

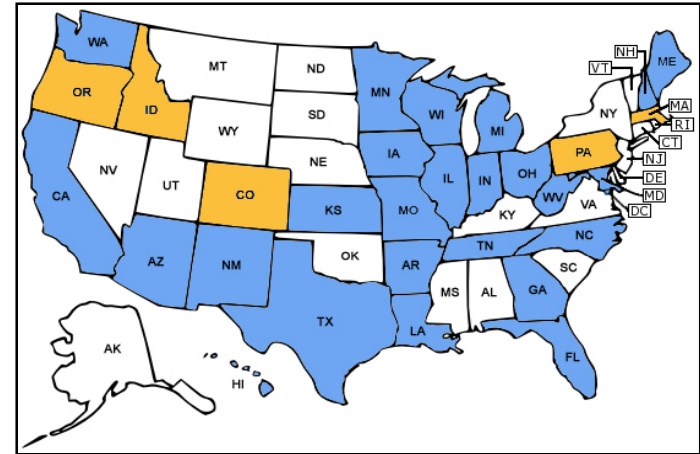
# Patient-Centered Medical Care: From Vision to Reality

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**Safety Net  
Medical Home Initiative**



# Safety Net Medical Home Initiative



- 5-year PCMH demonstration project to help 65 safety net primary care sites implement PCMH
- 5 Regional Coordinating Centers employ practice coaches who provide direct support to sites and support state-based learning communities
- Administered by Qualis Health in partnership with the MacColl Center for Health Care Innovation



# Funders



Beth Israel Deaconess  
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# Change Concepts for Practice Transformation:

## *Sequenced Changes*





## Engaged Leadership

### **Goal:**

To have effective, involved leaders help staff see a better future, and give them the tools, resources and time to achieve it.

## Quality Improvement Strategy

### **Goal:**

To have in place a sustainable, broadly inclusive approach to continuous quality improvement that includes trusted performance measurement and a strategy for changing practice.



# Laying the Foundation: Why is it Important?

- Leadership and QI strategy provide the foundation for re-design.
- Practices that succeed in quality improvement initiatives have *adaptive reserve* – the ability to learn and change.
- Key feature is leadership that can: envision a future, facilitate staff involvement, and devote time and resources to make changes.
- Practices that don't routinely measure and review performance are unlikely to improve.



## What Does it Actually Look Like?

- The responsibility for conducting quality improvement activities is shared by all staff, and made explicit through protected time to meet and specific QI resources.
- Quality improvement activities are conducted by practice teams with *meaningful* involvement from patients and families.
- Leaders support continuous learning throughout the organization. They review and act on data.
- PCMH is built into hiring. Training and incentives focus on rewarding patient-centered care.



## What Have We Learned?

- Turnover is one of the most disruptive events to successful transformation:
  - PCMH transformation must be embedded in the organization to protect against leadership turnover.
- Most sites have little capacity to collect, analyze, and report data from valid, reliable measures.
- QI is difficult unless information technology is stable.
- All staff must understand the value of measurement and have confidence in using data to *drive* change.



## Empanelment

### **Goal:**

To assign all patients to a provider/care team to facilitate continuous care and population management.

## Continuous, Team-Based Relationships

### **Goal:**

To develop skilled and well organized care teams, and ensure that patients are able to see their care team consistently over time.

Teams should be designed to meet the needs of patient panels (typically include provider, MA, RN, front desk staff)



# Building Relationships: Why is it Important?

- Empanelment is *the* platform for population health:
  - Links patients to care teams
  - Profoundly changes culture and sense of accountability
- Team involvement in the care of chronically ill is the single most powerful intervention.
- Patients who have a continuity relationship with a personal provider have better health process measures and outcomes:
  - Continuity of care increases the likelihood that the provider is aware of psychosocial problems impacting health.



