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Rural Health Clinic Readiness for Patient-Centered Medical Home Recognition: Preparing for the Evolving Healthcare Marketplace [Policy Brief]

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Purpose

The patient-centered medical home (PCMH) model both reaffirms traditional primary care values such as continuity of care, connection with an identified personal clinician, provision of same day- and after-hours access and also prepares providers to succeed in the evolving health care system by focusing on accountability, continuous quality improvement, public reporting of quality data, data exchange, and patient satisfaction. However, little is known about the readiness of the over 4,000 Rural Health Clinics (RHCs) to meet the PCMH Recognition standards established by the National Council for Quality Assurance (NCQA). This policy brief reports findings from a survey of RHCs that examined their capacity to meet the NCQA PCMH requirements, and discusses the implications of the findings for efforts to support RHC capacity development.

Background: Transformation of Primary Care Practices to PCMH

While originally developed to renew the practice of family medicine by developing provider-led, integrated care delivery teams that engage patients and their families in their preventive, acute, and chronic care, the PCMH model has become a widely accepted strategy to prepare primary care practices to cope with the changing demands of the healthcare marketplace. As envisioned by some health reform experts, PCMHs are considered essential for the ability of health care organizations to meet financial savings and quality improvement targets.[1,2]

As a result, there has been growing policy interest in promoting the transformation of primary care practices to PCMHs, with the 2010 Patient Protection and Affordable Care Act providing financial incentives to encourage PCMH implementation.[3,4] The emerging literature on PCMH transformation identifies numerous barriers to widespread adoption of the model, especially in smaller primary care practices such as RHCs, including: chronic shortages of primary care clinicians, limitations to the primary care practice infrastructure, insufficient health information technology capacity in primary care settings, and limited progress in revising reimbursement policies for primary care.[5,6] Our past work on RHC adoption and meaningful use of electronic health records (EHRs) strongly suggests that RHCs will face the same barriers, all of which typify the rural healthcare environment.[7]

PCMH Recognition Standards

In 2008, NCQA released its PCMH Recognition tool, which laid out standards through which physician practices could be recognized as PCMHs.[8] This tool has become the "de facto standard for Recognition

Key Findings

Based on their performance on the "must pass" elements and related key factors, Rural Health Clinics (RHCs) are likely to have difficulties gaining National Center for Quality Assurance's (NCQA) Patient-Centered Medical Home (PCMH) Recognition.

RHCs perform best on standards related to recording demographic information and managing clinical activities, particularly for those using an electronic health record.

RHCs perform less well on improving access to and continuity of services, supporting patient self-management skills and shared decision-making, implementing continuous quality improvement systems, and building practice teams.

RHCs are likely to need substantial technical assistance targeting clinical and operational performance to gain NCQA PCMH Recognition.

For more information about this study, contact John Gale at jgale@usm.maine.edu

This Research & Policy Brief is based on a longer Working Paper. To view the full report, please visit the Maine Rural Health Research Center at:
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as a PCMH although alternative recognition programs have been developed by the Joint Commission, the Utilization Review Accreditation Commission, and the Accreditation Association for Ambulatory Health Care."[4,9,10] NCQA's PCMH 2011 standards are focused on practices' capacity to:

1. ensure patient access to care and care continuity;
2. identify and manage patient populations;
3. manage care;
4. support patient self-management;
5. track and coordinate care; and
6. participate in performance measurement and quality improvement.

These six standards include 28 elements with multiple individually scored factors under each element for a total 100 points.[11] Within each standards area, one element is designated as "must pass" with a score of 50 percent or higher to achieve PCMH recognition. The six "must pass" elements are:

PCMH 1, **Element A:** Access during office hours;

PCMH 2, Element D: Use data for population management;

PCMH 3, Element C: Care management;

PCMH 4, Element A: Support self-care process;

PCMH 5, Element B: Referral tracking and follow-up; and

PCMH 6, Element C: Implement continuous quality improvement.

