



U.S. Department of Health and Human Services  
Assistant Secretary for Planning and Evaluation  
Office of Disability, Aging and Long-Term Care Policy

# **PHYSICIAN PERSPECTIVES ON THE INFLUENCE OF MEDICAL HOME RECOGNITION ON PRACTICE TRANSFORMATION AND CARE QUALITY FOR CHILDREN WITH SPECIAL HEALTH CARE NEEDS**

January 2014

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This report was prepared under contract #HHSP23320095642WC between HHS's ASPE/DALTCP and Mathematica Policy Research. For additional information about this subject, you can visit the DALTCP home page at [http://aspe.hhs.gov/office\\_specific/daltcp.cfm](http://aspe.hhs.gov/office_specific/daltcp.cfm) or contact the ASPE Project Officers, Hakan Aykan and David de Voursney, at HHS/ASPE/DALTCP, Room 424E, H.H. Humphrey Building, 200 Independence Avenue, S.W., Washington, D.C. 20201. Their e-mail addresses are: [Hakan.Aykan@hhs.gov](mailto:Hakan.Aykan@hhs.gov) and [David.DeVoursney@hhs.gov](mailto:David.DeVoursney@hhs.gov).

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## ABSTRACT

**Objective:** To examine perspectives of physicians serving children with special health care needs (CSHCN) related to two questions: Did physicians and practices undergo explicit changes in order to achieve the highest level of National Committee for Quality Assurance (NCQA) patient-centered medical home (PCMH) recognition?; Did these changes lead to higher quality care for CSHCN?

**Methods:** Semi-structured discussions with 20 pediatricians and family physicians at practices that achieved NCQA Level 3 PCMH-recognition prior to 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 already existing practice characteristics, but a few, in smaller practices, reported substantial transformation. Few physicians had seen information to help them assess the impact of being a PCMH on utilization and outcomes. Many said recognition helped practices improve financial arrangements with payers and participate in quality initiatives. Challenges in providing care for CSHCN included identifying a population with heterogeneous diagnoses and needs, communicating with other providers and health systems, and building sustainable care coordination procedures.

**Conclusions:** PCMH-recognition can be valuable to practices as public acknowledgement to payers and patients that certain procedures and processes are in place; it can also catalyze new and continued transformation. Programs and policies seeking to transform primary care for CSHCN may consider leveraging physicians' motivations and finding creative mechanisms to help practices build internal care management systems and linkages with the medical neighborhood.

**What's New:** Little is known about how formal medical home recognition influences primary care practice transformation. In this study of early-adopters, recognition largely acknowledged what practices were already doing but was a catalyst for practice transformation in a few smaller practices.

**Key Words:** Patient-centered medical home, children with special health care needs, primary care, practice transformation, medical home recognition.

## ACRONYMS

The following acronyms are mentioned in this report and/or appendix.

A1c	Glycated Hemoglobin
ACO	Accountable Care Organization
ADHD	Attention Deficit Hyperactivity Disorder
ASPE	Office of the Assistant Secretary for Planning and Evaluation
CSHCN	Children with Special Health Care Needs
DNA	Deoxyribonucleic Acid
ED	Emergency Department
EHR	Electronic Health Record
ER	Emergency Room
FQHC	Federally-Qualified Health Center
HIT	Health Information Technology
IT	Information Technology
MAX	Medicaid Analytic eXtract
NCQA	National Committee for Quality Assurance
NPI	National Provider Identifier
PCMH	Patient-Centered Medical Home
QI	Quality Improvement



# I. INTRODUCTION

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.<sup>1,2,3</sup> 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,<sup>4,5,6,7</sup> and primary care medical societies, payers, providers, and consumer groups endorse the model.<sup>8,9,10</sup> Pediatric practices that have implemented components of the PCMH model may provide better care to CSHCN than those without such components.<sup>11,12</sup>

A number of organizations have emerged to recognize practices as PCMHs. This process is much like an accreditation process through which practices are recognized if they meet specific criteria. Although multiple organizations offer processes to recognize primary care practices as PCMHs, the National Committee for Quality Assurance (NCQA) has emerged as the “market leader”<sup>13</sup> and its guidelines have become the de facto standard for many transformation efforts. Although the number of practices obtaining PCMH-recognition from NCQA has increased quickly, few studies have examined the extent to which physicians in such practices believe the recognition process influenced practice transformation and care quality for CSHCN.

