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In This Issue...
Patient-Centered Medical Home



Meet Ken Bertka, M.D., F.A.A.F.P.,
Ohio's Candidate for AAFP President-Elect

So, You are Thinking About Becoming a Patient-Centered Medical Home

Burke-Tillema serves as project coordinator for Cincinnati Aligning Forces for Quality, an initiative of Health Improvement Collaborative of Greater Cincinnati and Robert Wood Johnson Foundation. She is a member of the PCMH Workgroup and has been involved in the Cincinnati pilot and co-pilot program since its inception.

Graham is a professor of family medicine at University of Cincinnati, Cincinnati, and has recently taken on the role of project director for Cincinnati Aligning Forces for Quality. He chairs the PCMH Workgroup, directing the Cincinnati pilot and co-pilot program.

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For anyone considering patient-centered medical home (PCMH) practice transformation, we must first answer the question: What is a PCMH? There are six essential elements to PCMH which include the following: physician-directed, team-based care; whole person orientation; enhanced access; coordination of care; quality and safety; and payment reform for added value.¹ More specifically, PCMH is a team-based model of care led by a personal physician who provides continuous and coordinated care throughout a patient's lifetime to maximize health outcomes. The PCMH practice is responsible for providing for all of a patient's health care needs or appropriately arranging care with other qualified professionals. This includes the provision of preventive services, treatment of acute and chronic illness, and assistance with end-of-life issues. It is a model of practice in which a team of health professionals, coordinated by a personal physician, works collaboratively to provide high levels of care, access and communication, care coordination and integration, and care quality and safety.² These elements are the hallmarks of the PCMH and can transform your practice into a more efficient, higher functioning organization.

In a PCMH, patients should have superb access to care and should be able to easily make appointments, including selecting both date and time. Further, waiting times should be short, e-mail and telephone consultations should be offered, and off-hour service should be available. The practice should help patients become fully engaged in their own care. Patients should be provided with information on treatment plans, preventive and follow-up care reminders, access to medical records, assistance with self-care, and counseling. Practices should utilize clinical information systems to support high quality care, practice-based learning and quality improvement. This can be achieved through maintaining patient registries; monitoring adherence to treatment; having easy access to lab

and test results; and receiving reminders, decision support and information on recommended treatments.

Practices should also coordinate specialist care and put systems in place to prevent errors that occur when multiple physicians are involved and should also provide patients follow-up and support. Another important component is integrated and coordinated team care which depends on a free flow of communication among physicians, nurses, case managers and other health professionals. This aids in avoiding duplication of tests and procedures. Patients should be given the opportunity to routinely provide feedback to doctors. A cost-effective and efficient way of doing this is for practices to take advantage of Internet-based patient surveys so that they can learn from patients and inform treatment plans. Finally, it is important that patients have accurate information on physicians to help them choose a practice that will meet their needs. All of these aspects of PCMH revolve around the practice becoming more patient-centric.

So, if this is what a PCMH is, why would you consider your practice becoming one? Practices may choose to undergo the PCMH transformation process for many reasons including the following: quality improvement; increased efficiency; improved patient, physician and staff satisfaction; and improved economic performance. The transformation consists of changes that fall into two main categories: attitude and cultural changes and process and structural changes. In the former category, practices make changes that result in proactive, population-based, patient-centered and team-based care. In the latter category, practice changes include moving to open access care, offering group visits, adopting an electronic medical record (EMR) and launching quality improvement initiatives.

Though there are many changes that must take place for a practice to become a PCMH, the payoff for you as the physician, for your practice and for your patients may be well

worth the effort... and there is data to back that up. In a sampling of results from several different PCMH sites there was a 30-40 percent reduction in emergency room visits; an 11 percent reduction in ambulatory sensitive admissions; a 40 percent decrease in asthma hospitalizations; a 24 percent reduction in total hospital inpatient days,³ and a 15-18 percent increase in net revenues.⁴ If you are interested in learning more, there are some excellent resources available to you online.

