So you want to be a Patient-Centered Medical Home (PCMH). You’re not alone. Many primary care physicians (PCPs) have embarked on the same journey and for good reason. It’s been shown that PCMHs can lower the cost of healthcare, increase revenue for both providers and payers, and improve patient outcomes. In addition, the technology requirements to be recognized as a PCMH now closely mirror those needed to prove “meaningful use” of health information technology (HIT) under the new healthcare legislation.

Accomplishing meaningful use means securing up to $44,000 in incentive funds from the federal government. It also means aligning your practice with the parameters needed to become recognized as a medical home.

The organizations that created the standards and methods for recognizing PCMHs recently worked
with the federal government to align the two agendas. Thus, the technology needed to accomplish meaningful use (e.g., e-prescribing, electronic medical records [EMRs], patient registry, evidence-based diagnostic tools, electronic claims processing) is, for the most part, the same technology needed to become a PCMH. This way, PCPs can simultaneously accomplish both goals without breaking the bank. This makes 2011 the best year to go electronic!

“The PCMH model aligns PCPs with what they do best. It’s the potential future of healthcare,” says Steven Waldren, MD, director of the American Academy of Family Physicians’ (AAFP’s) Center for Health IT. “Dr. Barbara Starfield’s pioneering research on cost and quality relative to the penetration of primary care physicians versus the penetration of subspecialists noted that the more primary care physicians you had in a community, the lower the cost and the higher the quality. So, coordination of care—having someone who really understands primary care in a specialty like family medicine—that’s a highly skilled position. I think there are opportunities to get the entire team—physicians, mid-levels, nurses, everybody—working in concert. We have a huge workforce shortage in primary care and we need to work together as a team to fill that gap.

“Physicians need to think of it as a journey they’re likely already on,” Waldren says. “There are many aspects of the medical home that they’re doing just by being a good primary care practice. So, it’s not ‘we have to start all over and dump everything.’ It’s really—how do you continue to improve and move forward from where you’re at today.”

**RADICAL CHANGES**

As a conscientious physician, you’ve educated yourself on the PCMH initiative. You may have visited the Web sites of the AAFP, the American College of Physicians (ACP), the American Academy of Pediatrics (AAP), and the American Osteopathic Association (AOA). You may have read “Joint Principles of the Patient-Centered Medical Home,” the basic tenants of becoming a PCMH, written in 2007 by the four primary care organizations just mentioned. You probably know that PCMHs strive to be:

- service oriented for patients;
- more efficient for better profit;
- more effective for better patient outcomes;
- more fun to work in for staff and physicians.

You have some understanding of the scrutiny your practice will be under during your journey to becoming a PCMH. However, you might not be fully aware of the radical changes that will take place in your practice, nor the extent to which technology will play a role in your becoming a recognized PCMH.

**THE TECHNOLOGY OF THE PCMH**

IT plays a major role in the formation and ongoing support of the PCMH. As of 2011, PCPs that wish to be recognized as medical homes must demonstrate the ability to:

- disseminate critical patient data to the entire care team;
- engage patients in their own healthcare by enabling them to communicate directly with care providers through email, and through a Web portal, where patients can schedule appointments with their care team, and securely access, review, and track their medical records over the Internet;
- electronically prescribe medication (e-prescribe); and
- provide electronic support for quality measurement and performance improvement programs to operate.

But what does all that mean? And what technology is needed to accomplish it?

“Technology is just a tool to be able to implement the transformation that primary care practices have to go through,” Waldren says. “There’s a set of capabilities that are needed in a practice, and for each one of

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**A BRIEF HISTORY OF THE PATIENT-CENTERED MEDICAL HOME**

The medical home model first got its start in pediatrics in the late 1960s. The ability to track the healthcare of special needs children became an important aspect of those practices, and the government provided pediatricians with federal funding to assist in the implementation of the technology they needed.

For decades, those medical home capabilities (e.g., care coordination, extra help for the families, etc.) stayed within pediatrics. Then, in this decade, four large primary care organizations—the American Academy of Family Physicians (AAFP), the American College of Physicians (ACP), the American Academy of Pediatrics (AAP), and the American Osteopathic Association (AOA)—along with the National Committee for Quality Assurance (NCQA) recognized that medical home type functionality enables primary care physicians (PCPs) to once again take the lead in healthcare, and fulfills the federal government’s drive to lower costs and improve care for patients. They developed the Physician Practice Connections® – Patient-Centered Medical Home™ (PPC-PCMH) standards, through which primary care practices can become recognized as medical homes.
those capabilities, there are tools—technologies—in place.

