Patient-Centered
Primary Care
COLLABORATIVE

"Improving Patient-Centered Medical Home (PCMH) Recognition: Board-Endorsed Recommendations of the PCPCC Accreditation Work Group"

Patient-Centered Primary Care Collaborative
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BACKGROUND:

The ideal attributes of the patient-centered medical home (PCMH) need a timely update. The concept appears to have different meaning to patients and consumers, health care providers, and payers/health plans. Likewise, the meaning (and purpose) of the current recognition/certification processes for PCMHs can be equally confusing. For example:

- Patients and consumers may assume that a certified medical home is a "good housekeeping seal of approval" limited to those practices that demonstrate the ideal attributes – or outcomes – of a PCMH.
- Sometimes primary care providers assume that investing in PCMH certification will provide them with guidance on achieving transformation to become a "high-performing advanced primary care practice." Given their limited time and capacity, they expect PCMH certification to lead to increased reimbursement, better patient care, and leverage the skills of their entire practice team.
- Employers and health plans would like to assume that PCMH-certified practices have differentiated themselves through an external validation process that demonstrates the delivery of advanced primary care, making the practice eligible (depending on the payer) for increased payment and/or preferred network status.
- More recently, Medicare assumes that the PCMH will serve as an "Alternative Payment Model" that qualifies an eligible practice for value-based reimbursement under the recently passed Medicare payment reform law (MACRA), as well as a measure of quality improvement. The rules around "who" may be a medical home are under development.

Imagine a primary care practice beginning its journey to become a patient-centered medical home, focused on the long-term goal of Triple Aim outcomes. Where do they begin and how do they connect the dots from the vision of the Triple Aim to "certification" as a PCMH? Are they following a specific roadmap or sequential process in order to succeed – and is that the same roadmap as the "test" required to become certified? Or is it putting that knowledge into practice and achieving outcomes that gets you "certified?" Can a practice be certified but not transformed? And finally, when practices do pass the certification "exam," what does it mean in terms of expectations for increased reimbursement?

CREATION AND CHARTER OF THE ACCREDITATION WORK GROUP:

The PCPCC Board of Directors asked staff to convene a select group of experts in patient-centered advanced primary care to help identify the opportunities and challenges of the current PCMH certification/recognition

process, especially at it pertains to the public – patients, consumers, employees, and employers/health plans – as well as to primary care practices. To inform this effort, the PCPCC Accreditation Workgroup was formed in July 2015.

Directive from the PCPCC Board: Due to growing concern about PCMH certification/recognition potential lack of alignment with meaningful primary care practice transformation, the PCPCC Board of Directors requested a diverse workgroup of recognized leaders[i] to:

- **Identify and analyze opportunities** in the current PCMH certification/recognition marketplace, especially as it relates to meaningful and ongoing primary care practice transformation; i.e. *identify the aspirations of the medical home model of care [with an eye toward the public];*
- **Identify and analyze challenges**, to include administrative burden, in the current PCMH certification/recognition marketplace; i.e. *identify where there are needed improvements in the current approach and/or standards;*
- **Provide the PCPCC Board of Directors with recommendations** that can be used to *help inform PCPCC advocacy efforts concerning public and private sector policies* that promote the PCMH model of care *(aspirational goal).*

Workgroup activities:

The PCPCC Accreditation Workgroup met several times over four months through a combination of in-person and virtual meetings. Technical advisors were consulted throughout the process and had an opportunity to provide verbal and written comments. On November 11, 2015, the co-chairs of the group presented draft recommendations to the PCPCC Board. After discussion (and minor editing) the Board of Directors enthusiastically approved the following recommendations:

Recommendation 1: Consensus Statement

PCMH recognition should ultimately be a "good housekeeping seal of approval" demonstrating achievement of the attributes (outcomes) ensuring consumer confidence in the practice and its clinicians. Recognized practices should be rewarded with increased payment or participation in other "preferred programs."

In the immediate term, recognition should focus on a simplified set of evidence-based "change concepts"[1] (processes) that lead to achievement of the PCMH attributes (outcomes), and a less administratively burdensome way to recognize that practices have mastered the change concepts (and are therefore likely to reflect attributes of an ideal PCMH).

Recommendation 2: Guiding Principles to Improve PCMH Recognition

A. Align all recognition programs with the attributes/outcomes of the ideal PCMH (in PCMH definitions, such as AHRQ & Joint Principles of PCMH)
    a. Clarify language around PCMH recognition to describe its purpose (accreditation, certification, qualification, etc.)
    b. Update attributes (outcomes) of PCMH to include AWG additions[ii]

[1] "Change concepts" are general ideas/directions for transforming a practice to stimulate specific, actionable steps that lead to improvement. (Wagner EH, Coleman K, Reid R, Phillips K, Sugarman JR, 2012, *Guiding Transformation: How medical practices can become patient-centered medical homes*, published by The Commonwealth Fund, February)

c. Acknowledge that PCMHs are foundational to ACOs and other organized, integrated health systems and primary care teams should be included in shared savings/financial incentives models

B. Identify "change concepts" most essential to achieving the attributes/outcomes
   a. Identify (through continued research) those change concepts that result in attributes, in the most parsimonious/simple manner (as demonstrated by the evidence)
   b. Include AWG recommendations in "change concepts" (process)

C. Promote change concepts that result in PCMH attributes/outcomes
   a. Re-focus recognition programs toward PCMH attributes and essential change concepts
   b. Reference to public sector payment reforms (increased value-based reimbursement through MACRA, etc.)
   c. Reference to private sector payment reforms (increased value-based reimbursement, benefit redesign, tiered networks, etc.)