RHC Survey

To assess RHCs' readiness to be recognized as PCMHs, we surveyed a random sample of 488 RHCs using an instrument focused on the key features of the NCQA PCMH Recognition tool. We received 225 responses for a 46.7 percent response. Although the relatively small "n" for most subsets of responses makes it difficult to generalize from our findings, the responses suggest some of the key strengths and weaknesses RHCs will face in seeking PCMH recognition.[12] Given the complexity of the NCQA Recognition framework and the need to maintain a reasonable survey length, we did not address every element and factor. Instead, we aligned our questions with the core concepts and characteristics of NCQA's PCMH model.

NCQA's 2011 PCMH Recognition tool emphasized the use of EHRs to manage patient care by integrating the Office of the National Coordinator for Health Information Technology-defined Stage One Meaningful Use measures into the Recognition criteria. As a result, RHCs without an EHR in use (25 percent did not have an EHR and 16 percent had purchased but not yet implemented an EHR)

were unlikely to meet factors associated with certain elements (e.g., the ability to provide electronic access to health information). In those cases, we report the results for only RHCs with an EHR in use (59 percent). In cases where meeting a factor is not dependent on the use of an EHR, we report the results for all RHCs. In cases where RHCs without an EHR are able to meet the expectations of performance for factors closely aligned with the meaningful use measures, we report the performance of RHCs with an EHR separately from those without an EHR. In this policy brief, we report RHC performance for the six must pass elements and key factors. Further detail on RHC performance across all six standards areas can be found in our full study.[13]

Findings: RHC Capacity and PCMH Recognition

RHCs are likely to struggle with PCMH implementation based on their performance on the six must pass elements and key factors (See Table 1). Specifically, participating RHCs performed best on PCMH recognition standards related to the use of EHRs for recording patient demographic and clinical data, ordering and tracking medications, and ordering and tracking laboratory tests and imaging studies (This applied only to the 59 percent of respondents with an EHR, not the 41 percent without an EHR in use). Study RHCs, in general, did less well on elements related to improving access to care, ensuring continuity of services from the patient's identified provider, supporting patient self-management skills, developing the practice team, tracking and monitoring referrals, exchanging clinical information, measuring performance, and implementing continuous quality improvement systems and documenting the results. Although an ERH is not required for some of these factors, overall performance in these areas would likely increase with greater ERH adoption among RHCs.

Access

The expansion of patient access during office hours (a must pass element) and after office hours are key aspects of NCQA PCMH Recognition. The access area in which RHCs performed best involves the provision of same day services, with 63 percent reporting they do so. For other access standards for which we had data RHCs performed less well as a group, with performance ranging from 5 percent of clinics providing email consultations to 29 percent offering scheduled evening and weekend visits.

The provision of culturally and linguistically appropriate services (CLAS) is another important access standard. Seventy two percent (n=199) of responding RHCs served non-English speaking patients. Of these 199 RHCs, 34 percent used internal staff to serve non-English speaking patients, 26 percent used outside services, and 27 percent used a combination of the two.

Population Management

The use of data for population management is another must pass element. Although generating a disease registry is more easily accomplished using an EHR, respondents with and without an EHR generated diseases registries and used them for population health management. Among respondents with an EHR that responded to the question (n=121), 64 percent (n=77) used their EHRs to generate a patient registry for at least one condition. Among respondents without an EHR that responded to this question (n=82), 31 percent (n=25) created reports or registries to manage patients with chronic conditions. Forty-two percent of clinics with an EHR used disease registry data for population health management and 47 percent for individual health management. In comparison, 44 percent of clinics without an EHR used their disease registry data for population health management and 72 percent for individual health management.

