



Implementing Patient-Centered Medical Home Pilot Projects: Lessons from AF4Q Communities

A resource from *Aligning Forces for Quality's Ambulatory Quality Network*

As the patient-centered medical home (PCMH) model emerges as a key vehicle to improve the quality of healthcare and to control costs, many AF4Q communities are implementing pilot programs that promise to reinvigorate primary care as the driver of larger changes within regions.

The widely endorsed 2007 joint principles of the patient-centered medical home, developed by a coalition of professional organizations, focus on the many attributes that make primary care a locus of quality improvement: access to care, enhanced communication between patients and their health care team, and care coordination. The principles also stress evidence-based practice, electronic health records (EHR), and payment models that support these activities.

For AF4Q communities, patient-centered medical home initiatives promise to move the dial on key dashboard indicators, enabling consumer-driven care, activating patient engagement, rationalizing and coordinating processes and ultimately improving outcomes.

At AF4Q's May 2010 national meeting, a panel of AF4Q community leaders shared their experiences with patient-centered medical home pilot programs. Each has a unique perspective on the challenges and opportunities involved in recruiting practices, supporting change and engineering payment models that can sustain medical homes. Read brief summaries below.

The Ambulatory Quality Network: A Learning Community across Communities

Welcome to the first in a series of updates from the Ambulatory Quality Network, a peer learning network designed help communities build the infrastructure for ongoing improvement in primary care. Launched in early 2010, the Network consists of peer-to-peer learning groups, online resources, and direct technical assistance from local and national experts.

PCMH pilot common themes:

» **Collaborative program design and plans for sustainability**

Program success and sustainability often depend on initial investments in multi-stakeholder planning. “It’s all about breaking out of isolation to form relationships,” says Maine’s Lisa Letourneau. Maine’s PCMH pilot was fortunate: it was initially recommended in the State Health Plan, supported by the state legislature, and participated in by multiple healthcare coalitions, payers and other groups. Including such a wide array of stakeholders has increased the project’s visibility and opened opportunities for ongoing financial support.

» **Locale-sensitive recruiting**

Each site planned practice recruitment carefully and in response to local culture, needs and expectations. In Maine, for instance, the project appealed to primary care physicians’ professional motivation rather than financial incentives.

» **Use of NCQA standards**

All of the PCMH pilots discussed here used the National Committee for Quality Assurance (NCQA) PPC-PCMH standards to qualify and quantify care in the medical home. NCQA’s Patient-Centered Medical Home standards are available at no cost, and emphasize the systematic use of patient-centered, coordinated care management processes. In Cincinnati, practices benefited from a specially-trained consultant who helped organize NCQA submissions.

» **Financing**

Across all sites, NCQA recognition has been key to buy-in from insurers, many of whom supported the pilots with both start-up funding and per member, per month payments for the length of the pilot. Sites gained financial support for planning, implementation and evaluation from a host of public and private sources.

» **Struggles with technology implementation**

Implementing new technology was sometimes more difficult and time consuming than originally envisioned. Local know-how and resources created great variability. Western NY practices struggled with the cost of initial investments in EHR and eventually received EHR implementation support from the American Health Information Community (AHIC). Western NY practice enhancement associates (PEAs) are receiving more explicit training in implementing new technology necessary to the PCMH model.

» **Strong ties to measurement and reporting**

“Public reporting is what will get practices’ attention,” says Cincinnati’s Robert Graham, where the Collaborative’s pilot is focusing on five key diabetes measures. Maine is using geomapping to report practice types and the use of nurse managers and registries.

» **The difficulty of culture change**

Establishing patient-centered medical homes is more than a series of incremental changes that lead to practice redesign. It is a continuous process of change that requires profound shifts in culture. Says Graham, “It’s not only about changing processes and structures; it’s about changing attitudes to be more patient-centered, team-based and proactive. It’s changing who you are.”

PCMH Pilot Community Snapshots

Health Improvement Collaborative of Greater Cincinnati

The Health Improvement Collaborative of Greater Cincinnati's medical home pilot involves 11 primary care practices and more than 80,000 covered lives. An AF4Q workgroup that included local health plans, employers and providers worked together for a year to review medical home best practices and plan a model uniquely suited to the region. Three of Cincinnati's major insurers – Anthem, Humana and United Healthcare – were involved in the pilot's design and are reimbursing practices by an agreed-upon, performance-based formula.

Recruitment for the program began in July 2009, and required each practice to do a medical home "IQ assessment" based on NCQA criteria. In fact, participating practices must secure PCMH certification from NCQA to take part in the project. Throughout the course of the pilot, the practices then work toward Level Three certification. A co-pilot group of ten additional practices not chosen for full support during the pilot still have the opportunity to pursue PCMH without support from payers. They will have access to resources through AF4Q, including the group's learning collaborative and some support with NCQA submissions. The model seems to be working: two thirds of the practices have received a level three recognition from NCQA.

A detailed analysis of pilot results will be published at the close of the program, and the PCMH workgroup will work with stakeholders to determine whether and how to spread the model beyond the pilot group.

