Connecticut Health Policy Project

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Patient Centered Medical Home first adopters: Lessons from three Connecticut practices

On average, Americans receive only 5 percent of recommended health care and only 39 percent of Americans are confident that they can get safe, effective care when they need it[i]. Ninety one percent believe it is important to have one place or doctor responsible for their primary care and for coordinating care between practitioners[ii]. **A key issue in remodeling our health care delivery system is the need for coordination and continuity of care to improve quality and reduce costs.** One answer that is gaining momentum in Connecticut and nationally is the patient centered medical home (PCMH) model. PCMHs encourage care coordination by sharing information, reducing costs, improving efficiency, and engaging patients to make their own health care decisions and keep themselves well. The patient centered medical home model is not a destination but a long-term transformational change in how care is delivered.

If you have better control of chronic diseases you will avert dreaded outcomes, like the loss of vision for diabetes patients, and the risk of complications goes down.

Dr. Edward Rippel, Quinnipiac Internal Medicine, Hamden

The National Committee for Quality Assurance (NCQA) is the largest n PCMH accrediting body in the nation. **Connecticut has far fewer NCQA recognized PCMHs than neighboring states but the number is growing.** Connecticut's Medicaid program has had a PCMH-related option for two years, Primary Care Case Management and the state employee plan is implementing a large pilot PCMH pilot program for their members.

Connecticut practices face a number of challenges in implementing the PCMH model; **there are lessons to be learned from PCMH first adopters in the state who are leading the way for the model's expansion**. For this report we chose to interview a small practice, a large practice, and a safety net provider, each of which has recently achieved PCMH recognition by NCQA, the largest national PCMH accrediting body in the nation. We identified both common and unique challenges, solutions, and benefits that these providers faced throughout the process. Each of the three practices that we interviewed has done something novel in their adoption of the PCMH model. They have experienced similar challenges and successes. Their different methods of addressing those challenges as well as the paths they took toward practice transformation, are informative to state policymakers and other practices considering becoming a PCMH.

These practices shared a number of questions and concerns before they implemented the PCMH model; however, they all found ways to overcome these challenges.

Common Challenges	Solutions
Motivation and prioritization across the organization	> Strong administrative and clinical leadership >Designate staff to optimize work flow > Make PCMH an organizational priority >Avoid competing projects
Cost	> Streamlined work flows allowed for greater productivity > Practice management/electronic billing in-house > Government and insurance incentives
Coordinating care within the practice and beyond	>Effective use of EMR systems
Training	> “train, maintain, retrain” >Create practice handbooks that explicitly describe internal processes so that anyone in the practice can look up questions, and any new employees can learn quickly

A common challenge that these practices encountered was in making care coordination the top priority for the organization and gaining the strong commitment throughout the organization that is necessary to succeed. They each found that having strong clinical and administrative leadership overcame this challenge. All three organizations found that the cost of PCMH implementation was easier to recoup than expected. Through streamlined work flows and government/insurance incentive programs, all three practices were able to decrease costs and increase revenue. These practices also found that true care coordination, between primary care providers, staff, and other providers, was easily attained once all staff effectively learned to use the electronic medical record (EMR) system. An ongoing challenge facing these practices is the need to train staff, maintain that training, and retrain new staff. An internal handbook of PCMH processes within the organization was helpful in allowing current staff to look up any questions, and providing new staff with a tool kit to improve continuity of care. These solutions have helped each of these very different practices accomplish their common goal: to successfully implement a patient centered medical home, improve practice efficiency, and enhance the delivery of care to patients.

All three practices described similar benefits as a result of PCMH implementation.

Common benefits	How
Improved patient outcomes	> Coordinated care allows the provider timely access to critical information >Staff has more time to devote to supporting patients in managing their own health
Reduced costs/increased revenues	>Streamlined work flows >in-house billing >government and insurance pay-for-performance incentives >e-prescribing programs > increased patient volume
Efficiency of staff	>no more pulling charts or filing lab reports >less administrative time for busy providers

Each practice has found measurable improvements in patient compliance and health outcomes. These practices have benefited from reduced costs and increased revenues. The initial costs of implementation were recouped relatively quickly. All of these practices found that they are significantly more efficient as a result of implementation of the PCMH model.

A special concern for Connecticut is that 50 to 62 percent of physicians in the state are in solo practices, and between 70 and 88 percent of Connecticut physicians are in practices of four or fewer[iii]. **One common misconception about PCMHs is that it doesn't work for small practices. Dr. Edward Rippel of Quinnipiac Internal Medicine in Hamden was the first solo practitioner in Connecticut recognized by the NCQA PCMH program.** He is currently recognized at level 3, the highest level awarded by the NCQA. Dr. Rippel adopted EMR software in 2006 as a tool to better manage patient care. He began using an EMR because of his vision of how he wanted to practice primary care. That vision included providing preventative care and chronic disease management in a coordinated and consistent model. Dr. Rippel noted that, "If you have better control of chronic diseases you will avert dreaded outcomes, like the loss of vision for diabetes patients, and the risk of complications goes down." A simple database query through his EMR system can instantly provide information on which patients he needs to contact to follow up about sugar levels or cholesterol testing. Improved follow up has led to better health outcomes for his 3,000 patients. **For example, 100 percent of his patients with**

cardiovascular disease are now consistently taking stroke prevention medication. Before PCMH adoption close to 50 percent of his diabetic patients had hemoglobin A1c levels at treatment goal; now that number is up to 70 percent.