Among the 51 clinics with an EHR that reported how they use their registry data, their data use ranged from identifying patients for follow up (55 percent) to tracking the quality of care (75 percent). Forty-six percent also used their EHRs to generate patient reminders for at least 20 percent of their patients 65 and older or five years and younger for both preventive and follow up care. Of the 19 clinics without an EHR that reported how they use their registry data, their data use ranged from generating patient reminders (53 percent) to tracking the quality of care (90 percent).

Given the small number of respondents that answered these questions, caution should be exercised in comparing how clinics with and without EHRs use the data from their disease registries. Our survey does not allow us to explain the reasons behind these differences.

Care Management

As a must pass element, care management is a central function of PCMHs, particularly for patients with chronic health conditions. A small percentage of responding clinics (5 percent) employed care/case managers as part of their staff. Almost 64 percent of clinics with an EHR provided a visit summary within three business days to some or all of their patients. Two important parts of the process involve identifying specific patients that would benefit from care management, and sending them reminders to encourage the receipt of appropriate services. Overall, RHCs did reasonably well on these two factors with 59 percent using disease registry data to identify groups of patients for specific follow-up, and 66 percent using the data to generate patient reminders.

Self-Care Process

As a group, RHCs did not do well on the must pass standards related to supporting self-care processes. The percentage of clinics providing support and education of patient self-management ranged from a low of 6 percent for other conditions to a high of 43 percent for diabetes. Clinics performed somewhat better on the extent to which they provided patient-specific educational resources to 10 percent or more of their patients using the clinic's EHR (57 percent).

Referral Tracking and Follow-up

Referral tracking and follow-up, including the ability to exchange clinic information with other providers to facilitate referrals, is a must pass element. Slightly over half of RHCs (53 percent) met this standard. RHCs performed best on the provision of summary of care records for 50 percent or more of their patients transitioned to other settings of care (68 percent), and least well on the extent to which they monitored specialist referrals for continuous quality improvement (26 percent). Clinics also did well on the test tracking and follow-up standard with 90 percent (of those with EHRs) using their EHRs to record clinical lab test results, and 95 percent using their computerized physician order entry systems to order medications, laboratory studies, and other tests.

Continuous Quality Improvement

Clinic capacity for implementing continuous quality improvement (CQI) activities varied. Only 20 percent monitored outcome data for select conditions, and 34 percent monitored continuous quality improvement project results. Clinics did comparatively better in areas related to patient satisfaction. Among clinics that had conducted patient satisfaction surveys (approximately 60 percent of respondents), 77 percent had implemented changes in response to issues identified through the surveys. Responding RHCs used internal quality improvement data to create benchmarks and clinical priorities (43 percent) and to set goals around clinical guidelines (45 percent). Among clinics generating disease registries (n=70), 79 percent used the registry data to track quality of care for patients with chronic conditions.

Conclusions

From the results of this study, it is clear that many RHCs will need substantial support and technical assistance to build the capacity and systems needed to meet the standards for NCQA Recognition as a PCMH. This should not be too surprising given that

many RHCs, in terms of their staffing, capacity, and resources, tend to resemble small, private physician practices[7] which, historically, have had difficulty achieving PCMH recognition without access to financial support, practical training, revised payment methodology, on-site practice redesign expertise, and on-site care management personnel.[14-16] Our past body of work with the RHC program[7] suggests that RHCs will face similar capacity issues.

It should be noted that making the necessary changes will not be easy for RHCs, as many will involve changing practice culture, particularly for areas related to shared decision making, expanded practice hours, the expanded role of patients and families, and public reporting of quality performance data. Hence, it would be reasonable to target technical support to the must pass elements under each of the six PCMH standards areas. It would also be reasonable to target resources to areas that directly impact RHC operational and clinical performance, such as supporting the implementation and meaningful use of EHRs, implementing provider-relevant continuous quality improvement systems, enhancing patient access, improving team performance, improving internal use of data for clinical and operational performance improvement, and encouraging public reporting of quality data. Not only would such targeted technical assistance support RHCs in obtaining PCMH Recognition, it is also likely to enhance RHCs' clinical and operational performance.