D. Support a pathway for Technical Assistance (TA) for recognition
   a. TA is outside scope of AWG project (because TA does not have to be part of recognition) but its role is critical – must have an "on ramp" for practices wanting to transform
   b. Acknowledge role of multi-payer initiatives (e.g. CPC, MAPCP, SIM), Transforming Clinical Practices Initiative (TCPI)

Recommendation 3: For PCMH Accrediting Organizations – Recommended Improvements in PCMH Recognition

1. **Reduce the level of specificity**: focus more on the spirit/intent of the PCMH model; be less prescriptive and incentivize innovation.
2. **Push for parsimony**: focus on the essential change concepts for high-performing practices; recognize that practices begin at different starting points (i.e. fewer requirements for more advanced practices).
3. **Use aligned measures** from an evidence base that assesses: patient experience and quality outcomes; professional and staff satisfaction; cost efficiency/value for patients, payers, & providers.
4. **Simplify documentation reporting requirements**, make them reciprocal across various programs, aligned across accreditors (by all payers), and a logical by-product of high quality care (not an add-on).
5. **Move toward performance** demonstrating adoption of PCMH policies/procedures and away from documentation of policies and procedures.
6. **Apply recognition standards to all patients** and not just to a subset of high-risk, high-cost patients.
7. **Recognize established national/regional recognition entities** who have developed successful PCMH models that are supported by payers and providers in the region.
8. **Develop and use better quality measures** related to attributes/outcomes (such as wellness and function).
9. **Develop better methodologies** to measure change concepts or outcomes.

FOR ADDITIONAL REVIEW:

The PCPCC Board reviewed but did not specifically approve the Supportive Actions to Improve PCMH Recognition developed by the AWG (as it fell outside of the scope of the directive), but encouraged further development of these actions by staff and stakeholders in order to facilitate adoption of the AWG recommendations.

Supportive Actions to Improve PCMH Recognition and Adoption of the Model by Health Care Stakeholder Organizations:

Stakeholder	Actions to accelerate & reward PCMH certification	Critical factors necessary to scale and spread the PCMH model

A. Payers (Employers, Health Plans, Government)	• Promote change concepts that result in PCMH attributes/outcomes
	  ○ For public sector payment reforms (increased reimbursement through MACRA, SIM etc.)
	  ○ For private sector payment reforms (increased reimbursement, benefit redesign, tiered networks, etc.)
	• Invest in the development and use of better quality measures (attributes) and better methodologies to measure change concepts
	• Support research of essential change concepts, outcomes measures
		• *Support PCMHs as foundational to ACOs and other organized, integrated health systems and include primary care teams in shared savings/financial incentives model*
		• *Harmonize quality metrics/measures across payers*
		• *Support risk-adjusted comprehensive payment plus shared financial risk/savings on total cost of care to incentivize PCMH care*
		• *Invest in the development of better quality measures (attributes) and better methodologies to measure change concepts*
		• *Raise public awareness of the PCMH model and its ability to advance the Triple Aim*
		• *Support practices need for transparent, real-time, meaningful integrated data at the point of care that follows the patient across multiple sites of care*
		• *Acknowledge that practices want transparent, prospective attribution*
		• *Acknowledge that practices need support as they transition to this model of care (financial, peer support, learning collaboratives – consistent with goals of CPC, MAPCP, TCPI, SAN)*

B. Policymakers	• Promote change concepts that result in PCMH attributes/outcomes • For public sector payment reforms (increased reimbursement through MACRA, SIM, etc.) • Support pathway to Technical Assistance (TA) for certification • Outside scope of AWG (because TA does not have to be part of certification) but its role is critical – must have an "on ramp" for practices • Acknowledge multi-payer initiatives (e.g., CPC, MAPCP,	• *Support risk-adjusted comprehensive payment plus shared financial risk/savings on total cost of care to incentivize PCMH care* • *Support PCMHs as foundational to ACOs and other organized, integrated health systems and include primary care teams in shared savings/financial incentives models* • *Recognize that additional resources are required to facilitate change in smaller practice* • *Support harmonization of quality metrics/measures across payers* • *Invest in the development of better quality measures (attributes)* • *Build public awareness of the PCMH model and its ability to advance the Triple Aim* • *Provide for support for practices as they transition to this model of care (financial, peer*