## What Have We Learned?

- Empanelment is harder than it looks:
  - Assumes stability of providers and patients
  - Requires continuous attention
- Teamwork does not necessarily happen just because people are working on a team:
  - NEW relationships and NEW communication strategies have to be established.
  - Providers need to be trained and given protected time to lead the team.
- Creative practices are expanding the roles of less highly trained staff such as MAs or Community Health Workers.



## Patient-Centered Interactions

### **Goal:**

To encourage patients to expand their role in decision-making, health-related behaviour change and self-management and to communicate with them in a language and at a level they understand.

## Organized, Evidence-Based Care

### **Goal:**

To use planned interactions and follow-up with patients according to patient need, and to identify high-risk patients and ensure they are receiving appropriate care management services.



# Changing Care Delivery: Why is it Important?

- Patient activation is tied to health improvement.
- Patient involvement in QI activities and health center boards helps maintain the focus on patient and family needs.
- Well-organized care is patient-centered care.
- Well-organized care is good care:
  - Practices that do pre-visit planning (huddle) have better measures of chronic disease control and preventive care.



## What Does it Actually Look Like?

- Assessing patient/family needs and preferences, and involving patients in decision-making is systematic, not ad hoc.
- The principles of patient-centered care inform organizational level decisions and patient interactions.

## What Have we Learned?

- Effective practices train *all* staff on patient communication and engagement techniques: “teach-back”
- Strategies to involve patients in the re-design process are still being identified. High-performing practices have adopted: *“Nothing about me without me.”*



## Care Coordination

### **Goal:**

To track and support patients when they obtain services outside the practice, and ensure safe and timely referrals or transitions.

## Enhanced Access

### **Goal:**

To ensure that established patients have 24/7 continuous access to their care teams via phone, email, or in-person visits.



## Reducing Barriers to Care: Why is it Important?

- Evidence of cost savings comes, primarily, from improvements in care coordination and access.
- Even a *few* hours of off-hours appointment access is associated with reduced ED use.