Endnotes

1. Davis K, Schoenbaum SC, Audet AM. A 2020 Vision of Patient-Centered Primary Care. *J Gen Intern Med*. Oct 2005;20(10):953-957.

2. Longworth DL. Accountable Care Organizations, the Patient-Centered Medical Home, and Health Care Reform: What Does It All Mean? *Cleve Clin J Med*. Sep 2011;78(9):571-582.

3. Davis K, Abrams M, Stremikis K. How the Affordable Care Act Will Strengthen the Nation's Primary Care Foundation. *J Gen Intern Med*. 2011;26(10):1201-1203.

4. American Hospital Association, Committee on Research. *Patient-Centered Medical Home: AHA Research Synthesis Report*. Chicago, IL: AHA; September, 2010.

5. Nutting PA, Crabtree BF, Miller WL, Stange KC, Stewart E, Jaén C. Transforming Physician Practices to Patient-Centered Medical Homes: Lessons from the National Demonstration Project. *Health Aff (Millwood)*. 2011;30(3):439-445.

6. Berenson RA, Devers KJ, Burton RA. *Will the Patient-Centered Medical Home Transform the Delivery of Health Care?* Washington, DC: Urban Institute; August, 2011. Timely Analysis of Immediate Health Policy Issues.

7. Gale JA, Hartley D, Croll Z. *Meaningful Use of Electronic Health Record by Rural Health Clinics*. Portland, ME: University of Southern Maine, Muskie School of Public Service, Maine Rural Health Research Center; February, 2014. Working Paper #52.

8. American Hospital Association, Committee on Research. *Patient-Centered Medical Home: AHA Research Synthesis Report*. Chicago, IL: AHA; September, 2010.

9. Stange KC, Miller WL, Nutting PA, Crabtree BF, Stewart EE, Jaen CR. Context for Understanding the National Demonstration Project and the Patient-Centered Medical Home. *Ann Fam Med*. 2010;8 Suppl 1:S2-8; s92.

10. Burton RA, Devers KJ, Berenson RA. *Patient-Centered Medical Home Recognition Tools: A Comparison of Ten Surveys' Content and Operational Details*. Washington, DC: Urban Institute; March, 2012.

11. National Committee for Quality Assurance (NCQA). Standards and Guidelines for NCQA's Patient-Centered Medical *Home (PCMH) 2011*. Washington, DC: NCQA; November 18, 2013.

12. The survey was conducted electronically using Survey Monkey, which required participants to have a functioning email address. Data collection took place between June 2011-December 2012. The survey achieved a response rate of 47 percent based on a usable sample of 488 RHCs that received invitations to participate. Survey respondents were similar to the overall population of RHCs based on key characteristics. Due to the small number of responding RHCs (225), our results should be interpreted with caution. In some cases, an even smaller number of RHCs responded to specific questions. As a result, few of our findings are statistically significant and we

have not reported p-values. Nevertheless, these descriptive results provide an important first look at RHC capacity to meet the standards for PCMH Recognition.

13. Gale JA, Croll Z, Hartley D. *Rural Health Clinic Readiness for Patient-Centered Medical Home Recognition*. Portland, ME: University of Southern Maine, Maine Rural Health Research Center; January, 2015. Working Paper #57.

14. Rittenhouse DR, Casalino LP, Shortell SM, et al. Small and Medium-Size Physician Practices Use Few Patient-Centered Medical Home Processes. *Health Aff (Millwood)*. Aug 2011;30(8):1575-1584.

15. Scholle SH, Asche SE, Morton S, Solberg LI, Tirodkar MA, Jaen CR. Support and Strategies for Change among Small Patient-Centered Medical Home Practices. *Ann Fam Med*. May-Jun 2013;11 Suppl 1:S6-13.