“The path for each practice will be a little different depending on where the practice is,” Waldren says. “Some practices start with some of the technologies around open-access scheduling and work from there. Some will work on the quality side installing patient registries, and doing the quality improvement. Others start with implementing an electronic medical record. So, it really depends on where you are in your practice.

“But, of the things doctors should think about—having e-prescribing, a patient portal, an electronic medical record system, and a registry type of functionality—these are probably the most important.”

Most primary care practices have some combination of these in operation. However, they might not have the full capabilities required by PCMHs.

“PCMH is no more profound than ‘Extreme Makeover’ for primary care, so that the office works more efficiently, so that there’s better service for patients, so that there’s a better bottom line for physicians, and so that it’s a more fun place to work,” says Bruce Bagley, MD, the AAFP’s Medical Director for Quality Improvement. “It’s that simple—improving the organization, function and efficiency of the medical practice.”

Bagley admits that PCPs today who are considering become a PCMH might find the process somewhat daunting, due to competing messages, programs, and incentives coming out of the healthcare reform initiatives. However, he says, it’s all really “the same work.”

“They’re all saying that we should have better information technology support for the clinical side of our work,” Bagley says. “Registries, EMRs, email with patients, patient portals—they’re all whistling the same tune.”

**PATIENT REGISTRIES FOR CHRONIC ILLNESS CARE**

“We really need a team approach to care, where the physician isn’t the only one doing all the care,” Bagley says. “We need registries for chronic illness care, like diabetes, hypertension, heart disease, chronic obstructive pulmonary disease (COPD), and asthma. There should be registries for each of those in a practice, to ensure that patients get evidence-based guideline treatment on a timely basis.”

Bagley believes that PCMHs will be a central piece of the accountable care organization (ACO) model. The legislation, he notes, requires that there be “adequate primary care services” within the ACO. “I like to view the PCMH as one of the components of an ACO,” he says. “Like the other components—specialty
care, hospital care, imaging, lab, management, and IT—they each must contribute to the overall efficiency of the enterprise in order for it to be successful.”

For example, many EMRs currently operating in primary care practices enable physicians to complete the documentation necessary for a PCMH. However, they might not have the patient registry capability to enable the population-management functionality that a PCMH requires.

Primary care practices with EMRs in place that lack patient registries have few options. They can wait until their vendor creates a registry that will install into their EMR, they can use off-the-shelf software that culls patient data from the EMR to create a database from which a registry application would extrapolate the data, or they can install a new electronic health record (EHR) system that has built-in patient registry functionality.

“That’s one of the biggest gaps in current EMR technology. So many practices are trying to find ways around that, either by creating advanced spreadsheet applications, or implementing a stand-alone registry application to augment their current EMR,” Waldren says.

**E-PRESCRIBING**

A fair amount of practices are doing some sort of e-prescribing; however, in many instances, the orders are not going electronically to the pharmacy. Instead, the order is processed electronically within the EHR, but then printed out and faxed to the pharmacy. This by itself does not disqualify a practice from being recognized as a medical home. However, going from electronic to paper and then back to electronic—when the pharmacy tech has to enter the order into the pharmacy’s information system—increases the possibility for error and decreases the “convenience factor” for the patient.

“In our AAFP membership, about 70% of physicians have an electronic health record application in their practice,” Waldren says. “But when we looked at the functionality they were using, it’s a smaller percentage of those that are doing e-prescribing. It’s starting to take off, though.

“The big things that aren’t out there relative to the medical home have to do with registry type functionality for population-based management, and patient portal-type functionality to do patient engagement,” he says. It’s possible for a PCP to become recognized as PCMH using work-arounds to accomplish the required functionality during level one and level two of the PCMH review process. However, level three is a different matter altogether.

“NCQA recognition doesn’t require you to have the technology—it requires you to perform the functions,” Waldren says. “You can accomplish level one and level two PCMH, but in level three it becomes exceedingly difficult to do without a fully functioning EMR. And to get to a full vision of a PCMH, it’s very hard without robust HIT.