	SIM), Transforming Clinical Practices Initiative	*support, learning collaboratives – consistent with goals of CPC, MAPCP, TCPI).* • *Support practices need for transparent, real-time, meaningful integrated data at the point of care that follows the patient across multiple sites of care*
C. Clinicians (Individual practices and/or Health professions associations)	• Work with stakeholders to update PCMH governance documents (consistent with the AWG recommendations) • Embrace the culture of PCMH and a quality improvement learning culture (patient-centered and high performing care) • Seek out, and get engaged in local, regional, state-led, or federal continuous quality improvement efforts • Assist researchers with identifying change concepts that best lead to attributes. • Involve patients and families as partners in transformation and ongoing improvement efforts. • Implement population health infrastructure and use data to drive improved health across patient populations	• *Develop new business and organizational skills to thrive in alternative payment models (APM)* • *Improve connections with community supports/community-wide efforts to improve health of population* • *Get involved in local, state, and national health care delivery reform efforts, including payment reform.* • *Build public awareness of the PCMH model and its ability to advance the Triple Aim* • *Transparent, real-time, meaningful data at the point of care that includes data across care settings (that follows the patient)* • *Support and contribute to the development of new outcomes-oriented quality measures* • *Push for the need for transparent, real-time, meaningful integrated data at the point of care that follows the patient across multiple sites of care*
D. Patients, families, consumers & caregivers (and the organizations representing them)	• Work with stakeholders to update PCMH governance documents consistent with the AWG recommendations • Assist researchers to identify those change concepts that lead to improvements in attributes important to patients & families • Collaborate with practices in transformation and ongoing quality improvement	• *Improve connections with community supports/community-wide efforts to improve health of population* • *Build public awareness of the PCMH model and its ability to advance the Triple Aim* • *Engage in local, state, and national health care delivery reform efforts, including payment reform* • *Push for transparent, real-time, meaningful integrated data that follows the patient across multiple care settings*

E. Academia (Researchers)	• Update attributes (outcomes) of PCMH (AHRQ) consistent with AWG recommendations • Identify the change concepts most essential to achieving the attributes/outcomes • Update change concepts to reflect AWG additions • Identify (through continued research) those change concepts that result in attributes, in the most parsimonious/simple manner • Identify ways in which to better use data for quality improvement purposes at multiple levels: the point of care (patient, clinician level); the system level; and the payer level. • Support research related practices need for transparent, real-time, meaningful integrated data at the point of care that follows the patient across multiple sites of care	• *Provide training of existing and incoming workforce – need additional skills related to PCMH care, promoting primary care and interprofessional education* • *Assist in development of quality metrics/measures that can be harmonized across payers* • *Garner support from public health on population data sets (to help inform community health goals)* • *Help develop key public messages that effectively raise public awareness of PCMH* • *Examine new innovations in care (telehealth, patients as partners in QI, retail clinics, mobile applications, etc.) and ways to best integrate the innovations into primary care in order to achieve the Triple Aim*
F. Business - marketplace	• Work with stakeholders to update PCMH governance documents (consistent with the AWG recommendations) • Push for interoperability across EHRs and other technology platforms • Improve/update technology to support population health management to drive quality improvement; current EMR/EHR (driven by FFS coding) is not sufficient, not centered on patient care, nor supportive of population health • Support practices need for transparent, real-time, meaningful integrated data at	• *Support PCMHs as foundational to ACOs and other organized, integrated health systems and include primary care teams in shared savings/financial incentives model* • *Support harmonization of quality metrics/measures across payers* • *Improve connections with community supports/community-wide efforts to improve health of population* • *Support risk-adjusted comprehensive payment plus shared financial risk/savings on total cost of care in order to incentivize PCMH care*

	the point of care that follows the patient across multiple sites of care	

[i] Co-Chairs

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AHRQ + AWG	Definition from AHRQ + AWG Definition of Attribute
Person, **Family, Caregiver** centered	**A partnership among practitioners, patients, and their families ensures that decisions respect patients' wants, needs, and preferences, and that patients have the education and support they need to make decisions and participate in their own care.** The practice develops patient-driven and/or co-created health goals, through trusted relationships and compassionate partnership. The practice measures and takes action to advance health equity across its diverse patient populations.
Comprehensive	**A team of care providers is wholly accountable for a patient's physical and behavioral health care needs, including prevention and wellness, mental health, acute care, and chronic care.** The care is planned, proactive, longitudinal, and addresses the whole person (from preventive care to behavioral health and more).
Accessible	**Patients are able to access services with shorter waiting times, "after hours" care, and/or same day.** "The practice is there for me when, where and how I need you."
Coordinated	**Care is organized across all elements of the broader health care system, including specialty care, hospitals, home health care, community services and supports.** The practice makes a proactive effort to coordinate care across providers, settings, and community-based services, with shared information and knowledge.
High-Performing	The care team demonstrates positive health outcomes, patient and family experiences, professional and staff satisfaction, and enhanced value and/or cost-effectiveness.
Connected	The cohesive care team is connected with patients and families, system, medical neighborhood and community.
~~**Committed to quality & safety**~~	~~**Clinicians and staff enhance quality improvement through the use of health IT and other tools to ensure that patients and families make informed decisions about their health.**~~

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