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AF Williams' "Medical Home" Designation One Step in a Long Journey

By Tyler Smith

So you want to be a patient-centered medical home.

Get in line. The health care world is rife with discussions of how these new organizations will change the way we deliver and receive care. The patient-centered medical home (or PCMH), we're told, will replace the fragmented, inefficient systems we have today with a new model that features teamwork, coordinated care, integrated information systems and population-based disease management.

Ultimately, it will pave the way to a model of reimbursement that rewards providers for quality and outcomes instead of mere volume.

Those are lofty goals, which is why actually creating a medical home is hard, time-intensive work. Just ask the providers and staff at University of Colorado Hospital's AF Williams Family Medicine Clinic. They've made more headway than most in building a PCMH. But they won't hesitate to tell you it's a work in progress.

Late last spring AF Williams, which is based in the midst of the Stapleton small business district, became the first primary care clinic at the hospital to earn "Level 3" recognition as a patient-centered medical home from the National Committee for Quality Assurance (NCQA), a nonprofit organization that advocates for quality-of-care improvements.

The PCMH designation – which is the highest the nonprofit has to offer – is one of several accreditations NCQA awards physicians, medical groups and managed care organizations.

It's also hard to earn. AF Williams went through a rigorous two-year process, said Practice Manager Jeff Raikes, during which Practice Supervisor Cory Gorski had to submit voluminous documentation that showed the clinic met NCQA standards in nine areas *(see sidebar)*.

Achieving the designation, moreover, isn't an end in itself. Rather, it's a milestone in a long-term, hands-on process of redefining how providers deliver care. The goals are fundamental – improve patient access, streamline clinic processes, manage care collaboratively, measure outcomes, particularlyfor patients with chronic conditions, integrate information systems, for example – but there is no single path to success.

Open the pod doors. The core of AF Williams' approach is the "pod" – an area that clusters together teams of physicians, nurses, physician assistants, and medical assistants. The clinic has three

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pods, code-named gold, green and red, each responsible for three rooms per clinical provider.

The pods help to break down communication barriers erected when physicians and staff are scattered throughout the clinic, said Raikes, who wears a radio unit he uses to converse with staff as he roams about the clinic.

"Instead of providers having to look for a medical assistant, for example, the pod positions them adjacent to one another," Raikes noted. But just as importantly, he added, the pod represents a team concept that challenges the idea that a patient has only one provider.

> *"Continuity of care is key," Raikes said. "We have part-time providers; some are closer to full-time. If Dr. [Barbara] Kelly, for example, isn't here, patients get care from another team provider." That means less rescheduling and, perhaps, less anxiety on the part of patients when a particular provider doesn't happen to be in the office at the time of their visit.*

Each pod team meets regularly to discuss issues and opportunities to improve, pulling in care team assistants and other providers who play a role in patient care. A PCMH steering committee provides broader strategic guidance.

"A lot of the PCMH is about efficiency," added Colleen Conry, MD, an AF Williams physician and vice chair of the Department of Family Medicine at the University of Colorado School of Medicine.

In addition to creating the pods, the clinic redesigned its space to make every room the same, Conry said. For example, printers purchased with Family Medicine funds are in every room, in the same spot. The benefit: less running back and forth for documents, moving about the room looking for needed items, and other seemingly small, but time-consuming annoyances.

Conry, a Green Pod member, meets at the beginning of each day with her medical assistants to talk about her schedule and what she might need for her patient visits. "The MAs print out the patient list, write out [the patients'] needs, and have the room ready and all pretesting done before I come in," she said. "That means we can flip patients more efficiently."

Focus on quality. Each pod also works on individual process- and quality-improvement projects. One important effort aims to develop patient registries and devise methods for managing the care of patients with one of three chronic conditions that consume a large portion of health care resources: diabetes, hypertension and obesity.

The goal isn't simply to put the name of a patient with one of these conditions in a database, Raikes said. It's to develop a systematic registry workflow that guides care. For an obese patient (one with a body mass index of 30 or more), for example, that might begin with offering the patient educational materials and making a follow-up call to see if he or she wants to come in for a more focused appointment to address weight management.

From that point, a medical assistant or case manager might direct the patient to weight-management programs. And all the information would be recorded in the registry, and eventually analyzed.

The ultimate goal: collect patient data, pull reports from the registries and measure outcomes of clinical interventions to treat the diseases.

Just a few of the many staff members who helped AF Williams achieve Level 3 patient centered family home recognition from NCQA. Left to right: Ava Hsu, RN; Julie Przekwas, PA; Cindy Connor, Medical Records/CTA; Sabrina Burton, radiographer; Jeanine Currier, charge RN; Tonya Lee, RN; Britney Wolf, MA; Sarah Herrman, MA.

"It's important because of where we need to be as a practice," Raikes stated. "If we are going to take care of patients, we need to be able to help educate them and proactively help them with their lifestyles."

One piece of larger puzzle. The clinic is not an island of PCMH experimentation. In fact, it's part of much broader statewide and even national projects that aim to fashion varieties of medical homes united by common principles.