First, you will want to read up on the elements of PCMH. A good place to start is by visiting both the American Academy of Family Physicians and American College of Physicians Web sites. You may also want to make yourself familiar with TransforMED, an organization that provides ongoing consultation and support to physicians looking to transform their practices to effectively and significantly improve health care for their patients while increasing the satisfaction of family physicians and their teams. If this model fits with your vision and priorities for your practice and you want to become a PCMH, you can take the Medical Home IQ assessment through TransforMED's Web site. This tool will tell you where you already have strengths, as well as what areas within your practice need special attention as you begin transformation.

After you have completed the MHIQ assessment tool, you will want to sit down with your partners

and staff and talk through a plan for change. You will need to work cooperatively with your team to identify what to tackle first and what resources are needed. You will want to decide what disruption issues need addressed and what timeline you will follow. With a plan in place, becoming a PCMH is an achievable goal. Transforming the current health care environment to

one that emphasizes patient-centric primary care is within our reach.

References

1. Adapted from AAFP, ACP, AAP, AOA & PCPCC
2. American College of Physicians. http://www.acponline.org/running_practice/pcmh/understanding/what.htm
3. Sampling of results to date, selected from: Group Health

Cooperative of Puget Sound, Community Care of North Carolina, Geisinger Health System, and Johns Hopkins Guided Care PCMH Model
4. McGeeney, Terry. <http://www.transformed.com>

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Patient-Centered Medical Home Pilot Program: the Cincinnati Experience

Burke-Tillema serves as project coordinator for Cincinnati Aligning Forces for Quality, an initiative of Health Improvement Collaborative of Greater Cincinnati and Robert Wood Johnson Foundation. She is a member of the PCMH Workgroup and has been involved in the Cincinnati pilot and co-pilot program since its inception.

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The Cincinnati Patient-Centered Medical Home Pilot and Co-Pilot Project is one of several activities organized under the Aligning Forces for Quality initiative (AF4Q) sponsored by Health Improvement Collaborative of Greater Cincinnati. Funding for the pilot effort is being provided by Anthem Blue Cross and Blue Shield, Humana and United Healthcare; the participating practices; and Abbott Laboratories. Pilot practices receive a per member per month payment based on the assumption that each practice will be recognized by National Committee for Quality Assurance (NCQA) at Level 1. The Cincinnati patient-centered medical home (PCMH) experience is unique in that it is the first area in the country to create a program that involves both pilot and co-pilot groups of practices.

The intent of the pilot program is to provide structured assistance to a limited number of internal medicine and family medicine adult medical practices in the process of becoming fully recognized and transformed PCMHs. The 11 practices which are currently participating in the pilot program were selected out of an original application pool of approximately 30 practices in the 14-county region that makes up Greater Cincinnati. The practices are broadly representative of the primary care community, including both small and large practices, rural and urban sites, and independent as well as system-affiliated. The pilot program is planned as a two-year initiative which began in September 2009.

An innovative aspect of the Cincinnati PCMH pilot is the involvement of TransforMED, a subsidiary of American Academy of Family Physicians. TransforMED was developed to provide assistance and guidance to primary care practices striving to become fully functional PCMHs. TransforMED is organizing and guiding five, full-day learning collaboratives in the first year of the Cincinnati pilot program as well as maintaining monthly phone contact with each participating practice. The monthly calls assess the practices' progress and provide advice and assistance in dealing with specific medical

home transformation issues. Three collaboratives have already been held, with an early focus on NCQA application and recognition. All of the participating pilot practices were required to submit an NCQA application by the designated deadline in order to remain in the program. These practices also have to earn at least a Level 1 designation in order to continue receiving payment from the participating health plans. The collaborative activities do not stop with NCQA accreditation or designation. The practices quickly move on to a full range of cultural change activities which are necessary for the sustained functioning of the PCMH model.

The idea for the co-pilot program emerged when PCMH leadership recognized it would be impossible to accommodate all of the interested applicants in the pilot program, given the limitations of funding support agreed to by the health plans. With the goal of the AF4Q project to support the transformation of 50 percent of the Cincinnati area's primary care practices to the PCMH model over the next four to five years, it made sense to include as many interested practices as possible in a structured support system. There are currently 10 co-pilot practices participating in the program.