16. Fifield J, Forrest DD, Martin-Peele M, et al. A Randomized, Controlled Trial of Implementing the Patient-Centered Medical Home Model in Solo and Small Practices. *J Gen Intern Med*. Jun 2013;28(6):770-777.

Table 1. RHC Performance on PCMH 2011 Must Pass Elements and Key Factors

Standards Area	Element	Survey Measure	All RHCs	With EHR	W/O EHR
Enhance Access and Continuity	Access During Office Hours	Provides same-day appointments (n=225)	62.7%		
		Provides telephone consultations (n=225)	21.8%		
		Provides email consultations (n=225)	5.3%		
		Offers group visits (n=225)	11.6%		
Enhance Access and Continuity	After-Hours Access	Provides scheduled evening and weekend visits (n-225)	28.9%		
		Provides on-call evening and weekend visits (n=225)	19.6%		
		Provides telephone consultation/advice to patients (n=225)	21.8%		
Enhance Access and Continuity	CLAS	Serves non-English speaking patients (pts.) (n=198)	71.7%		
		Uses internal staff to meet linguistic needs (n=142)	33.8%		
		Uses outside services to meet linguistic needs (n=142)	26.1%		
		Uses a combination of internal and outside resources (n=142)	26.8%		
Identify and Manage Patient Populations	Use Data for Population Management (Mgt.)	Generates at least one patient list (disease registry) to manage patients with chronic conditions or other purposes (n=121; n=82)		63.6%	30.5%
		Uses disease registry for population health mgt. (n=77; n=25)		41.6%	44.0%
		Uses disease registry for individual health mgt. (n=77; n=25)		46.8%	72.0%
		Uses disease registry to generate patient reminders (n=51; n=19)		70.6%	52.6%
		Uses disease registry to track quality of care (n=51; n=19)		74.5%	89.5%
		Uses disease registry to identify pts. for follow-up (n=51; n=19)		54.9%	68.4%
		Uses disease registry to plan patient care (n=51; n=19)		62.7%	84.2%
Plan and Manage Care	Care Mgt.	Employs care/case managers (n=225)	5.3%		
		Pts. receive visit summary within 3 business days (n=121).		63.9%	
		Uses disease registry to identify groups of pts. for follow-up (n=70)	58.6%		
		Uses disease registry to generate patient reminders (n=70)	65.7%		
Provide Self-Care Support and Community Resources	Support Self-Care Process	Supports self-mgt. skills for asthma (n=225)	19.6%		
		Supports self-mgt. skills for congestive heart failure (n=225)	11.1%		
		Supports self-mgt. skills for depression (n=225)	13.3%		
		Supports self-mgt. skills for diabetes (n=225)	43.1%		
		Supports self-mgt. skills for coronary artery disease (n=225)	10.7%		
		Supports self-mgt. skills for other conditions (n=225)	5.8%		
		Uses EHR to provide pt.-specific educational resources to 10% or more of pts. (n=121)		57.0%	
Track and Coordinate Care	Referral Tracking and Follow-Up	Has performed at least one test of its capability to exchange key clinical information (n=120)		52.5%	
		Provides electronic summary of care for 50% or more of pts. transitioned to other settings (n=120)		68.3%	
		Monitors specialist referrals for CQI (n=225)	26.2%		
Track and Coordinate Care	Test Tracking/ Follow-Up	Uses a computerized physician order entry system to order medications laboratory studies, and other tests (n=104)		95.2%	
		Uses EHR to record clinical lab test results (n=124)		90.3%	
Measure and Improve Performance	Implement CQI	Monitors CQI project results (n=225)	33.8%		
		Monitors outcome data for select conditions (n=225)	19.6%		
		Has initiated changes after patient satisfaction surveys (n=152)	77.0%		
		Uses QI data to create benchmarks/clinical priorities (n=207)	42.5%		
		Uses QI data to set goals around clinical guidelines (n=207)	44.9%		
		Uses disease registry to track quality of care (n=70)	78.6%		