

Practice Management



There is No Place Like Home

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Life in Kansas

The fall 2008 issue of *The Ohio Family Physician* presented three excellent articles on the patient-centered medical home (PCMH). Jacob Bryan's article provided historical and evidential information as well as an overview of PCMH. Ken Bertka, M.D., and Annie Kessler's article discussed the proposed financial structure for PCMH and the requirements by the National Committee for Quality Assurance (NCQA) for PCMH recognition. Both articles described many of the elements needed to qualify as a PCMH. The third article written by Annie Kessler portrayed how the PCMH had been integrated into two Ohio family medicine offices that are involved in the American Academy of Family Physicians (AAFP) TransforMED project. These articles can be found online at <http://www.ohioafp.org/medicalhome/promotion.php>. From these articles it is clear that AAFP's 2004 visionary Future of Family Medicine Report, http://www.annfammed.org/cgi/content/full/2/suppl_1/s3, is nearly upon us and we need to prepare for the winds of change now.

The Twister

Even though most family physicians can identify with most of the tenets of PCMH, few of us can actually meet a significant number of the required specific qualifications. In fact, the number of changes needed in most practices will seem impossible if left until an enhanced payment opportunity appears. An attempt at a magical last minute transformation will likely tear many offices apart. This process in practical terms probably will take at least 3-4 years if none of the required standards are in place. The greatest concern for our AAFP leadership is that they will sell PCMH to purchasers, but be unable to deliver on the promises due to an unprepared primary care workforce.

Somewhere, Over the Rainbow

In our present odd payment system, we are paid primarily for episodic care and occasionally for preventive care. Often preventive care is an unpaid add-on to acute or chronic care. We are rarely paid for quality care and hardly ever for care management and coordination, such as occurs with chronic medical conditions. Thus, the present system pays best for acute care done in volume, and the result is less than optimal patient outcomes. Payment systems for PCMH recognize that the best patient care takes more time and a broader approach, but ultimately saves money and results

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in better outcomes with greater patient and physician satisfaction. PCMH requires changes in the present payment methodologies, and the newly proposed compensation system creates a financial environment that encourages this new model of care.

Follow the Yellow Brick Road

Today, every practice should create a roadmap with a time frame and methods for achieving a collection of goals leading to the practice becoming a PCMH. There is no correct specific order in which to sequence the changes; however, certain aspects may be more easily accomplished when some other elements are in place. The mechanisms for achieving each element will vary by practice size, support mechanisms and resources (human, financial and time).

NCQA presently has the only certification program for PCMH. Below is a summary of the standards and some transition examples, which are especially relevant for small- and medium-sized practices.

In December 2008, Centers for Medicare and Medicaid Services (CMS) is expected to announce eight states (or parts of states) to participate in a Medicare medical home pilot. Most likely CMS will only recognize two tiers. Medical Tier 1 will be in line with the NCQA Level 2, which requires use of an electronic medical record (EMR) or at least an electronic patient registry. For more information on

Standard	Points	Standard	Points
Standard 1: Access and Communication	4	Standard 5: Electronic Prescribing	3
A. Has written standards for patient access and patient communication**	4	A. Uses electronic system to write prescriptions	3
B. Uses data to show it meets its standards for patient access and communication**	0	B. Has electronic prescription writer with safety checks	2
		C. Has electronic prescription writer with cost checks	2
Standard 2: Patient Tracking and Registry Functions	21		
A. Uses data system for basic patient information (mostly non-clinical data)	2	Standard 6: Test Tracking	5
B. Has clinical data system with clinical data in searchable data files	3	A. Tracks tests and identifies abnormal results systematically**	5
C. Uses the clinical data system	3	B. Uses electronic systems to order and retrieve tests and high sensitive tests	13
D. Uses paper or electronic based charting tools to organize clinical information**	4	Standard 7: Referral Tracking	10
E. Uses data to identify important diagnoses and conditions in practice**	4	A. Tracks referrals using paper-based or electronic system	4
F. Generates lists of patients and reminds patients and clinicians of services needed (population management)	3		
Standard 3: Care Management	4	Standard 8: Performance Reporting and Improvement	4
A. Adopts and implements evidence-based guidelines for three conditions**	3	A. Measures clinical and/or service performance by physician or across the practice**	3
B. Generates reminders about preventive services for clinicians	4	B. Reports performance across the practice or by physician	3
C. Uses non-physician staff to manage patient care	3	C. Sets goals and takes action to improve	3
D. Conducts care management, including care plans, assessing progress, addressing barriers	3	D. Produces reports using standardized measures	2
E. Coordinates care/follow-up for patients who receive care in inpatient and outpatient facilities	3	E. Generates reports with standardized measures electronically to external entities	1
Standard 4: Patient Self-Management Support	20	Standard 9: Advanced Electronic Communications	15
A. Assesses language preference and other communication barriers	4	A. Availability of Interactive Website	1
B. Actively supports patient self-management**	6	B. Electronic Patient Identification	2
		C. Electronic Care Management Support	2
			4

Level of Qualifying	Points	Must Pass Elements at 50% Performance Level
Level 3	75 - 100	10 of 10
Level 2	50 - 74	10 of 10
Level 1	25 - 49	5 of 10
Not Recognized	0 - 24	< 5

Levels: If there is a difference in Level achieved between the number of points and "Must Pass", the practice will be awarded the lesser level; for example, if a practice has 65 points but passes only 7 "Must Pass" Elements, the practice will achieve a Level 1.