The objective of this study was to examine the perspectives of primary care physicians who serve CSHCN on changes they and their practices made in order to achieve the highest level of NCQA PCMH-recognition. Specifically, the study used information from physicians in pediatric and family practices that obtained Level 3 NCQA PCMH-recognition prior to 2011 to address two questions: (1) Did physicians and practices undergo any explicit changes in order to achieve PCMH-recognition? (2) Did any of the changes lead to higher quality care for CSHCN?

## II. METHODS

### Sampling and Data Collection

We conducted 20 semi-structured discussions with pediatricians and family physicians between November 2012 and January 2013. To recruit these individuals, we first identified all pediatricians and family physicians in Texas and Colorado who worked at practices that obtained Level 3 NCQA PCMH-recognition prior to 2011 using a data file purchased directly from NCQA. We selected these states in order to conduct a richer analysis in our parallel study using these states' Medicaid claims data to examine relationships between recognition status and service use. NCQA's data file contained name, address, and recognition level and date for all practices that received NCQA's Physician Practice Connections<sup>®</sup> Patient-Centered Medical Home<sup>™</sup> recognition between November 2008 and October 2011, as well as the name, specialty, and national provider identifier (NPI) of all providers in each practice.

We merged NPIs from this file with 2008 Medicaid Analytic eXtract (MAX) professional claims data<sup>14</sup> to identify providers who served Medicaid-covered CSHCN at practices that received recognition 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<sup>15</sup> to flag children with chronic health conditions. The resulting sample included 174 pediatricians and family physicians at 52 practices; practices were affiliated with 12 larger parent organizations. The purposive strategy for selecting the subset included in this study aimed to include the physicians who served the most Medicaid-covered CSHCN per practice, and to achieve variation in location and organization affiliation. NCQA sent emails to these physicians endorsing the study. The study team emailed recruitment materials and followed up by telephone until 20 physicians agreed to participate. We contacted 53 physicians. We paid a \$500 stipend to the practice of each physician who completed a discussion.

Two investigators (Dana Petersen and Joseph Zickafoose) conducted discussions, with third investigator (Mynti Hossain) audio-recording and taking notes. Discussions were conducted over the telephone and ranged from 20 minutes to 45 minutes in length. Participants received consent documents by email prior to the discussion and provided verbal consent. We used a semi-structured discussion guide and spontaneous verbal probes when additional information or clarification was needed. Prior to the discussion, we emailed each physician a worksheet describing the eight 2008 NCQA PCMH standards. During the discussion, we asked physicians to discuss why their practice sought PCMH-recognition and how obtaining recognition influenced the care they and their practices provided for children, especially CSHCN. We also asked physicians to review the worksheet and comment on changes their practices made related to each standard.

This study was approved by the New England Institutional Review Board.

## Data Analysis

Notes were documented as close to verbatim as possible. We used the audio-recordings to check notes and verify quotations and subsequently erased them. We coded the notes with a coding scheme that mirrored the domains in the discussion guide, and used an iterative consensus process to develop the final coding scheme.<sup>16</sup> In place of a measure of inter-coder reliability, we used established methods for addressing differences in coding by reconciling them through discussion and consensus.<sup>17,18,19</sup> One investigator (Mynti Hossain) completed coding of all discussion notes using qualitative research software (NVivo9.0, developed by QSR International). A second investigator (Dana Petersen or Joseph Zickafoose) reviewed and approved all final coding.

To distill findings, we used pattern recognition analysis to identify similarities and differences within domain categories and then examined patterns and associations.<sup>20</sup> Research team members developed summaries for selected topics. Each summary included quotes and estimates of the frequency of commentaries by domain and theme, and was reviewed by another team member. The full team discussed themes to clarify, confirm, refine, or elaborate them and consider implications. We used the following categories to describe the relative frequency of commentaries related to our findings: With respect to the number of physicians, “few” indicates  $\leq 3$ , “some” indicates 4-6, “many” indicates 7-9, “half or more” reflects 10-14, and “most” reflects 15-20.

## III. RESULTS

Of the participants, 11 were pediatricians and nine were family physicians (Table 1). More than half practiced at a federally-qualified health center (FQHC) or as part of a large integrated health system. Practices reported size based on the number of providers at a particular site, not their affiliated parent organization, and sizes ranged from two to 16 providers. The 20 practices were affiliated with six different parent organizations.

Nine physicians reported having a patient panel that included 15 percent or more of CSHCN. Based on the 2008 MAX claims data, physicians in our sample served an average of 22 Medicaid-covered CSHCN in 2008, ranging from one to 226.