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PCMH Pilot Community Snapshots

Quality Counts

For the Maine PCMH Pilot, it's all about relationships. Because Maine is a small state with only 450 primary care practices, many of them rural, the PCMH pilot was able to appeal to many practices' need to network and "break out of isolation to form relationships," according to Lisa Letourneau. Leadership relationships with public and private payers and state legislators were also a boon to getting the project off the ground and sustaining it. Says Letourneau, "It's about culture change, leadership and commitment. The professional motivation is more important than the financial motivation."

Primary care practices were invited to apply for the pilot in January 2009; more than 50 practices – 10% of the primary care community in Maine – applied. Like Cincinnati, Maine required practices to complete the American Academy of Family Medicine's free "Medical Home IQ" self-assessment, and asked practices to apply only if they were confident that they would be able to obtain NCQA PPC-PCMH recognition at Level 1 or higher within 6 months of being selected. A committee of providers, consumers, payers and employers selected a diverse group of 22 adult and 4 pediatric practices for the three-year pilot.

All pilot practices committed to achieving national (NCQA) medical home recognition (and have now achieved that), and agreed to make a specific set of 10 changes to meet "Core Expectations" which patients and other experts have identified as critical to delivering more patient-centered care. The pilot offers practices support through a PCMH Learning Collaborative, where leadership teams from each practice meet with each other and national experts to learn about best practices and share experiences. Practices also receive technical assistance and 1:1 QI coaching from a network or external resources.

Maine's Medicaid program and most of the major insurers have agreed to pay the pilot practices differently, endorsing a three-component model that includes a new, up-front "per member, per month" care management fee, continued fee-for-service payments, and payment that recognizes excellent performance by the practice, when possible.

The Maine project is marked by a commitment to using data for improvement, with the Maine Pilot committed to providing ongoing feedback to practices on their patient experience, clinical quality, and costs and resource use (using claims data). "Looking ahead, two of the big issues are capturing the power of patients in redesigning care, and linking current HIT opportunities with the patient-centered medical home," says Letourneau. "We see Regional Extension Centers (REC) and meaningful use as significant opportunities, and need to bring these together with the PCMH."

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PCMH Pilot Community Snapshots

P2 Collaborative of Western NY

Cooperative extension services are a familiar presence in New York's rural counties. P2's eight-county collaborative employs the same model to reach its cadre of sometimes isolated rural primary care practices with the inspiration and tools necessary to work toward today's PCMH model. In Western New York, practice enhancement associates (PEAs) modeled on cooperative extension agents play a key role in bringing improvement initiatives to primary care. Originally used in the United Kingdom and modified by the Oklahoma Physicians Resource/Research Network (OKPRN), PEAs can provide a wide range of support, from helping to improve preventive services and chronic disease management to catalyzing the changes necessary for practice re-design.

According to Ann Abdella, one of 40 primary care practices in Chautauqua County will soon be a PCMH and a half dozen more are willing to pursue the idea by applying for NCQA certification. In spite of good EHR penetration, there are many hurdles to clear before local practices will be ready to seek NCQA recognition. Moving forward depends on small steps. Currently, the Collaborative is working to create diabetes, asthma and kidney disease registries among their network of providers. Says Abdella, "registries are a benign way to get attention when there is resistance to EHR. They can be the first step forward for a reluctant provider to see the benefit of tracking data.

P2's systematic progress toward adoption of a PCMH model began with a telephonic survey that enabled them to give practices A through D rankings of their readiness for transformation. The results showed that while many practices say that they are using EHR, few are using it effectively for clinical care. Abdella's first targets for implementing PCMHs are those practices in the 'A' and 'B' categories, with the hope that 'C' and 'D' practices can be moved along the continuum over several years. Beacon and REC funding are accelerating the pace of change in the region; the Collaborative's next challenge is recruiting and training up to 30 PEAs with the skills needed to help with EHR implementation throughout the region.

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Patient-Centered Medical Home Resources

- » Joint Principles of the Patient Centered Medical Home at the Patient-Centered Primary Care Collaborative
<http://www.pcpcc.net/node/14>

- » Patient-Centered Medical Home resources from the American Academy of Family Physicians
<http://www.aafp.org/online/en/home/membership/initiatives/pcmh.html>

- » Patient-Centered Medical Home resources at the MacColl Institute
http://www.improvingchroniccare.org/index.php?p=Patient-Centered_Medical_Home&s=224

- » NCQA Patient-Centered Medical Home Program
<http://www.ncqa.org/tabid/631/default.aspx>

- » Maine Quality Counts Patient-Centered Medical Home Pilot Project
<http://www.mainequalitycounts.org/about-qc/patient-centered-medical-home-pilot-project-year-one-report-just-released.html>

- » Ensuring Access to a Modern, Medical Home: The Role for a Primary Care Extension Program in Health Reform at the Graham Center
<http://www.graham-center.org/online/graham/home/publications/presentations/2009/kgrumps-spcpf-extension.html>

- » TransforMED patient-centered model
<http://www.transformed.com/>

- » Cincinnati Patient-Centered Medical Home Progress Report
<http://www.the-collaborative.org/Portals/4/docs/AF4Q%20E-newsletter/June%202009/20090630.html>

- » Using practice enhancement associates (PEAs) to support the transition to EHRs at the P2 Collaborative of WNY, Inc.
<http://www.p2wny.org/provider/peas.php>