RESEARCH LETTER

Helping Primary Care Practices Attain Patient-Centered Medical Home (PCMH) Recognition Through Collaboration With a University

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Purpose: **Transforming a primary care practice into a patient-centered medical home (PCMH) is a resource-dependent endeavor. The objective of our study was to evaluate a facilitation model used to support rural primary care practices during a redesign of their processes to achieve recognition as National Center for Quality Assurance PCMHs.**

Methods: **The model was a collaboration between Community Care of North Carolina and a local university where undergraduate students worked directly with practices under the guidance of a Community Care of North Carolina PCMH Team.**

Results: **The facilitation model resulted in positive outcomes for both primary care practices and students.**

Conclusions: **Partnerships between care networks, agencies, payers, or practices and universities or colleges can yield mutual benefits and should be explored. (J Am Board Fam Med 2013;26:784–786.)**

Keywords: **Health Care Team, Medical Home, Patient-Centered Care, Primary Health Care, Rural Population**

Some of the challenges faced by a primary care practice considering recognition as a patient-centered medical home (PCMH) include staffing the human resources needed to write policy and procedure manuals, redesigning workflow, incorporating information technology, and documenting processes already in place.[1] These challenges are both human and financial and can be felt even more acutely in smaller rural practices.[2,3]

Methods

In 2011 North Carolina was selected as 1 of 8 states to participate in the 3-year Multipayer Advanced Primary Care Demonstration Project sponsored by The Center for Medicare and Medicaid Services.

Community Care of North Carolina (CCNC), in collaboration with Medicare, the Division of Medical Assistance, Blue Cross Blue Shield of North Carolina, and the North Carolina State Health Plan, led implementation of Multipayer Advanced Primary Care Demonstration Project in 7 rural counties. Each of the payers in the collaborative contributed resources to those CCNC primary care practices agreeing to transform their practices into PCMHs and achieve National Committee for Quality Assurance (NCQA) PCMH recognition within 12 months of the start date of the CCNC contract.

Staff members of AccessCare, one of CCNC's 14 networks and home to 3 of the rural counties involved, realized early on that additional manpower was needed to transform the practices and complete the application within 12 months. The NCQA estimates that it takes roughly 100 to 200 hours to document and upload approximately 150 documents to complete an application. One idea to meet this need was to collaborate with Appalachian State University's College of Health Sciences. Health care management and preprofessional students were recruited. The CCNC PCMH team provided the training and identified the primary

Table 1. Clinic Characteristics and Patient-Centered Medical Home (PCMH) Levels of Achievement

Clinic Characteristics	Clinic											
	1	2	3	4	5	6	7	8	9	10*	11*	12*
PCMH level achieved	2	1	1	2	3	2†	1†	2	2†	3	3	3
Students (n)	2	3	2	2	1	2	3	3	2	1	1	1
Semesters (n)	2	3	1	2	1	2	4	4	3	1	1	1
Hours spent with student each week (n)	3.5	4	3	3	1	4	4	8	4	2.5	2.5	40
Clinic staffing (n)												
Physician	2	3	1	1	2	1FT 1PT	0	2	0	3	2	2
Nurse practitioner	1	2	1 PT	1	2	1	2	0	1	0	2	2
Physician assistant	0	0	0	0	0	0	0	0	0	0	0	0
Clinical support staff‡	0	1	0	3	4	3	1	2	3	0	0	0
Administrative support staff§	11	11	5	5	7	4	2	5	2	9	7	10
Clinic operations before initiating PCMH project												
Used electronic scheduling	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes
Electronic medical record	Yes	No	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Allowed same-day appointments	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

*Clinics have regional management.
†Clinic submitted additional documents to achieve a higher level of recognition.
‡Clinical support staff include licensed practical nurses, registered nurses, medical assistants, and medical technologists.
§Administrative support staff include practice managers and all other nonclinical staff.
FT, full time; PT, part time.

care practices. The first steps were to develop a syllabus and curriculum, agree on the core documents, build a website to house resources, design a class schedule, and introduce students to the standards, elements, and factors required of a PCMH. Students met on campus with CCNC's PCMH team Wednesday evenings to learn about the PCMH process. Students then assisted their assigned practice in implementing new processes, writing policies, and redesigning workflows. Weekly meetings and access to the CCNC PCMH team via E-mail and telephone provided opportunities for students to ask questions and discuss implementation challenges. Ongoing contact and communication between students and the CCNC PCMH team proved to be especially important for the clinic's achievement of recognition as a PCMH because members of the facilitation team often had a better understanding of the PCMH guidelines than clinic staff.

Results

All practices participating in the study achieved NCQA PCMH status: 4 practices achieved level 3, 5 achieved level 2, and 3 achieved level 1. Table 1 outlines the characteristics of the practices, student participation, and the level of NCQA PCMH each achieved.

A key factor in the success of our model was a liaison between the practices and the university. In our case, this was the CCNC PCMH team, which was made up of a family physician and a local practice manager, both of whom worked part time for CCNC, and a nurse case manager who worked full time. Community need and available resources should determine the composition of the liaison team. For example, liaison team membership could include the manager of an independent practice association, personnel from a local hospital, or an area representative of a third-party payer.

Conclusion

Overall, our facilitation model using collaboration between a community liaison (CCNC's PCMH team) and a university undergraduate program provides insights for implementation of complex projects such as the transformation and redesign of primary care practices to achieve NCQA recognition as a PCMH. Similarly structured facilitation models can also be used to implement quality initiatives or information technology systems. Undergraduate students benefit from the experiential par-

ticipation, and rural primary care practices benefit from achieving NCQA recognition as a PCMH. Partnerships between universities and health care agencies provide mutual benefits.

References

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