<b>TABLE 1. Characteristics of Participating Physicians (N=20)</b>		
<b>Characteristic</b>	<b>Number</b>	<b>% or Range</b>
<b>Practice Type</b>		
FQHC	6	30%
Integrated	6	30%
Independent, single-site	2	10%
Independent, multisite	4	20%
Other <sup>a</sup>	2	10%
<b>Practice Size,<sup>b</sup> median (range)</b>	5.5	2-16
<b>State</b>		
Colorado	14	70%
Texas	6	30%
<b>Physician Specialty</b>		
Pediatrician	11	55%
Family physician	9	45%
<b>Level of Involvement in Recognition,<sup>c</sup></b>		
None to minimal	12	60%
Some	2	10%
High	6	30%
<b>NOTES:</b>		
a. Other includes a pediatrics practice in a county hospital and a family medicine residency training program in an independent, single-site practice.		
b. Practice size denotes the number of physician, physician assistant, and nurse practitioner providers reported by the physician respondents for each site.		
c. Level of involvement reflects physicians' self-reported level of participation in their practice's PCMH-recognition process.		
Integrated = integrated health system.		

## Medical Home Recognition and Primary Care Practice Transformation

### *Factors that Motivate and Support Practices in PCMH-Recognition and Functioning*

Physicians described several, often overlapping, altruistic and financial motivations for their practices' obtaining NCQA PCMH-recognition (Table 2). Some perceived organizing as a PCMH as key to providing high-quality care and said that it was "the right thing to do." Others described recognition as acknowledgment for how they organized their practice. One physician said that NCQA was the "gold standard," while another said "having that status is about having a national badge. Now we can say, 'We do this and we do it well. We're a leader.'" Some physicians commented about the perceived future of health care, suggesting that their practices sought recognition because it was critical to remaining competitive in the health care market by attracting patients and higher payments. One physician said, "It was about making a darn good case for getting paid for what we are doing."

<b>TABLE 2. Pediatricians' and Family Physicians' Perceptions of Factors That Motivate and Support Practices in Obtaining PCMH-Recognition and Functioning as PCMHs</b>
<b>Many physicians described common motivations and supports for becoming recognized PCMHs.</b>
"It's [NCQA PCMH-recognition] one component of many that helps us improve quality in population-based care" (pediatrician in a large, integrated system).
"Everyone who knows about quality, knows about NCQA. It's good to have that effort be acknowledged" (family physician in an FQHC).
"We're really proud of it [NCQA PCMH-recognition]. We tell everyone we can. It helps us build our institution because we're a draw for insurance contracts" (family physician in an "other" practice).
"More important is that the system we have ... is very set up to be a medical home. We have the resources, like the care coordinator, psychologist, dietician, and primary care physicians" (pediatrician in a large, integrated system).
"Every year, with funds generated through local giving, they [the hospital's foundation] pay the salaries of two care coordinators at our clinic. It's wonderful -- there's no way we'd be able to do that otherwise" (pediatrician in an independent, multisite practice).
"The biggest motivator was that [the practice] joined a pilot study in [our state]. We undertook this journey to become a medical home on varying levels [as part of the pilot]. That helped prompt recognition" (family physician in an independent, single-site practice).
"We had a coach in the practice from outside the practice who did a lot of team transformation ... and quite frankly, the pilot offered money. There was financial incentive for us to become a medical home" (family physician in an independent, single-site practice).
"They had initially helped us with some practice improvement things like office flow and referral coordination and things like that. Having that [the coaches] for the practice really helped a lot. I don't think we could have done it [become a medical home] without the coaches" (family physician in an independent, single-site practice).

A key motivating factor and external support for practices was participation in PCMH demonstration projects and quality improvement (QI) initiatives. Many physicians reported that participation in such efforts provided important supports such as learning collaboratives, practice coaches, and in a few cases, enhanced reimbursement.

Participation in these efforts also allowed some practices to obtain data from external sources, such as insurance companies and health information exchanges, which enhanced their QI strategies and ability to function as PCMHs.

Physicians described additional external factors as supporting their ability to obtain recognition and function as a PCMH (Table 2). Many described factors related to being well connected to other service providers in the “medical neighborhood,” including access to patient notes through interoperable electronic health records (EHRs) and notifications of emergency department (ED) visits, hospitalizations, and discharges. Physicians within an integrated health system frequently discussed the value of resources shared across sites, such as nurse care coordinators. As one such physician said, “We have so much support outside of our office that I feel like we’re in a unique position to provide better care.” A few physicians discussed the importance of linkages to other systems that are critical to child well-being, such as social service agencies and school systems, in supporting their practice’s ability to operate as a PCMH.