Since the PCMH transformation Dr. Rippel's staff no longer wastes time pulling charts and filing lab reports; they are able to spend their time helping patients manage their health. Following a check-up, Dr. Rippel can complete an electronic report for a healthy adult in just a few clicks, freeing up time to spend with patients who need it most. Although there was an upfront cost to adopt the PCMH model, his practice recouped the costs within two years through associated savings and revenue enhancements resulting from streamlined work flows and greater productivity. An additional source of savings came from moving medical billing in-house rather than outsourcing; "Since our EMR has a practice management module built into it, we can do electronic billing for a whole day's work in *fifteen* minutes." This small practice has also increased revenues as a result of the PCMH transformation from government and insurance pay-for-performance programs, e-prescribing government incentives, and increased patient volume. Dr. Edward Rippel has demonstrated that even small practices in Connecticut can adopt the PCMH model and share in its benefits.

Safety net providers and their at-risk patient populations have the most to gain from the PCMH model. Community health care centers, as a mainstay of Connecticut's health care safety net, are very well positioned to adopt this model of health care delivery. Rising demand for services, tightening resources, and complex patients make the efficiencies and care coordination of PCMHs critical to sustainable success and improved health outcomes at safety net provider practices. **Community Health Center (CHC) Inc. is one of the largest health care providers in Connecticut;** with a special commitment to uninsured and underinsured populations. They have twelve stationary locations and two mobile centers that currently serve over 130,000 patients. CHC Inc. first considered the use of the PCMH model back in 2004, before the NCQA began their recognition program. However they did not apply for formal recognition until 2011, when revised standards expanded the definition of a primary care provider to include nurse practitioners and physician assistants, a critical part of the care team at community health centers. The PCMH commitment at CHC Inc. came from the top, gaining support among the senior clinical staff before being accepted by the entire practice. The key challenges facing their practice are creating a sustainable foundation for true care coordination between all of the different parts of their practice and ensuring that the model is sustained over time. CHC Inc. has found that it is a constant challenge to "train, maintain, and retrain" staff in EMR use and care coordination, making it difficult to retain the continuity that is essential for the practice to succeed. Senior Vice President and Clinical Director of CHC Inc., Margaret Flinter believes that, "the PCMH model is essentially a model of really good primary care; in the community health center setting.

The PCMH model is essentially a model of really good primary care in the community health center setting

Margaret Flinter, APRN
Community Health Center, Inc.

It's a really good model of community oriented primary care that goes further to acknowledge the particular and unique needs of the neighborhood, community and target population." Efficient care coordination through PCMHs is the ideal delivery model for community health centers in Connecticut.

ProHealth Physicians, a large private practice in Connecticut with over 300 primary care providers that see 292,000 patients in Connecticut is also adopting this model of care for all their patients. Building on their adoption of EMRs, ProHealth looked forward to improve clinical outcomes, track tests and referrals, and share information among providers. To align these goals, ProHealth chose to pursue PCMH recognition as the first step toward becoming a medical home. Similar to the experience at CHC Inc., ProHealth found that strong leadership commitment was crucial. They approached the entire process as a team effort of four key staff focused on making the transition successful. These leaders were instrumental in gaining commitment within the organization to improve coordination of care. ProHealth learned that becoming a PCMH must be a comprehensive organizational objective including designating staff to develop optimized work flows that address the PCMH requirements. Cheryl Lescarbeau, VP of Clinical Performance noted, "it is important to ensure that providers understand why this transformation is critical and avoid competing large projects and priorities to enable everyone to focus on PCMH as the single most important transformation objective. Clinical leadership and engagement are critical success factors."

Clinical leadership and engagement are critical success factors
Cheryl Lescarbeau, VP Clinical Performance
ProHealth Physicians

Each of these practices has implemented the PCMH model in a unique environment that makes sense for their patients -- whether it's creating a solo practice PCMH, a community based safety net PCMH, or a turning a large primary care practice into PCMHs. The lessons they've learned are the foundation for the model's expansion across Connecticut. These successes demonstrate how effective care coordination can improve delivery of care and health outcomes while reducing costs for practices and Connecticut's entire health care system.

Kimberly Kushner
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2011 CT HPP Interns
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[i] Commonwealth Fund Biennial Health Insurance Survey, 2007; McGlynn, et. al., "The Quality of Health Care Delivered to Adults in the United States," New England Journal of Medicine, 348: 2635-2645, 6/26/03.
[ii] How, SK, et. al., "Public Views on US Health System Organization: A Call for New Directions", Commonwealth Fund Data Brief, August 2008.
http://www.commonwealthfund.org/Content/Publications/
Data-Briefs/2008/Aug/Public-Views-on-U-S--Health-System-Organization--A-Call-for-New-

Directions.aspx

[iii] Andrews, E and Westbrook, T; SustiNet Patient Centered Medical Home Advisory Committee Final Report, July 2010.