For example, AF Williams is both a training ground and incubator for ideas for Family Medicine residents, providers and staff. In December 2008, the Family Medicine Department and the state's 10 other family medicine residencies launched the Colorado Family Medicine PCMH Project, with funding from the Colorado Health Foundation.

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The goal: help residency training sites – AF Williams is one – meet the criteria to become federally designated PCMHs.

Family Medicine is one of four project partners, joining the Colorado Association of Family Medicine Residencies, the Colorado Institute of Family Medicine, and HealthTeamWorks, a Lakewood-based nonprofit that focuses on a broad range of health care system improvement initiatives.

The overall project goal is to help residency sites redesign their practices and their curricula, said Nicole Deaner, MSW, HealthTeamWorks Residency PCMH Project Program manager.

"We come into practices to train staff and residents on quality improvement and educate them about PCMH concepts," she explained.

Work in progress. That's not a cut-and-dried task. At a late July steering committee, Deaner joined a broad-ranging discussion between Raikes; Medical Director Kelly; Family Medicine Resident Associate Director Linda Montgomery, MD, and other committee members about the state of the clinic as a PCMH.

The group tackled a variety of issues, including the green pod's progress in creating a registry for hypertensive patients; the status of residents in learning PCMH concepts and developing projects; the importance of strong physician leadership in clinical projects; the challenges of communicating progress on a daily basis – even how to clarify the clinic's core values.

Attending physicians and staff are not the only ones responsible for developing the clinic's medical home program. Residents too play an important role. The Family Medicine residency program, in fact, is one of only a handful in the nation that is part of the Preparing the Personal Physician for Practice (or P^4) program, a six-year demonstration project developed by the American Board of Family Medicine and the Association of Family Medicine Directors.

As a P^4 site, AF Williams provides the setting for residents to complete a three-year course of training that not only educates them in PCMH concepts, but asks them to apply the knowledge to quality-improvement projects (*Insider*, Dec. 15, 2010).

At a meeting at the clinic in early July, residents discussed creating a patient agenda – a one-page form patients would use to identify the reason for their visit, symptoms they want their provider to be aware of, requests for refills and other basic information. Raikes said the clinic hopes to be able to start using the form in the fall.

How to talk, how to pay. One of the knottiest remaining challenges is the financial barrier imposed by today's health care payment system. Chronic disease management, for example, requires lots of follow-up phone calls and emails to answer patients' questions, ensure they receive education, get and take their medications, and so on. Yet payers typically do not reimburse providers for that care.

"It's been shown over and over again that a PCMH approach is cost-effective," Conry said.

> *"But the biggest problem is there is no one to pay for case management. We're trying to keep people out of the hospital, but in the weird financial world we're in, people are hesitant about that."*

She said the clinic is working with Colorado Access, a nonprofit health plan for underserved patients, on a program that would pay clinics a relatively small case management fee, perhaps $1 to $4 per member per month. "We would then use the dollars to plow back into the practice," she said.

Another barrier, Conry said, has been figuring out how to extract data from the patient registries the clinic is building. "Epic captures it, but it's difficult to get it back," she said. For now, Family Medicine clinics are using a software application developed by CINA (Clinical Integrated Network of America) that extracts data from the electronic record (*Insider*, April 8, 2008).

Raikes characterized the buy-in for the PCMH concept among providers and staff as "excellent," adding, "We have residents who say that the reason they chose AFW is because we are a PCMH. It is ingrained in our culture as this is what we do at AFW and how we take care of our patients." But he acknowledged there is still work to be done in that area.

"With part-time providers," he said, "we need to make sure to include them, via email, and when they are in the clinic, get their input. I think everyone accepts what we are doing. The challenge is keeping them informed as to how some changes may affect their workflow." Medical assistants, he said, work closely with providers to help them with that.

The ultimate judge of success, Raikes said, will be how changes the clinic makes take hold. "When we implement new patient-centered processes, sustaining changes and measuring our success will be critical."

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What's a Patient-centered Medical Home?

"A patient-centered medical home integrates patients as active participants in their own health and well-being," the American Academy of Family Physicians said in May, 2008.

"Patients are cared for by a physician who leads the medical team that coordinates all aspects of preventive, acute and chronic needs of patients using the best available evidence and appropriate technology. These relationships offer patients comfort, convenience, and optimal health throughout their lifetimes."

Clearing the Hurdle

To get the NCQA (National Committee for Quality Assurance) to designate it as a Level 3 patient-centered medical home, the AF Williams Family Medicine Clinic had to submit supporting documentation to show it met requirements in nine different categories.

Each section, in turn, had about 30 separate elements, Practice Manager Jeff Raikes said. Clinic Supervisor Cory Gorski uploaded a total of 76 pieces of supporting documentation – ranging from one to 15 pages in length – Raikes said.

The clinic had to pass each section and score at least 75 of 100 possible points. AF Williams' final score was 89.

The sections:

- Section 1 Access and Communication
- Section 2 Patient Tracking and Registry Function
- Section 3 Care Management
- Section 4 Patient Self-Management Support
- Section 5 Electronic Prescribing
- Section 6 Test Tracking
- Section 7 Referral Tracking
- Section 8 Performance Reporting and Improvement
- Section 9 Advanced Electronic Communication