### ***Characteristics of Practices Prior to the PCMH-Recognition Process***

Most physicians reported that PCMH-recognition largely represented acknowledgment for the care that their practice was already providing (Table 3). This perception was consistent across physicians in all practice types in this study. Some physicians described NCQA-recognition as one step on an existing path to improving care that the practice was already headed down: “It’s a continuum. It’s the path we’ve been on for 10-15 years prior.” Another physician in a large health system said, “We had a pretty good system to begin with. I think the only change was to utilize the services we already had in place more.”

Most physicians described aspects of practice infrastructure and care processes that were in place prior to NCQA-recognition, including a focus on QI, formal care coordinators, and EHRs (Table 3). Other aspects of PCMHs that at least a few physicians described as being present in their practice prior to NCQA-recognition included use of nurses to provide advice during and after office hours; enhanced access through expanded office hours, electronic communication, and virtual visits; access to hospital records to help monitor and coordinate care; referral tracking; physical workspaces organized to facilitate team-based care; and access to non-physician providers, such as dietitians and psychologists. With respect to CSHCN, all physicians described at least one example of tailored care processes. At one end of the continuum, physicians used registries to identify and manage care for children with more common special needs like asthma and attention deficit hyperactivity disorder (ADHD). At the other end of the continuum, some physicians had access to special needs clinics, chronic care programs, and pediatric asthma programs staffed by nurse care coordinators.

<b>TABLE 3. Pediatricians' and Family Physicians' Perceptions of Their Practices' Transformation Before and After NCQA PCMH-Recognition in 2009-2010</b>
<b>Most physicians perceived that their practices underwent little change in order to achieve NCQA PCMH-recognition.</b>
<p>"We figured we were just legitimizing or making official what we'd already been doing for special needs kids for a few years" (pediatrician in an independent, multisite practice).</p> <p>"To be honest, I think that [health system] has this in their DNA. I don't see it as a thing where [health system] looked at NCQA and said, 'Oh, we should do this.' We've done it for a number of years" (pediatrician in a large, integrated health system).</p> <p>"I started a quality improvement lunch discussion group several years ago. That was converted to an official quality improvement committee and that group was called on to address all the needed changes between the different clinical groups [for NCQA-recognition] .... I think we were already very oriented towards quality" (family physician in an independent, multisite practice).</p> <p>"We [the practice] used to keep close tabs on them [CSHCN] even before. The care coordinator tracks all of our hospital admissions and ER visits and there hasn't been significant change" (pediatrician in an independent, single-site practice).</p>
<b>For practices that did make changes, most physicians reported changes as refinements and standardization of existing processes.</b>
<p>"We had to have a lot more structure and standardized approach in the clinics .... We standardized the way we do medication management. We have the same process in place when we're doing the well-child things that have to be done. We have a process for making sure we get x-ray reports back. We're doing preventative services and we're monitoring to make sure we are calling people back. We're standardizing those processes so that it doesn't matter which clinic someone goes to. They [will] get the same service" (pediatrician in an FQHC).</p> <p>"We've always tracked referrals, but maybe we've tried harder since 2008 not to let things fall through the cracks" (pediatrician in an independent, multisite practice).</p>
<b>Some physicians described more substantial changes in their practice to achieve PCMH-recognition.</b>
<p>"We went from having no quality improvement (and we thought we were doing a decent job then) to collecting data and measuring our outcomes. We actually had numbers to see how we were doing and that was a wake-up call" (family physician in an independent, single-site practice).</p> <p>"We really changed our workflows and redesigned our systems that allowed us to get out of that cottage-age century. We started using modern, industrialized processes. We adopted proved strategies like huddling in the morning, for example" (family physician in an independent, multisite practice).</p> <p>"We started a couple of initiatives around tracking and monitoring kids, such as asthmatic monitoring. And we've been trying to do a better job of tracking ADHD kids ..." (pediatrician in an independent, multisite practice).</p>
<b>Many physicians described ongoing practice transformation after achieving PCMH-recognition.</b>
<p>"That was part of a little brainstorm in the PCMH [pilot] ... I think I just called up the [local mental health organization] and asked if they would be interested in putting someone in our office for a couple of days a week and they thought that would be a reasonable thing to try. That's been going well and has been going for a year and a half now" (family physician in an independent, single-site practice).</p> <p>"We realized there was a gap there [in referral tracking], and we're actually now trying to figure out where the gap is between when we make the referral and what percent of people actually get to the specialist and what percent of time we actually get the report back. We realized those were two gaps in our process" (family physician in an "other" practice).</p> <p>"As of the upgrade [to the practice EHR], for the patients that are on the patient portal, with two clicks, I can directly send the patients the lab results with a little note from me. That's a huge improvement in my ability to communicate with my patients .... We have a new, enhanced IT team too. We've had to grow to be able to organize and process the data that comes from the EHR to make it meaningful" (family physician in an FQHC).</p>

