One Family Physician's Top Ten list for creating a PCMH at your practice

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To have an ideal, smooth-running medical home according to the NCQA PCMH model, there is no question that doctors need help! Here's a top 10 list of practical requirements, in no particular order.

1. Consensus at executive levels of practice (including partners and manager). This includes a designated, decisive leader who will not hesitate to move forward with the project du jour. (Transformation involves multiple "projects du jour", sometimes many juggled at once, sometimes sequential).

2. A capable office manager and/or clinical team leader(s) who can promote harmony and teamwork, champion change, and interact well with both front & back office staff to ensure they appropriately adopt & use new tools (software, registries, etc.) This person also needs to be a whiz at organization, implementing policy & procedure manuals, & documentation.

3. Nurturing. This usually will come from the manager and team leaders, who convene regular meetings and encourage the staff to maintain change. The team needs to adapt workflow TOGETHER based on staff and patient feedback.

4. A capable team. I cannot underestimate the importance, and the complexity and difficulty, of building a good, diverse team. I have personally spent 5 years of trial & error, with hires, fires, relocations, illness and maternity leaves, and staff friction. In a moderate-sized practice, there will nearly always be some stress & transition among your employees. You must get wrong people off bus, right people on bus, but it's tough to judge who the right or wrong people are. Sometimes we just have to live with the group we have because suitable replacements aren't available.

5. Good timing. First, this includes a game plan with an achievable time line. According to Nutting et al, this may be 3-4 years. Secondly, you need to assess staff dynamics to be sure it's a good time for the team to learn something new. Over the years, we have had periods of extreme staff conflict, or several staff members bereaved at the same time, or financial crunches that hindered any chance of change. Again, I have personally lived through times when there was no way I could learn or absorb a new software program or workflow pattern, due to stress overload or fatigue. If staff members are too distracted by personal-life drama, they will only be half-attentive to the proposed change in the practice.

6. Good finances (a profit at baseline) & financial analysis: where were we, where are we, where are we going if we adopt certain changes? Raw data is best provided by billers, office manager, and accountant. There is still no substitute for the practice owners' analysis, and this can easily occupy most of a dreary rainy weekend.

7. Feedback loops that get closed: surveys of staff, patients, colleagues to detect where the model isn't working, and a process to modify the model. It's a CQI process and many of us have experienced stagnation in practices where nothing got decided, done, changed.

8. IT support. I've been fortunate to find a good, experienced local health IT professional through a colleague's referral. Unfortunately, this is a new and growing field with many people willing to charge "rich" doctors outrageous fees for little concrete work. Some will sell programs, but won't service them. Except for the most basic charting programs, doctors are usually not well equipped to install and maintain their own hardware, software and security configurations. EMR and practice management programs may or may not have much online or phone support available. It is important to ask existing users how much support the vendors of these products provide; and also identify a

source of reasonable-cost local IT support. I don't think we are ready as a nation to mandate EMRs in every medical home within two years.

9. Community support. Small practices won't have in-office dietician, counselor, nurse educator, exercise consultant, physical therapist.

10. For highest-level integration: Regional support that includes hospitals (the vaporware inter-operative EMRs), consulting specialists, business community, AND global/national support (all payers, pharmacies/PBMs for e-rx etc.) Few hospitals are willing to take on interoperability as a project. They are too stressed with their own higher-priority mandates.

Practices planning to move forward with PCMH initiatives need to be realistic. There is too much for any one person to take on. Some of the elements in my top-ten list are beyond a doctor's control, or depend on management or IT resources that may not be available in under-resourced areas such as urban or rural settings.