“The capabilities [PCPs] should address are 1) patient registries, 2) the ability to do quality measurement and tracking, and 3) e-prescribing and patient engagement,” Waldren says. “Those are the big components needed to support meaningful use, which are also key components of the medical home. You can do that inside of a full EMR, or you can do it with
ligher-weight technology coming out that’s focused on those different types of functionalities. But, those are the key capabilities to think about first.

“This allows the practice to focus on capturing good clinical data that’s codified and structured,” Waldren says. “That way you can leverage the decision-support tools that are out there, and when you go to do the documentation part of it with the full EMR, you already have a ‘problem list’ ready to go. You don’t have to then go through the process of documenting that stuff. It’s already been documented and it just needs to be pushed into the system.”

NINE SPECIFIC FUNCTIONALITIES
There are nine specific “functionalities” a practice must demonstrate in order to become recognized by the National Committee for Quality Assurance (NCQA) as a Patient-Centered Medical Home, much of which is provided through electronic health record (EHR) functionality (list taken from the NCQA Web site):

1. access and communication;
2. patient tracking and registry functions;
3. care management;
4. patient self-management and support;
5. electronic prescribing;
6. test tracking;
7. referral tracking;
8. performance reporting and improvement;
9. advanced electronic communication.

“...a set of milestones, as you implement the different functionalities sets of the medical home.”

SPEAKING FROM EXPERIENCE
In April of this year, the NCQA recognized Hudson Headwater’s Health Network (HHHN) as a Level 3 PCMH—the highest level that can be achieved. The multi-hospital healthcare organization applied and was awarded Level 3 recognition in just one step.

“...a set of milestones, as you implement the different functionalities sets of the medical home.”

“You can’t reasonably accomplish Level 3 medical home with out having an electronic medical record (EMR) in place,” says John Sawyer, an MD of Internal Medicine and Medical Director at HHHN, in Queensbury, New York. “So, the implementation of the EMR was a 2-year process that took place prior to our application to become a medical home.” HHHN next focused on e-prescribing.

“We realized that electronic prescribing was the minimum we’d need, along with allergy and formulary checking,” Sawyer says. “Best practice meant installing computers and Internet access at the point of patient contact in the exam rooms using tablet PCs or other mobile Internet devices. Desktop computers were less desirable, but preferable to putting a computer outside the exam room for the staff to use. “Carrying computers around instead of paper charts—logging in and out of computers instead of writing everything down—this was a huge adjustment for our staff,” he says. “Being able to care for panels of patients or patient populations was also a major change in orientation. You need to orient your practice around patient access for visits, phone calls, and patient portals. Focus on the patient’s needs as opposed to the provider’s needs. And having an organized lead person in the practice who’s not necessarily one of the providers will help get you through the hurdles,” Sawyer says.

REVENUE OF THE MEDICAL HOME
In my opinion, there are two basic reasons why practices have chosen to become a PCMH.

One, it’s the right thing to do, and two, the potential for payment reform,” says Martin Serota, MD, vice president and chief medical officer at AltaMed Health Services in Los Angles, California. AltaMed expects to be accredited by The Joint Commission as a PCMH in July 2011.

According to Serota, The Joint Commission’s “approach is more oriented toward large-scale enterprises like AltaMed, than the National Committee for Quality Assurance (NCQA) model, which focuses more on individual physician practices.” AltaMed is a large Federally Qualified Health Center (FQHC) operating 40 healthcare sites, with more than 100 physicians, delivering more than 500,000 physician visits per year.

“Most practices have always wanted to do the right thing, and long ago adopted many of the principles we now bundle under the term PCMH,” Serota says. “Unfortunately, our current reimburse-
The PCMH movement is as much a way to collectively negotiate for payment reform as it is a way to drive process improvement.”

Nowhere in healthcare is the need for payment reform more keenly felt than in primary care. That’s because the current fee-for-service payment environment is making it increasingly more challenging to remain profitable and open for business.

