Physician Perspectives on Medical Home Recognition for Practice Transformation for Children

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Abstract

Objective: To examine child-serving physicians' perspectives on motivations for and support for practices in seeking patient-centered medical home (PCMH) recognition, changes in practice infrastructure, and care processes before and after recognition, and perceived benefits and challenges of functioning as a PCMH for the children they serve, especially children with special health care needs.

Methods: Semistructured interviews with 20 pediatricians and family physicians at practices that achieved National Committee for Quality Assurance level 3 PCMH recognition before 2011. We coded notes and identified themes using an iterative process and pattern recognition analysis.

Results: Physicians reported being motivated to seek PCMH recognition by a combination of altruistic and practical goals. Most said recognition acknowledged existing practice characteristics, but encouraged ongoing, and in some cases substantial, transformation. Although many physicians said recognition helped practices improve financial arrangements with payers and participate in quality initiatives, most physicians could not assess the specific benefits of recognition on patients' use of services or health outcomes. Challenges for practices in providing care for children included managing additional physician responsibilities, communicating with other providers and health systems, and building sustainable care coordination procedures.

Conclusions: PCMH recognition can be valuable to practices as a public acknowledgement to payers and patients that certain processes are in place, and can also catalyze new and continued transformation. Programs and policies seeking to transform primary care for children should leverage physicians' motivations and find mechanisms to build practices' capacity for care management systems and linkages with the medical neighborhood.

Keywords: child health; medical home recognition; patient-centered medical home; practice transformation; primary care

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What's New

Little is known about how formal medical home recognition influences pediatric primary care practice transformation. In this study of early adopters, recognition largely acknowledged what practices were already doing, but was also a catalyst for ongoing, and at times substantial, practice transformation.

ALTHOUGH THE MEDICAL home concept emerged in the 1960s as a model for improving care for children with special health care needs (CSHCN), policy interest in the medical home has accelerated in recent decades within and outside of pediatrics.[1–3] Early evidence suggests that organizing primary care practices as patient-centered medical homes (PCMHs) has the potential to improve quality and reduce total health care costs in a variety of patient populations,[1,4–7] and a wide range of primary care medical societies, payers, providers, and consumer groups endorse the model.[8–10] CSHCN and their caregivers face a variety of barriers to accessing needed care, coordinating care, and receiving indicated preventive and chronic care services, and the PCMH model seeks to address these challenges by promoting improvements in access, care coordination, patient tracking and quality improvement (QI), and family engagement.[2,3,11,12] The NCQA 2008 Physician Practice Connections Patient-Centered Medical Home Program includes 9 standards: 1) access and communication, 2) patient tracking and registry functions, 3) care management, 4) patient self-management support, 5) electronic

prescribing, 6) test tracking, 7) referral tracking, 8) performance reporting and improvement, and 9) advanced electronic communications. Level 1 certification requires a minimum score on 5 of 10 "must-pass" elements within standards 1 to 4 and 6 to 8. Level 2 and 3 certification requires a minimum score on all 10 of 10 "must-pass" elements in addition to scoring points on other PCMH factors within the various standards (level 3 requires more points on other factors than level 2). Pediatric practices that have implemented more components of the PCMH show promise in providing better care to children in their practices, including CSHCN, compared with practices without such components.[13–15]

Since 2008, the National Committee for Quality Assurance (NCQA) has recognized practices and providers who meet its standards for PCMHs and submit required documentation and fees.[16] NCQA has since updated its standards for the 2011 PCMH program to include 6 standards and 6 "must pass" elements. However, all providers and practices in the current study received 2008 certification. Additional detail can be found on the NCQA Web site, available at: http://www.ncqa.org/tabid/631/Default.aspx. Although it is not the only PCMH recognition program available, NCQA's initiative has a high profile and is widely used in many multipayer initiatives.[17] Although the number of practices obtaining PCMH recognition from NCQA has increased quickly, few studies have examined the extent to which physicians in practices believe obtaining recognition influences practice transformation and care quality, and fewer have examined the influence of obtaining recognition on child-serving practices and the ways they serve CSHCN, in particular.

The objective of this study was to examine the perspectives of physicians in pediatric and family practices that obtained the highest level of NCQA PCMH recognition (level 3) before 2011 on practice transformation and the quality of care for children, especially CSHCN. Specifically, we address 3 questions: (1) what motivated and supported practices to seek PCMH recognition and function as a PCMH? (2) What activities did practices undertake to achieve PCMH recognition and function as a PCMH? (3) What were the perceived benefits and remaining challenges of functioning as a PCMH for practices and the children they serve?

METHODS

SAMPLING AND DATA COLLECTION

We conducted 20 semistructured interviews with pediatricians and family physicians in NCQA level 3–recognized practices in Texas and Colorado between November 2012 and January 2013. We selected these states to supplement our parallel study using these states' Medicaid claims data to examine relationships between recognition status and service use.[18] To identify providers, we used a data file purchased directly from NCQA that contained name, address, and recognition level and date for all practices that received NCQA's Physician Practice Connections Patient-Centered Medical Home recognition between November 2008 and October 2011, as well as the name, specialty, and national provider identifier of all providers in each practice.

We merged national provider identifiers from this file with 2008 Medicaid Analytic eXtract professional claims data[19] to identify providers who served Medicaid-covered CSHCN at practices recognized before 2011. CSHCN were defined using Medicaid eligibility data (children qualifying on the basis of disability) or by applying the Chronic Illness and Disability Payment System algorithms[20] to flag children with chronic health conditions. The resulting sample included 174 pediatricians and family physicians at 52 practices. Reflecting the landscape of practices that received recognition under the 2008 NCQA standards, the 52 practices were affiliated with 12 larger parent organizations. Our purposive sample was limited to 20 physicians because of budget constraints. To identify respondents, the study team first e-mailed recruitment materials, including a letter from NCQA endorsing the study, to the 20 physicians (1 per practice) who served the most Medicaid-covered CSHCN. When we received a refusal or nonresponse after 5 telephone follow-up calls, we proceeded to the physician who served the next highest number of CSHCN, limiting our sample to 1 provider per practice. We contacted 53 physicians to achieve 20 interviews, a 38% response rate. We did not screen for leadership in PCMH transformation activities because we were seeking a broad sample of physicians at diverse practices who served Medicaid-covered CSHCN, regardless of their level of involvement in PCMH recognition activities. Because PCMH recognition is applied at the practice level, all providers within a practice should experience changes in care delivery made to obtain PCMH status even if they were not directly involved in the recognition process. We paid a $500 stipend to the practice of each physician who completed an interview.

Two investigators (D.M.P., J.Z.) conducted interviews, and a third investigator (M.H.) audio-recorded and took notes. Interviews were conducted using telephone and were 20 to 45 minutes long. Participants received consent documents by e-mail before the interview and provided verbal consent. We used a semistructured discussion guide and spontaneous verbal probes when clarification was needed (protocol is available in the Supplementary Material). Before the interview, we e-mailed each physician the NCQA definition of a PCMH and a worksheet describing the nine 2008 NCQA PCMH standards. During the interview, we asked physicians to discuss their perspectives on: (1) why their practice sought PCMH recognition; (2) what changes they observed in their practices' infrastructure and care process related to each NCQA standard; and (3) the benefits and remaining challenges when functioning as a PCMH for their practice and the care they provide for children, especially CSHCN. In interviews, we used the Maternal and Child Health Bureau definition of CSHCN: "children who have chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services beyond those required by children generally."