### **Changes Made to Achieve PCMH-Recognition**

For physicians who reported changes made in their practice to achieve PCMH-recognition, most described refinements and standardization of existing processes

(Table 3). A few physicians reported that, although the practice did not make significant changes, the recognition process affected the QI activities the practice emphasized. A family physician in a multisite independent practice said, “We were already a high-quality organization. But I think it did help us focus on finishing the job and maintaining a technical exactness to quality improvement.” One physician described the successful care coordination for a child newly diagnosed with Turner syndrome and when asked if the same level of coordination would have happened without PCMH-recognition, replied, “Yes, I’m sure this would have happened without recognition, but I think it’s a lot more integrated. It’s probably a little smoother now.”

Some physicians reported making more substantial changes in their practices to achieve PCMH-recognition (Table 3). These physicians, commonly from smaller and independent practices, described changing practice culture to emphasize team-based care and QI, adjusting workflows, shifting staff responsibilities, and dedicating resources to patient registries, tracking strategies, and care coordination. A physician in a single independent practice said, “It’s been transforming, and it has to be for it to work. If a group goes in to only get a plaque to put on their wall, it’s not going to work. It has to transform your office. Maybe in large ones they have QI teams but mine is an average-sized family practice and those are the ones that really have to change and transform their practice.”

### ***Ongoing Practice Transformation after Initial PCMH-Recognition***

For many practices, NCQA-recognition solidified a commitment to QI that they already embraced, and many physicians described ongoing transformation activities after their practice achieved recognition (Table 3). These included expanding the types of services offered, refining and broadening their use of patient registries, improving referral tracking processes, and upgrading health information technology (HIT). One physician described institutionalizing a QI mechanism: “We put in place a regular time and place to say ‘This is not working. How do we make this more efficient?’” She also spoke of ongoing work to “enlist people around the improved quality mantra.”

Some physicians emphasized how PCMH-recognition caused their practice to look more closely at processes they thought were high functioning and identify areas for improvement, including team building, integration of PCMH principles into practice culture, and clinical processes. A family physician in an independent practice that is also a residency training program said, “We hadn’t fully implemented the philosophy of the PCMH as well as we thought. What we really had to do was get everyone together, break down into teams, do strategic planning, tactical planning, decision-making, to get everyone down to the rank and file people to feel what a PCMH was ... I call it ‘the tyranny of the pretty good.’ ... when you think you’re pretty good there’s not a lot of impetus to change.” Similarly, a family physician at a single independent practice said “when we looked at the PCMH guidelines ... we said, ‘this is how we’re pretty much already doing things, so it’ll be a piece of cake ...’. Of course it wasn’t! We thought we were doing so well. When we started running the reports ... we found out we weren’t doing that well.”



## **Perceived Benefits of Functioning as a Patient-Centered Medical Home**

### ***Perceived Impact of PCMH Status on Patients***

Many physicians provided anecdotal evidence or hypothesized about how organizing like a PCMH was related to better patient care, but few had seen information they felt could help them assess the impact on utilization or clinical outcomes (Table 4). Most physicians, particularly family physicians, felt they were even less able to assess impacts on the subpopulation of CSHCN in their practice because the group was small and diverse. For those who did discuss impacts on CSHCN, they emphasized the importance of continuity of care, using registries to track patients for proactive preventive and chronic care management, and care coordination involving formal care coordinators and exchange of information with other care sites, such as EDs and specialists' offices.

### ***Perceived Impact of PCMH-Recognition Process on Practices***

Many physicians viewed PCMH-recognition as a stepping stone for improved financial arrangements with payers, including per-member-per-month care management payments on top of fee-for-service and pay-for-performance reimbursements (Table 4). Additionally, some physicians described how their practices leveraged their PCMH infrastructure for participation in additional system transformation initiatives that could be beneficial to their patients' care and their practices' reputation and finances. These included state and federally funded PCMH initiatives, health information exchanges, EHR meaningful use programs, and accountable care organizations (ACOs). In one extreme example, a family physician described how his practice expected "an extra \$2 million over the next four years" through participation in a state Medicaid ACO, a state immunization database, a national practice-based research consortium, a federal quality measures reporting initiative, and a federal primary care transformation program.