“In a fee-for-service-world, primary care physicians get paid for office visits,” Bagley says. “The problem is that most payment plans don’t take into account the different business models for a primary care practice versus, say, a neurosurgeon. Unlike the latter, PCPs make all their money in the office. Since payers have traditionally treated payments the same to control costs, primary care has gotten strangled to death over the last 10 years, because there’s no margin in it.” Patient self-management is a big component of the PCMH model. Through the practice’s Web portal, patients can interact directly with their care team. This “non-visit”-based care (e.g., motivation interviewing, shared goal setting, home monitoring, and contact between visits) is not reimbursable under the current fee-for-service payment system.

In response, health plans are developing new methods to reimburse PCMH physicians for services rendered, as well as for gathering and reporting data on performance improvement measures. Such healthcare activities would be paid for by a “care management fee.” This is a fee that health plans can use to incentivize quality and efficiency.

Sawyer says that you need to orient your practice around patient access for visits, phone calls, and patient portals. “Focus on the patient’s needs as opposed to the provider’s....”

The NCQA PPC-PCMH is a scoring system based on three levels of functionality.

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*The NCQA has evaluated and recognized more than 2,000 primary care practices in the U.S. as Physician Practice Connection-Patient-Centered Medical Homes (PPC-PCMH). Additional information on these standards can be found on the NCQA website at www.ncqa.org.
plans pay to PCMHs on a “per patient per month” basis. It could be as little as a few dollars per patient per month, but cumulatively, for a practice with hundreds or thousands of patients, it would be significant. Potentially, a PCP's revenue could increase dramatically, while the quality of their care improves as well.

“If a practice got three, four, or five dollars per month for every single patient in the practice, then that ends up being a lot of money,” Bagley says. “Depending on the market conditions, there should be some enhanced reimbursement that can come in a number of different forms. It can be ‘enhanced fee for service,’ it can be a ‘care management fee,’ or it could be ‘performance bonus incentives for quality measures.’ We think there has to be a blended payment model where [the revenue] comes from all of these.”

“The people that are going to be successful, whether they’re primary care or hospital folks, or specialty care or imaging doctors, are the ones that are going to be the most adaptable as the system changes,” Bagley says. “They’re going to have to be able to respond to the changing payment incentives. So, if it means extra money for reporting quality measures, you better have a system in place to help you collect those efficiently and send them in, which is one of the meaningful use criteria.”

PREPARING FOR PCMH-DRIVEN HEALTHCARE

Fortunately, the federal government and state governments now agree that medical homes can dramatically improve our healthcare system. Forty states have passed more than 330 laws in support of PCMHs, and the federal government now provides incentive funds to offset the cost of implementing the technology necessary to become a PCMH. At last count, 2,314 practices are recognized by the NCQA as PCMHs. Along with the move toward ACOs, PCMHs bring primary care back to the center of healthcare.

“In 30 years of watching this, I’ve never seen so many people talking about the central importance of primary care to a viable healthcare system, not only for accessibility, but for overall cost savings,” Bagley says. “So, when you hear the politicians, the health plans, and physicians of all stripes all acknowledging that primary care has to be the central focus of the healthcare system, it’s very different from what we’ve heard in the past.”

“All these practice changes can’t be done overnight. It takes time,” he says. “Especially when you’re trying to keep everything pumping the way it is now in the current payment environment. There’s not a lot of time and energy to make all these changes, so you have to do it a little more slowly.”

Nevertheless, Bagley encourages PCPs to make the changes sooner rather than later. “If somebody clicks a switch a year from now and virtually all payments rely on having these capabilities—and you haven’t done anything—you’re going to be scrambling,” Bagley says. “In level one, it’s possible for a practice to do a fair amount without advanced technology,” Waldren says. “So, the first step is to ask if there’s the possibility for a ‘differential payment’ in your area for the medical home, and if so, what’s required. I would focus there first. Then, you’ll know if there are things you can do that will increase your revenue for just being a medical home.

“After that, I would think about the needs of your practice and your patients relative to the different pieces of the medical home, to decide how to focus your efforts for the next step,” he says. “Doing ‘meaningful use’ makes a lot of sense because you get $44,000 [in Medicare incentives],” Waldren says, “and you’re required to do e-prescribing, quality measurements, and some of the patient portal stuff, so you’re already on your way toward achieving the medical home by getting those functionalities into your practice.”

The author has spent more than 10 years as a reporter and writer covering information technology in healthcare. He is the former editor in chief of Health Management Technology magazine. Send your feedback to medec@advanstar.com.