Practices with a numeric score of 0 to 24 points or less than 5 "Must Pass" Elements do not Qualify.

The above tables are also available on the OAFP Web site at www.ohioafp.org/medicalhome/resources.php.

the Medicare medical home pilot please go to <http://www.cms.hhs.gov/DemoProjectsEvalRpts/MD/list.asp>. For the standards review (see table on p. 24), an estimated time for implementation (ETI) assumes that no elements are in place and the practice has made a strong commitment to transform to PCMH.

But First You Must Prove Yourself Worthy

- Standard 1: AAFP will soon release model written standards to address these measures. The model standards focus on issues of scheduling, a personal clinician, coordination of care, improved access and removal of language barriers. Data collection to show compliance with these standards could occur using a one-week survey of the specific area being addressed. ETI: four weeks (two-week implementation, one-week survey and a one-week reevaluation with adjustments).
- Standard 2: The medical practice will need a data management system (DMS) for organizing demographic and clinical information. The DMS (either an EMR, electronic registry or a highly evolved paper system) will need to be able to manipulate the information to produce some basic reports on common clinical conditions encountered in the practice. The DMS also needs to be capable of producing patient reminders for routine tests or immunizations. ETI: 18 months-two years for an EMR implementation and probably a similar time frame to adjust paper-based systems (if it is even possible).
- Standard 3: This is an extension of Standard 2 that focuses on three common conditions in the medical practice. It also addresses team care (more on this concept below), care management plans and continuity-of-care between

inpatient and outpatient transitions. ETI: three months.

- Standard 4: This standard focuses on language and communication barriers, plus assisting patients with disease self-management. The barriers assessment must include an evaluation of the patient's limitations if any; but, it does not include any measures that focus on barrier removal. The practice or its medical system may provide self-management programs or classes, or the practice may refer the patient to community-based resources. ETI: four weeks.
- Standard 5: Electronic prescribing has no must-pass elements; however, there are some relatively easy points to be earned with this measure. Acquiring and using an online prescription service, such as SureScripts® or RXHUM®, will improve patient safety in either a paper-based or EMR office. ETI: six weeks.
- Standard 6: The practice must systematically track any tests ordered as well as the results, and systematically follows up with patients. It also evaluates how a DMS is used to order lab and radiology tests and retrieve the results. This may be done without an EMR. ETI: two weeks for tracking and six weeks for documenting the order/retrieval process.
- Standard 7: The practice must use a paper-based or electronic system to assist in tracking practitioner referrals designated as critical until the consultant report returns to the practice. The referral origination process must include the referring clinician information (the origin of the referral) and clinical details, including the reason for requesting the referral plus any

relevant clinical information. This may be accomplished by merely faxing a copy of the last office note and a health summary with the referral. ETI: two weeks.

- Standard 8: This standard requires various measures of physician performance including disease data, patient satisfaction data and patient safety data. These measures are then compared to national benchmarks and the results are shared with the physician. The data is then used to develop action plans to achieve improved scores. This standard also assesses the practice's ability to report measures electronically to external entities. ETI: six months.
- Standard 9: This element promotes Web-based functionality that supports patient access and patient self-management. This requires an EMR or a Web-based product for compliance. ETI: two weeks.

Lions, Tigers and Bears...Oh My!

Change can be frightening to office staff and unnerving to physician leaders. Of all the modifications mentioned above, I would suggest that the team care mentioned in standard No. 3 might be a good starting point for most offices. Rather than viewing this as a loss of control, physicians need to see this as work redistribution. Certain functions simply do not need direct physician oversight. By eliminating the "physician bottleneck" the office becomes more productive, workflow more evenly dispersed and opportunities for care less likely to be missed. Brief protocols can be written to maximize

the potential of all members of the office staff and examples can be found on the Ohio Academy of Family Physicians Web site under the medical home section, www.ohioafp.org/medicalhome. Building a team of diverse membership, such as social workers and pharmacists, has been actually shown to improve care. More information about this concept can be found at <http://www.annfam.org/cgi/content/full/5/5/457>.