## **Challenges to Maintaining Medical Home Recognition and Functioning as a Patient-Centered Medical Home**

Some physicians noted challenges related to maintaining PCMH status including additional responsibilities for both physician and non-physician staff, making it difficult to complete daily duties. As one physician described, "The list of what I'm supposed to be doing in a medical home keeps growing and we have to be creative about how to provide that because there isn't enough time." Another challenge was documentation to maintain PCMH-recognition, which some physicians considered time-intensive and labor-intensive: "You don't realize how much work it is to maintain certification."

<b>TABLE 4. Pediatricians' and Family Physicians' Perceptions of the Impact of PCMH Processes on Patients and PCMH-Recognition on Practices</b>
<b>Most physicians had not seen data to track impacts on patients but could discuss anecdotes or hypotheses about the perceived impact of care in a PCMH.</b>
<p>"I don't know that we have good outcomes data yet. We run tons of reports and we follow up, but I don't know if it's been long enough to tell if we have outcome improvements" (pediatrician in an FQHC).</p> <p>"It's not like asthma [special health needs]. There are so many different disease states, that we don't have data that can show 'the more you do of this, the fewer admissions you'll have'" (pediatrician in a large, integrated system).</p> <p>"When special needs kids go the ER, they are hospitalized at a much lower threshold than other kids because ER doctors are intimidated by their conditions and err on the side of caution. When kids come to our clinic for acute care, it's different because we know what their baseline is and are more likely to decide we can manage something outpatient. Also, we help them coordinate with good home care that helps keep kids healthy day in and day out" (pediatrician in an independent, multisite practice).</p> <p>"One thing that applies to kids with special needs is monitoring whether they're getting the care they need .... You need to get the ones who are coming in and the ones who aren't coming in ... it's more proactive [care in a PCMH]. ER visits are lower with asthmatics. You'll be less likely to go to the ER if you are on your controller in the fall. If no one calls you and reminds you [like we do] and if you had a good summer, you'll forget and then you'll be in the ER in the fall" (pediatrician in a large, integrated system).</p> <p>"The chronic care coordinators, qualitatively, are a tremendous asset to families. It's hard to measure quantitatively. They help families with understanding their Medicaid benefits, working with an autism diagnosis, whatever. They can provide a lot of services and education to families" (pediatrician in a large, integrated system).</p>
<b>Many physicians perceived PCMH-recognition as beneficial to practices' finances and reputation as well as a stepping-stone toward participation in other system transformation initiatives.</b>
<p>"Some of the insurance companies have started to create plans focused around this [PCMH-recognition] .... [The insurance company] definitely saw some value in [NCQA-recognition] and is throwing some money at it. So we're part of that and we're going to get some per-member-per-month stipend ..." (family physician in an independent, single-site practice).</p> <p>"We were also involved in a pilot for an ACO. We hope, in the future, that there will be payment based on performance for that" (family physician in an independent, single-site practice).</p> <p>"It's helpful for fundraising. It must look great. Very few in our area have this designation. We get money from the City Council and other places too" (pediatrician in an FQHC).</p>

When asked about potential downsides of operating as a recognized PCMH, some physicians replied that the process required a large financial investment from the practice. One physician described the costs involved in implementing an EHR and another commented that getting recognized meant "a lot of upfront money and staff costs, without a lot of reimbursement." Two physicians reported staff turnover related to adopting new PCMH features at their practices, including one employee leaving due to discomfort with the transition to an EHR and another because of the shift in practice culture from a "doctor-says approach to a team approach."

### ***Challenges and Opportunities to Improve Care for CSHCN in a PCMH***

All physicians tailored some care processes for CSHCN. Nonetheless, they described several factors affecting their ability to improve primary care for CSHCN in their PCMH practices. Many physicians described how an established system for sharing information with specialists and children's hospitals, often through EHRs, was critical to their ability to coordinate and manage care for CSHCN. An equal number of physicians provided examples of how inadequate communication and information

sharing with these providers undermined their ability to provide timely and coordinated care. Physicians cited both a lack of effort from specialists and hospitals and a lack of interoperable HIT as contributing factors.

Consistent with other PCMH studies, sustainable financing was a concern for some physicians, particularly for care coordination activities. Physicians also cited other family and system factors that they perceived impeded their ability to improve care for CSHCN, including limited family follow through on treatment plans due to lack of engagement or financial constraints, unstable insurance coverage for families, and bureaucratic requirements from payers.

