibility a priority.
The PCMH model holds that primary care should be accessible, continuous and comprehensive care. Healthcare system cost-savings goals are defeated if patients aren't able to have timely or after-hours access to their primary care doctor and so turn to the ER instead, or

let conditions worsen to the point where it will take more time and resources to restore the patient's health.

Letting physician assistants and nurse practitioners take on more responsibilities is one way of accomplishing that, but so too is adopting alternative means of communications, such as email, telephone or teleconferencing, given the fact that many patients these days have video capabilities on their PCs, tablets or smart phones.

That's a great alternative to being in the office 24/7 – and it's made even better by the fact that CMS just set up billing codes for PCMH practices that doctors can use to obtain compensation for patients they don't see personally in their offices.

5. Leverage EMR data and analytics to further quality care.

Physicians have long operated on a one-to-one patient model, and of course it will remain important to relate to individual patients at an individual level. But PCMH providers have to go beyond the episodic care model to embrace the population health management model, so that they understand exactly what percentage of their patients are experiencing problems with high cholesterol, high blood pressure, uncontrolled diabetes, congestive heart failure, and so on.

That requires an EMR system and data analytics expertise. Any practice with anything remotely resembling a significant number of patients has no other choice when it comes to recording data and then being able to draw out the information it needs to better manage healthcare performance.

Yes, there's a long road to becoming a PCMH provider, and the truth is that not every practice will succeed. But those clinicians that go into the process with their eyes open to what it will demand of them start out ahead of the game. Those that stick with it will realize that the end result was well worth the extensive efforts.

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