Poppies

Change fatigue was mentioned in one of the previously noted articles, and it should be a real concern. Any change can cause additional stress for office staff and multiple simultaneous modifications can more than multiply this effect. An office becomes at risk of becoming dysfunctional because of all the changes that have occurred. Hence, steady change at a reasonable speed is more likely to lead to long-term success. It is extremely important that each office pick one of the standards now to begin the transition. Since the implementation of an EMR is probably the longest and most stressful change of all, an office may wish to start with an easier initial project.

If I Only had a Brain...a Heart...Da Nerve...

A physician champion for PCMH is needed in each office. This person needs to monitor the process to know when a transition has been successful and it is time for a new challenge, or conversely when a change is not occurring smoothly and a reevaluation is needed. Office staff acceptance is improved when a member from the medical and front

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fee standards were set, grievance committees addressed complaints from patients, and doctors could be sanctioned for substandard patient care. That system, which was good but never perfect, was undercut by the courts and Federal Trade Commission, and today the marketing of medical products and services is increasingly driven by marketplace standards and ethics.

The Association's influence on medical care standards fell apart for a mixture of reasons, including the tendency of medical specialists to give primary loyalty to their specialty societies rather than AMA. The quality of patient care today is monitored by hospitals and by state medical boards, many of which do a good job as regulators but are less effective in promoting ethical practice, in motivating physicians to "go the second mile" for the patients they serve.

Think for a moment about the word "professionalism." At one time it conveyed the meaning of a highly trained and highly motivated person who could be trusted to put the patient's best interests first. The word has been taken over by marketers and has lost any connotation of caring or altruism—we now see advertisements for professional dry cleaners and articles about professional hockey players. In this writer's view, it is time for physicians to find a new sense of service to patients that reflects the times and the continuing need to believe that what we do is much more than medical mechanics. I do not know where the motivation for that renewal will come from, but it is past time for us to start talking about it.

Part of the problem is the common but often unrecognized tendency of people to go from one extreme to the opposite, rather than finding a rational middle ground. This has happened in

the area of patient privacy. As institutions grew and their work became more complicated, there was sloppiness that sometimes led to private health matters becoming general knowledge. However, today's regulations tend to stifle useful dialogue among professionals (that word again!) that could facilitate high quality, cost-effective care and deter abusive behavior by patients. I recall a small episode many years ago when a new-to-me patient requested that I refill an opioid-containing cough prescription which he said that he desperately needed. He handed me a well-worn prescription label with the name and dose of the product that he wanted. Having observed no cough or abnormal lung findings during the encounter, I stepped out to a telephone and called his out-of-town pharmacy to inquire about refilling the medicine. I introduced myself and said something like, "Mr. X is here and says that he urgently needs a refill of his prescription for Nocofatol." "Yep," the pharmacist replied, "that is exactly what he would say." Message conveyed.

On other occasions, pharmacists would tell me whether a patient who was supposedly taking a medicine regularly was in fact getting refills on schedule, and whether they were also getting the same or similar medicine from other physicians. This kind of information, used with discretion, could and did deter abuse of the system in some instances and let me provide useful, positive guidance in others. It is regrettable that this sort of communication among professionals has died out under the guise of protecting patient privacy.

A focus on ethical patient

care should not be seen as a burden, but rather as a salutary, liberating concept that frees us to feel good about the patient care that we provide. There is a sort of parable that makes the point well. It was written by a protestant pastor, Harry Emerson Fosdick, but it works well for all children of Abraham and for those with no religious affiliation. The full text is in Bartlett's Familiar Quotations, but here is a short paraphrase:

The River Jordan originates in the nation of Lebanon and flows south to the Sea of Galilee, which is between Jordan and the West Bank territory. This water is fresh and is used for many purposes including human consumption and crop irrigation. The river continues southward from the Sea of Galilee to the appropriately named Dead Sea. This body of water has no outlet. As a result, very little life is found in it and the water is too salty to be of much use.

The point is simple: that which gets and gives in a balanced way thrives, while that which only gets becomes foul and ugly. Bottom line: get and give in proportion, and you will be richly rewarded.

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office is included on an office improvement team. The process needs frequent monitoring with open lines of communication. One form of this improvement method is the Plan-Do-Study-Act model and it can be found online at <http://www.ihi.org/IHI/Topics/Improvement/ImprovementMethods/HowToImprove>. It is critical that any change be measured to determine if progress is being made.

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There is presently a tremendous amount of momentum toward PCMH by public and private payment systems. Strong evidence is emerging that PCMH will be more than financially viable. It is likely that PCMH payment will be combined with traditional payment methods (fee-for-service) and pay-for-performance programs. Family physicians need to develop a plan for implementing parts of PCMH into their practices now since it is nearly impossible to implement as a whole package, especially in small- to medium-sized groups.