MCKESSON

White Paper

Best Practices Content: Patient-Centered Medical Home (PCMH)

Providers want to deliver – and patients deserve – personalized care. Key to this objective is that patients and their primary care practices (PCPs) take the time to form partnerships to develop coordinated, focused care plans. Many patients and their families, however, depend on their providers to develop and maintain their care plans. Though providers want to perform this responsibility, they face administrative and technical challenges in today's complex healthcare environment that can reduce the amount of time they spend with patients.

About PCMH

With the patient-centered medical home (PCMH) model, practices can transform their patient care – and physician vitality. PCMH is a proven care model created by four major primary care associations – the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics, the American College of Physicians and the American Osteopathic Association – with input from the nation's largest employers, including McKesson.

As its name denotes, the focus of the PCMH model is patients. Primary care physicians oversee all aspects of patient care, including coordination of specialists (for example, physicians, nurses, and nutritionists). This patient focus follows the core principles of PCMHs to improve quality and safety, increase patient engagement and maximize provider efficiencies, while lowering costs.

Providers and patients benefit from their collaborative experience in the PCMH model. Providers can manage their time to build lasting partnerships with patients, and, when appropriate, their families. These partnerships result in coordinated and/or integrated primary care, including chronic condition management, for children, youth and adults that is comprehensive and focused.

Accordingly, patients become proactive in their medical care when they can count on their primary providers to know them, to listen to them and to address their health issues efficiently and accurately.

McKesson Practice Care™ PCMH Services

McKesson Practice Care PCMH Services is a collaborative effort between McKesson Corporation and TransforMED™. TransforMED is a non-profit, independent subsidiary of the American Academy of Family Practice, and its mission is the transformation of healthcare delivery to achieve optimal patient care, professional satisfaction and success of primary care practices. McKesson is a reseller of the TransforMED services for small practices. In addition, TransforMED provides consulting input on McKesson's EMR design to allow for easier and faster adoption of the PCMH model. The McKesson Practice Care™ PCMH Service is also a member of the Patient-Centered Primary Care Collaborative. The mission of the Collaborative is to advance an effective and efficient health system built on a strong foundation of primary care and the PCMH. The Collaborative adheres to the Joint Principles of the PCMH (http://www.pcpcc.net/joint-principles), and drives ongoing communications between providers and patients.

Becoming a PCMH and PCMH Components

The following sections cover the components a practice must follow to achieve PCMH Recognition.

McKesson Practice Care PCMH Services can help your practice achieve PCMH recognition from one of the governing bodies and position your practice for internal success as well as for the potential incentives from public and private payors for improving cost and quality metrics.

For more information on the Patient-Centered Primary Care Collaborative, visit http://www.pcpcc.net/who-we-are. For information on McKesson Practice Care™, visit http://www.mckessonpracticesolutions.com/ehr-solutions/medical-practice-care.

Becoming a PCMH and PCMH Components

To achieve PCMH Recognition, a healthcare organization must earn accreditation according to a specified set of standards from a medical home recognition or accreditation program that adheres to the joint Guidelines for Patient-Centered Medical Home Recognition and Accreditation Programs. These guidelines build on the Joint Principles of the PCMH.

The following organizations offer PCMH accreditation programs:

- National Committee for Quality Assurance (NCQA)
- URAC (formerly the Utilization Review Accreditation Commission)
- Joint Commission
- Accreditation Association for Ambulatory Health Care (AAAHC)

For more information on the requirements to achieve PCMH Recognition, visit http://www.mckessonpracticesolutions.com/ehr-solutions/medical-practice-care.

PCMH Standards

While each accrediting body has its own version of PCMH requirements, they all adhere to the Joint Principles. The NCQA is the most popular accreditation program, currently with over 20 thousand providers having achieved some level of recognition. The NCQA has three (3) levels of recognition with level III being the highest. Each level reflects the degree to which a practice meets the requirements of the elements and factors that compose the standards. For each element's requirements, the NCQA provides examples and requires specific documentation. The NCQA Recognition levels allow practices with a range of capabilities and sophistication to meet the standards' requirements successfully. The point allocation for the three levels is as follows.

- Level 1: 35–59 points and all 6 must-pass elements
- Level 2: 60–84 points and all 6 must-pass elements
- Level 3: 85–100 points and all 6 must-pass elements

Following is a high-level description of the NCQA's six PCMH guidelines for 2011, the current set of recognition standards:

Table 1: Summary of NCQA PCMH 2011 Standards

Standard	Content Summary
Enhance Access/Continuity	• Patients have access to culturally and linguistically appropriate routine/urgent care and clinical advice during and after office hours • The practice provides electronic access • Patients may select a clinician • The focus is on team-based care with trained staff
Identify/Manage Patient Populations	• The practice collects demographic and clinical data for population management • The practice assesses and documents patient risk factors • The practice identifies patients for proactive and point-of-care reminders
Plan/Manage Care	• The practice identifies patients with specific conditions, including high-risk or complex care needs and conditions related to health behaviors, mental health or substance abuse problems • Care management emphasizes: – Pre-visit planning – Assessing patient progress toward treatment goals – Addressing patient barriers to treatment goals • The practice reconciles patient medications at visits and post-hospitalization • The practice uses e-prescribing
Provide Self-Care Support/ Community Resources	• The practice assesses patient/family self-management abilities • The practice works with patient/family to develop a self-care plan and provide tools and resources, including community resources • Practice clinicians counsel patients on healthy behaviors • The practice assesses and provides or arranges for mental health/substance abuse treatment
Track/Coordinate Care	• The practice tracks, follows-up on and coordinates tests, referrals and care at other facilities (e.g., hospitals) • The practice follows up with discharged patients
Measure/Improve Performance	• The practice uses performance and patient experience data to continuously improve • The practice tracks utilization measures such as rates of hospitalizations and ER visits • The practice identifies vulnerable patient populations • The practice demonstrates improved performance

McKesson Practice Care can help your practice meet the specific elements in the standards from the NCQA to achieve PCMH recognition. For information, contact McKesson Practice Care PCMH Services.

Financial Incentives

In addition to providing patient-focused, collaborative care, practices that achieve PCMH Recognition can take advantage of financial incentives offered by health plans and employers, as well those of federal and state-sponsored pilot programs.

Many payors have recognized the financial contribution that the PCMH model can have on reducing healthcare costs and are rewarding PCPs for adopting the model. For example, Wellpoint, the nation's largest commercial payor, has committed $2B between 2012 and 2014 to accelerate the PCMH model with its PCPs. Nearly half of those dollars have been allocated for PCP incentives.

Following are examples of how payors are financially rewarding PCPs for adopting the PCMH model:

- **Enhanced fee for service (FFS):** A payor increases fee for service reimbursement for a practice that achieves PCMH Recognition. This is often in the form of a specified percentage increase based on achieving certain levels of recognition.
- **Care coordination fee:** A payor provides a per-patient, per-month fee to help fund the hiring of a Care Coordinator within the practice. In some cases, a payor may actually provide a Care Coordination resource.
- **Shared savings bonus:** Because of the savings realized by the payor via reduced ED visits, reduced hospitalizations or unnecessary interventions, the payor will often use a portion of those savings to reward the contributors of high-performing PCPs.

The amount and type of incentives varies by state and payor. McKesson Practice Care will help you identify PCMH incentive opportunities that may exist in your geography and, through our sister company McKesson Health Solutions, we can help provide your payor with the necessary tools to make the PCMH model more impactful.

For more information regarding McKesson Practice Care and the Patient Centered Medical Home, visit http://www.mckessonpracticesolutions.com/ehr-solutions/medical-practice-care.