To provide support to the co-pilots, four learning collaboratives were scheduled to provide an opportunity for the physician and staff leadership of co-pilot practices to meet together as part of the process of seeking NCQA recognition, and achieving other specific objectives related to transforming into PCMHs. These collaborative sessions are provided to the participating co-pilots free of charge and involve a variety of practical exercises as well as helpful advice about the various elements of the transformation process.

Both pilot and co-pilot practices are given access to the TransforMED Delta Exchange, a Web-based learning community for practices across the country undergoing the PCMH transformation. Practices were also provided with a subscription to the American College of Physicians Medical Home Builder Web site. This site provides a broad range of information related to the PCMH concept, and is especially helpful in preparing practices for submission to NCQA for recognition.

The pilot group population involves approximately 80,000 to 90,000 patients, with a per member per month payment spread among the participating health plans, for 30,000 covered lives. The co-pilot group does not receive a per member per month payment, though it involves another 70,000 to 80,000 patients. In Cincinnati, we have learned that committed physician leadership is essential for success. Having per member per month payment up front is a great motivator, but even without receiving this payment the co-pilot group remains committed and the practices are working hard toward transformation. We have also learned that the NCQA application process is difficult, time consuming and labor intensive. Having local, knowledgeable consultation support for all of the practices has proven extremely helpful.

Our hope is that in the long run, we can leverage the experience of "early adopters" to assist spreading PCMH transformation to other practices in the Greater Cincinnati area. We also hope to engage purchasers and plans in a statewide coordinated strategy to provide up-front incentives. Ultimately, we would like to use a strong, statewide base of PCMH practices as a foundation to facilitate quality improvement, cost reduction and system integration.

Pilot Practices

- Zile Family Health Care Inc.
- The Family Medical Group
- Summit Medical Group
- Queen City Physicians-Hyde Park
- Group Health Associates-Springdale
- Fairfield Medical Group Inc.
- The Christ Hospital Medical Associates
- Queen City Medical Group (TriHealth Physician Practices)
- UC Health Primary Care (West Chester-Tylersville)
- University Internal Medicine-Montgomery
- UC Health Primary Care (West Chester-Union Centre)

Co-Pilot Practices

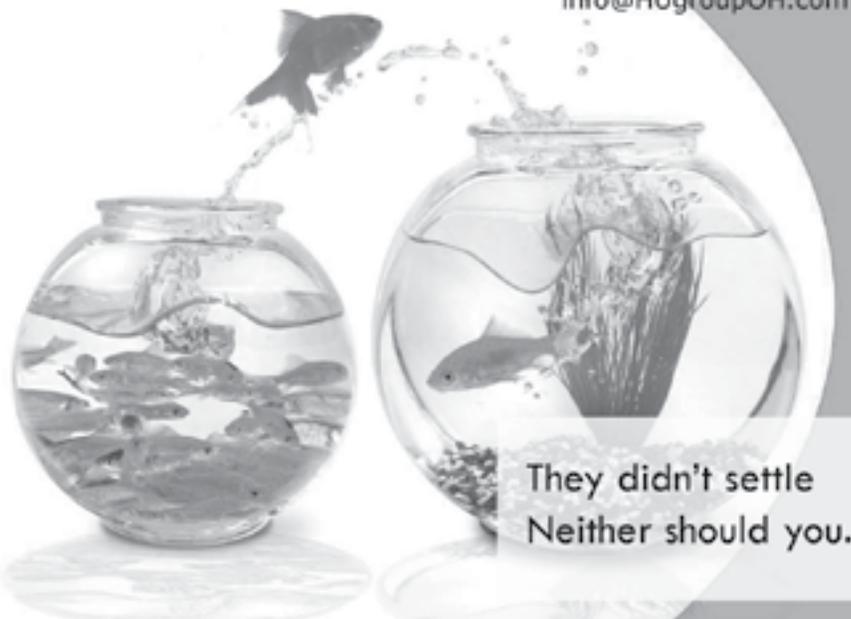
- Internists of Fairfield
- Lincoln Heights Health Center
- Lisa Larkin, M.D. & Associates
- Maineville Family Physicians
- Queen City Physicians-Groesbeck
- Queen City Physicians-Madeira
- Queen City Physicians-Western Hills
- The Christ Hospital Medical Associates-Family Medicine
- Winton Hills Medical Center
- Wright State Family Medicine

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