Partnering with Universities and Colleges to Facilitate the PCMH Process

An Innovative Plan to Place Healthcare Management Students into Practices to Promote Healthcare Transformation

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Practices contemplating the Patient-Centered Medical Home recognition process are confronted with an arduous task. Perhaps the most palatable constraints are time management combined with staff allocation decisions. Outside consultants can be expensive and disruptive to practice flow. Collaborating with a local college or university’s healthcare management or other health career students might be one answer. This article will explore that option.

KEY WORDS: Patient-Centered Medical Home; PCMH; primary care; healthcare management; multipayer initiative.

Part of the challenge of promoting Patient-Centered Medical Home (PCMH) recognition within a practice is allocating that practice’s resources—particularly staff time—in order to facilitate that process. That is, one of the most important things a medical practice can do after it has decided to pursue PCMH recognition is to then decide who will do the work. Most estimates of the time it will take to complete the process are between 100 and 200 hours of manpower.

Part of the PCMH recognition process is picking the work team. Even in a smaller practice, this usually includes a clinical champion and at least one administrative champion. In larger practices, there are usually more personnel resources available to do the work; but even there, large potential costs loom as key personnel must take time from their normal tasks to work on PCMH recognition. However you look at it, this costs the practice money.

What might be at least part of the solution to this problem? Community Care of North Carolina (CCNC) has developed an innovative program with the Appalachian State University (ASU) College of Health Sciences and its Health Care Management Program that takes junior and senior college students and places them within local primary care offices to add “boots on the ground” and help facilitate the PCMH process.

THE FIRST SEMESTER

The team was mobilized quickly, working with one of the ASU Health Science faculty to get the word out to the students; develop a curriculum and a syllabus; develop forms; set up a schedule of didactic sessions on Wednesday nights on campus; design a Web site for the students, which included core curriculum materials, a calendar, contact information, etc.; and set up appointments for the students to

THE STORY

CCNC is a 501c3, nonprofit organization, which makes medical homes available to well over 1 million North Carolinians and covers all 100 counties in the state within 14 regional networks. There are more than 5500 primary care providers caring for our patient base.

One of CCNC’s current initiatives (through the Center for Medicare and Medicaid Innovation) is to be part of the Multi-payer Advanced Primary Care Practice Project (MAPCP), which is underway in seven rural counties in North Carolina. Three of those counties—Ashe, Avery, and Watauga—are in the northwest portion of the state. Watauga County is home to Boone, North Carolina, and ASU, which is the fourth largest university in the state.

One of the requirements for the MAPCP initiative is to complete PCMH recognition within a year of beginning the project. So as a network, we were faced with about 30 practices that needed to complete that requirement. One of the members of our team came up with the idea to couple with ASU’s College of Health Sciences to get the job done. As it turned out, it was a match made in heaven. The students would have a fantastic experience out in the field working in the physicians’ offices, and we would get free labor!
Having the students there made the transition much easier, comfortable with the adaptation to electronics of any kind, and some of the practice staff and doctors were not terribly enthusiastic about electronic medical records at the beginning of the project, at the outset was the fact that technology was second-nature to the students.

Each student developed a PowerPoint presentation about PCMH and the MAPCP, which they were to give to the practices. This was certainly helpful for them to get an overview of what they would be doing within the practices and good for the practices as many of them had not yet been exposed to the concept of PCMH, much less the Multi-payer Project. Some of the resources the students used were materials developed by CCNC to help practices in the PCMH process including Webinars and a Web-based PCMH workbook containing examples of documentation other practices had used in their journey toward PCMH recognition.

During the first semester (Fall 2011), there were five students involved. After they signed their HIPAA forms and Business Associate Agreements, all jumped in to help “their” practice. The students were initially most helpful in capturing work flow and helping the practices put together Policy and Procedure handbooks. It was readily evident that most of the practices were already doing many of the requirements necessary for PCMH recognition, but had never actually taken the time to write down the procedure or policy pertaining to it. Following their first semester experience, one of the comments most commonly heard from the practices was that the resulting Policy and Procedure manual the students had helped them develop was a very useful exercise in that it standardized things like job descriptions or inclement weather policies and was a good reference guide for new hires.

**Technology was second-nature to the students.**

One of the benefits of having college students working with us on the project that none of us could have foreseen at the outset was the fact that technology was second-nature to them. A number of the practices did not have electronic medical records at the beginning of the project, and some of the practice staff and doctors were not terribly comfortable with the adaptation to electronics of any kind. Having the students there made the transition much easier, and the students were looked at as a valuable resource and a true asset to the practices in this regard. When tasked with running a clinical report, the students were often more facile than were the office managers in some cases. A couple of practices actually had the students work to resolve some connectivity problems they had been experiencing.