A few physicians also emphasized that CSHCN are a heterogeneous group that includes a wide range of chronic conditions, making it more difficult to identify and care for patients with less common conditions than for those with conditions that present more uniformly and have clear care guidelines, such as asthma or type II diabetes in adults. These physicians said that the heterogeneity of the overall CSHCN group made it challenging for practices to build registries and develop proactive tracking systems. This heterogeneity also results in a lack of pay-for-performance targets, and other than altruism, there is less incentive for providers, especially family physicians, to invest in systems of care for complex CSHCN. One physician said, “With diabetes, it’s pretty cookbook. You know, is their A1c below seven? But with the [CSHCN], each one of them has their own varying needs and it’s much more complicated.” She continued, “It has to start with identifying them and deciding what you want to do with them. Do you put them on a special list where we call them on a regular basis, or do we just check their chart more often? This is a higher level of being a medical home -- the next step. That’s where practices struggle because it’s not a homogeneous group.”

### ***Expanding the Transformative Power of PCMH-Recognition***

When asked what features they thought were missing from the NCQA-recognition process, some physicians expressed that recognition was too heavily metric driven and may underemphasize features of care that are more difficult to measure, namely patient experience. Physicians described how NCQA’s recognition emphasized measurable infrastructure and system characteristics such as a practice’s telephone system or accessible hours and its implementation of evidence-based standards of care, but that it failed to address “softer” characteristics. As one physician explained, speaking about the effort her practice spends ensuring high-quality communication with patients and specialists, “you can get certified [as a PCMH] and choose not to do those things [focus on high-quality communication]. Those are the softer things that the certification process alludes to, but are hard to measure.” Another physician said, “There’s less emphasis in [NCQA-recognition] on things that patients would actually see and experience. It takes a whole lot more to make [patients’] experience positive.”

## IV. DISCUSSION

This study explored physician perspectives on PCMH-recognition by analyzing qualitative data gathered through telephone discussions with 20 pediatricians and family physicians. Respondents were staff at child-serving primary care practices that obtained NCQA-recognition prior to 2011 and therefore were among the first wave of practices in the United States to achieve such recognition. In theory, NCQA-recognition should be both acknowledgment and catalyst: an acknowledgement that certain procedures and processes are in place (some of which may have been implemented explicitly in order to obtain NCQA-recognition) and a stimulus for continued practice transformation through ongoing QI. Our findings suggest that NCQA-recognition is both, although with some qualifications.

Specifically, to most physicians in this study, PCMH-recognition meant that NCQA acknowledged that key health care delivery and organizational characteristics were in place; as a result, the recognition process itself led to few changes. Some of these physicians noted, however, that the process drove refinements of existing infrastructure and the standardization of important ongoing QI strategies. Practices that needed only to refine current systems to obtain PCMH-recognition typically were affiliated with larger parent organizations.

Physicians working in small, independently owned practices reported that they did not have many PCMH components in place when they began the recognition process and that obtaining recognition stimulated significant practice transformation. To support this transformation, most of these practices received external resources through participation in pilot or demonstration projects.

Our findings align with previous research that PCMH transformation is resource intensive and that external supports such as learning collaboratives, coaches, and financial incentives are important inputs.<sup>21,22</sup> We also found that practices were motivated to seek recognition by a combination of altruistic goals to improve patient care and practical goals to improve practice finances. Programs and policies seeking to transform primary care practice should continue to leverage both these motivations. This observation is especially salient for smaller practices, which are likely to be highly represented in future waves of practices seeking PCMH-recognition. Physicians also described ways that PCMH-recognition served as a springboard for participation in additional health system transformation activities, such as ACOs. This indirect benefit of recognition is underemphasized in prior studies and may be an additional motivation for practices in the future.

CSHCN are especially likely to benefit from high-quality primary care because, compared with other children, their medical conditions place them at higher risk for poor health outcomes and because they use more services. When asked whether

recognition influenced the care provided to CSHCN, respondents noted that their practices had taken steps to improve referral tracking and other aspects of care coordination, either in preparation for or as part of the recognition process. Generalizing our findings is limited because our study included only a small sample of volunteer physicians from an even smaller number of parent organizations in two states. Moreover, our respondents worked at practices that were early-adopters of PCMH-recognition; their views may differ from those of physicians in practices that either choose not to obtain PCMH-recognition or that did so later, using NCQA's revised standards. Physicians who chose to participate in the study may be different (for example, may hold more positive PCMH beliefs) than physicians who did not participate or were not asked to do so. Finally, the data may be subject to recall bias because we asked physicians to consider activities that occurred in 2008, approximately four years before the time of our study.