## What Have We Learned?

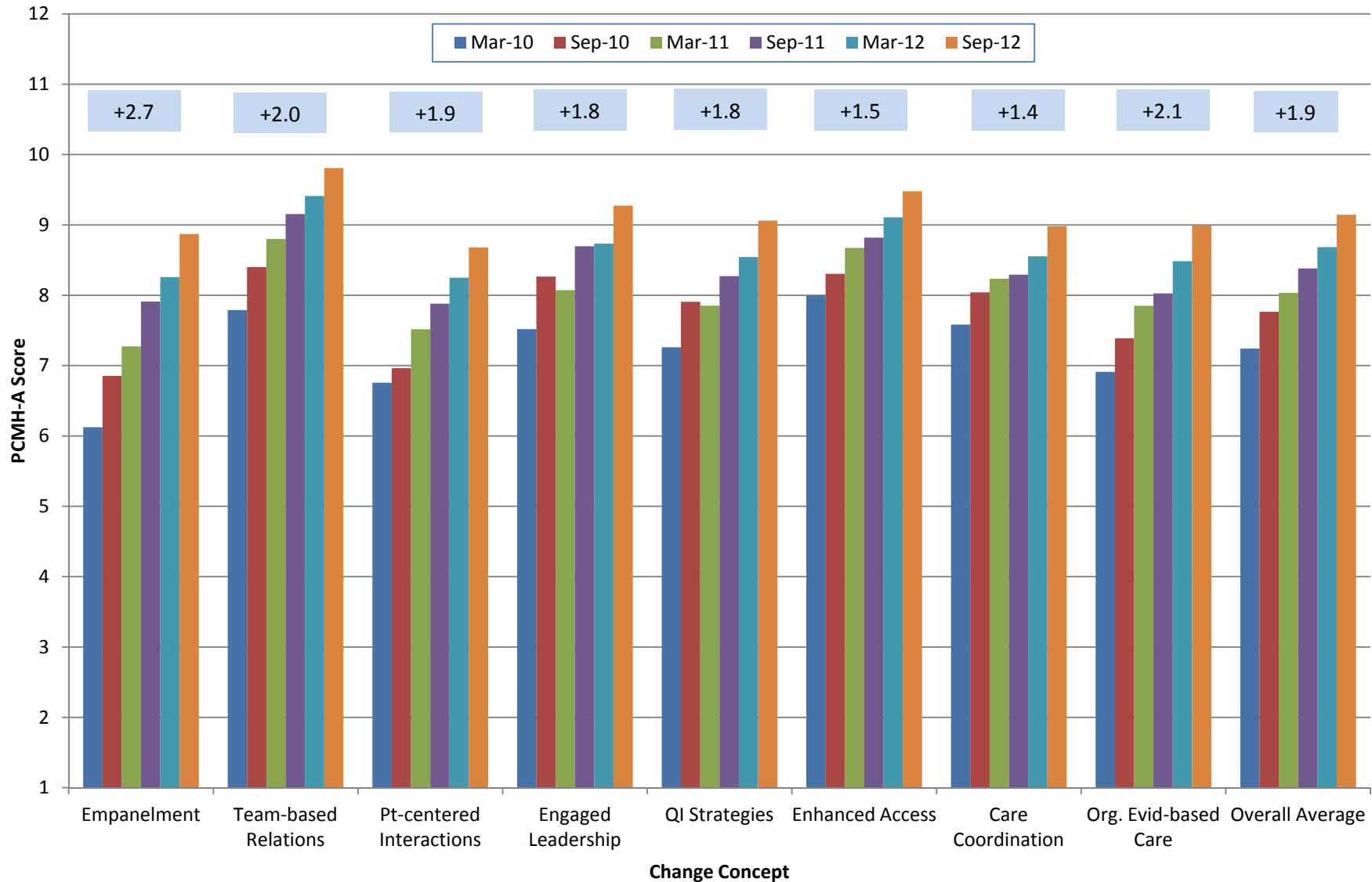
- Care coordination isn't left to chance. Effective practices assign key activities and embed them in daily work.



## Average Change Concept Scores Across All Partner Sites

Mar 2010 - Sep 2012

(Numbers in boxes contain the increase in Change Concept score from Mar 2010 to Sep 2012)





# What does a practice need to become a PCMH?

- Internal support:
  - Leadership and vision: adaptive reserve
  - Long-term perspective and commitment
  - Willingness to invest in their practice and their staff
- External support:
  - Resources and tools
  - Payment system that rewards value, not volume
  - Medical Home *Neighborhood*'
  - **Access to a practice coach and a learning community**



# External Support: Why It's Important

- Practice coaches:
  - Articulate the “roadmap” and help connect the dots
  - Educate
  - Provide “process facilitation” (e.g., project management skills)
  - Assess needs and priorities
  - Identify tools to support the work
- Learning communities:
  - Sites learn best from one another
  - Some aspects of PCMH (leadership, teams) are difficult to *teach*
  - Provide ongoing support
  - Spread and sustainability



## How Can Philanthropy Help?

- Invest in technical assistance:
  - Practice coaching
  - Learning communities
  - Resources and tools
- SNMHI experience shows even a small amount can have a powerful impact.
- Provide vision and direction, and help set priorities
- Advocate for alignment:
  - Help practices and payers connect the dots



## SAFETY NET MEDICAL HOME INITIATIVE

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### Patient-Centered Care for the Safety Net

The Safety Net Medical Home Initiative is a national Patient-Centered Medical Home demonstration project that is helping 65 primary care safety net sites become high-performing medical homes and improve quality, efficiency and patient experience. [Learn more about the Initiative.](#)

The Initiative created a framework for PCMH transformation and has published a library of resources and tools to help practices implement the PCMH Model of Care. [Access our PCMH materials.](#)



MacColl Center for Health Care Innovation

<http://www.safetynetmedicalhome.org/>