At the end of the semester, the students were tasked with writing a summary paper of their experience. To a participant, the students took real ownership of their practice and assignments. All stated that it had been the best experience of their education thus far. They were treated as integral members of the team and consistently exceeded everyone’s expectations. All of the students left their practices wanting more from them because the students had brought their practices much closer to the goal of PCMH recognition. One of the practices actually hired one of our graduating seniors who participated in the Practicum to help the practice finish the process of submitting its Survey Tool to the National Committee for Quality Assurance.

**LESSONS LEARNED FROM THE FIRST SEMESTER**

One thing we definitely learned from the first semester was the importance of making sure practice teams held regular meetings with regard to their “Road to Recognition.” This has to do with practices really taking ownership of the process. We could provide all kinds of great tools like the “Quick Look Assessment” found in the Workbook, which helps practices know where they are in the process quickly and easily. But unless the teams have meetings to understand where they are and who is doing what, the information is not disseminated practice-wide. Whole-practice buy-in is all important. It also adds to the ownership part of the equation. We encouraged the students to not drive this process. It was more important for someone in the practice to do that. Otherwise, if the students do all the work for the practice, as opposed to the students supporting the practice’s work, when the student leaves, the practice is a little lost.

Another issue that arose during the first semester was the fact that working within the Practicum, several of the students were unable to keep their money-paying jobs and manage their course load at the same time. Students averaged about 10 hours a week at their practices and doing the other tasks assigned to them in the Practicum course. For their efforts, the students receive three semester hours of academic credit that counts as elective credit. Next year, since the students’ experience has been so rich, the University has decided to allow two semesters of the Practicum in Primary Care to substitute for the required six semester
hours of internship, which is required to earn their B.S. in Health Care Management degree.

A $10,000 grant was applied for and obtained from Blue Cross and Blue Shield of North Carolina (BCBSNC) Foundation in order to support the student’s efforts for the following semester. We estimated 10 students, working 100 hours over the length of the Practicum, averaged out to about $10 an hour—which was about what they would have made flipping hamburgers at 5 Guys. All of them were happy to trade the jobs they were doing for the experience they got with the Practicum.

BCBSNC Foundation was kind enough to support our efforts because we were working in mainly rural practices. In addition, a couple of our counties are in the process of implementing Rural Health Clinics, and one of the practices where the students worked supported one of the local Migrant Worker Clinics. We will be working in our local Health Departments as well in the near future. Through the Foundation’s Health of Vulnerable Populations focus area, our efforts are coupled with the Foundation’s in improving the health of North Carolinians who need it most.

During our second semester, the PCMH Leadership Team also refined our goals and curriculum and helped the students and practices to have an even better experience. Of the nine students we had the second semester (one dropped the course early secondary to carrying 21 credit hours), two were veterans from the first semester and were very helpful in mentoring the new students who came on board.

**NEXT STEPS**

Of the current nine students, five plan to work with us full-time during their required summer internships, which will provide an additional 300 hours (per student) to the practices over the summer in a much more concentrated manner. It is hoped that already having prior experience, they will be able to help their practices finish the PCMH recognition process successfully. As we add more practices to the Multi-payer Project, these experienced students will be invaluable to the newly added practices as they go through their recognition process.

The plan to help support the students this summer will be to go back to the BCBSNC Foundation and ask for $1500 per student for the 300 hours they are required to work. Our hope is that the practices that want help with their PCMH process will match those funds for a total of $3000 to help the students in their efforts. Some students do their internships for nothing, so we expect the list of applicants to be quite long.

We are also supportive as a network in promoting PCMH efforts throughout the region in the adjoining counties that are not involved in the MAPCP.

There is no reason that this program could not be taken state-wide. We are already speaking to the School of Public Health at the University of North Carolina, Chapel Hill to adopt the program for its students. Any college or university that has a College of Health Sciences, Health Care Management or Health Administration program, School of Public Health, medical school, nursing school, or business school could institute the program. Our group would be happy to provide any or all of our resource materials. These could easily be adapted to any other school wishing to participate in a program like this. All that would then be needed is a group of educators (and students) that would be willing to network with community health service providers that would have a stake in achieving PCMH recognition. There is currently an initiative from BCBSNC that gives physicians “credit” toward the points necessary to achieve their Blue Quality Physician program if they help other physician practices in the community achieve PCMH recognition. That certainly could be a good match in our state.

Many of us believe that the PCMH is one of the greatest hopes to keep primary care medicine relevant, intact, and in the leadership role it deserves as we move through a world that puts a premium on efficiency, quality, and cost-containment. It quite possibly may also be the road upon which we close the reimbursement gap between the specialists and primary care doctors as we continue to show the true and now undisputed value of primary care and family medicine.