Despite its limitations, this study offers physician voices and viewpoints on the NCQA-recognition process and suggests that PCMH-recognition can be both an acknowledgement of the strength of a practice's infrastructure and a marker of commitment to new and continued change. Given their complex, costly, and long-term needs, CSHCN and the practices that serve them will require particular attention as PCMH models are more broadly implemented.<sup>23</sup> In addition to gathering data from a larger sample of physicians, future studies may consider potential differences between early-adopting and late-adopting PCMH practices and focus empirically on whether PCMH-recognition is an indicator of excellence, as measured by more appropriate service use, better care coordination, better care experience, and fewer adverse outcomes for CSHCN.

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## APPENDIX A. PHYSICIAN DISCUSSION TOPICS

### A. Practice Characteristics

- Practice type, size, and ownership.
- Number of CSHCN served and percentage of total patients.

### B. Perspectives on NCQA-Recognition

- Physician involvement in the NCQA-recognition process.
- Primary reasons/motivations for practice to seek NCQA-recognition.
- Perceptions on whether NCQA-recognition signifies that a practice provides better, or different, care than those without recognition and, if so, how.

### C. Impact of NCQA-Recognition on Practice Transformation

- Changes in the organization of the practice made to achieve NCQA-recognition.
- Changes in physician clinical processes made as a result of achieving NCQA-recognition.
- Changes specifically related to providing care for CSHCN made as a result of achieving NCQA-recognition.
- Most promising or rewarding outcome of achieving NCQA-recognition.
- Features of being a PCMH that have not lived up to their promise yet.
- Downsides of achieving NCQA-recognition.

### D. Impact of NCQA-Recognition on Children's Health Service Use and Outcomes

- Observed changes in service use among CSHCN related to practice transformation to achieve NCQA-recognition.
- Observed changes in outcomes for CSHCN related to practice transformation to achieve NCQA-recognition.
- Observed changes in service use and outcomes for children without special needs.
- Perceived benefits to parents and families of CSHCN related to NCQA-recognition and receiving care at a PCMH.
- Factors that may impede practice's and physicians' ability to improve care quality and outcomes even with NCQA-recognition.

### E. Relative Impact of NCQA Standards

- Discussion of 2008 NCQA PCMH standards and elements handout.
- Perceptions on relative importance or promise of standards for increasing the quality of care and improving outcomes for CSHCN.
- Standards missing or underemphasized in 2008 NCQA-recognition process.
- If interviewee chooses, opportunity for additional comments (free thought).



**TABLE A.1. 2008 NCQA Standards and Elements Handout**

<b>Standard</b>		<b>Definition and Selected Examples</b>
1	Access and Communication	The practice provides patient access during and after regular business hours, and communicates with patients effectively. <ul style="list-style-type: none"> <li>• Patients have personal clinicians.</li> <li>• Same day appointments, based on triage, are available.</li> <li>• Telephone advice lines are available with timely response.</li> </ul>
2	Patient Tracking and Registry Functions	The practice has readily available, clinically useful information on patients that enables it to treat patients comprehensively and systematically. <ul style="list-style-type: none"> <li>• The practice can generate lists of patients and take action to remind patients or clinicians proactively of services needed.</li> </ul>
3	Care Management	The practice maintains continuous relationships with patients by implementing evidence-based guidelines and applying them to the identified needs of individual patients over time and with the intensity needed by patients. <ul style="list-style-type: none"> <li>• The practice follows guidelines for screenings, immunizations, risk assessments, and counseling and uses patient reminders for appointments, medication refills, and tests.</li> </ul>
4	Patient Self-Management Support	The practice works to improve patients' ability to self-manage health by providing educational resources and ongoing assistance and encouragement.
5	Electronic Prescribing	The practice seeks to reduce medical errors and improve efficiency by eliminating handwritten prescriptions and by using drug safety checks and cost information when prescribing.
6	Test Tracking	The practice works to improve effectiveness of care by using timely information on all tests and results. <ul style="list-style-type: none"> <li>• The practice tracks test orders to ensure results are received, flags abnormal tests, and follows-up.</li> </ul>
7	Referral Tracking	The practice seeks to improve effectiveness, timeliness and coordination by following through on consultations and referrals.
8	Performance Reporting and Improvement	The practice seeks to improve effectiveness, timeliness and other aspects of quality by measuring and reporting performance, comparing itself to national benchmarks, giving physicians regular feedback and taking actions to improve.
9	Advanced Electronic Communication	The practice maximizes use of electronic communication to improve timeliness, effectiveness, efficiency and coordination of care. The practice offers patients the use of an interactive website.

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