Safety Net Medical Home Initiative

CHANGE CONCEPTS FOR PRACTICE TRANSFORMATION

QUALIS HEALTH

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THE CHANGE CONCEPTS FOR PRACTICE TRANSFORMATION

Becoming a Patient-centered Medical Home (PCMH) means wholesale transformation of practice systems for most primary care organizations. But wholesale transformation ultimately entails a broad assortment of small changes in different aspects of the practice. Eight "change concepts" comprise the Change Concepts for Practice Transformation, the Safety Net Medical Home Initiative's PCMH transformation framework. These 8 change concepts represent the critical dimensions of PCMH transformation. Each change concept includes multiple "key changes" that describe the general directions for the changes. Two questions frequently asked by practices implementing the eight change concepts and 33 key changes are: "How do all these fit together?" and "Where do we begin?"

How do the change concepts fit together? Payer and policymaker enthusiasm for the PCMH Model of Care stems from their belief that a practice that provides high-quality primary care will improve outcomes and reduce healthcare costs by meeting patient needs for accessible, continuous, comprehensive, and coordinated services and evidence-based, patient-centered, planned care. The eight change concepts collectively enable the delivery of care consistent with these expectations.

"Where do we begin?" We think that the change concepts naturally divide into four groups: laying the foundation, building relationships, changing care delivery, and reducing barriers.

Change concepts in *laying the foundation*—"Engaged Leadership" and "Quality Improvement Strategy—reflect the fundamental base required to enable the practice to learn and implement change. If these foundational changes are not addressed first, meaningful transformation cannot occur. The change concepts directed at *building relationships* among teams, and between patients and providers—"Empanelment" and "Continuous, Team-based Healing Relationships"—prepare the practice to deliver care efficiently, and increase the likelihood of productive interactions between patients and care teams. The next change concepts—"Patient-centered Interactions" and "Organized, Evidence-based Care"—focus on *changing care delivery*. These changes encompass the practice system modifications associated with improvements in clinical performance. The final two change concepts—"Enhancing Access" and "Care Coordination"—focus on *reducing barriers* to the seamless delivery of care. These changes are no less important than the change concepts addressed earlier, but they are more difficult to implement in systems that are not already routinely providing well-organized, patient-centered care.

LAYING THE FOUNDATION

ENGAGED LEADERSHIP

- Provide visible and sustained leadership to lead overall cultural change as well as specific strategies to improve quality and spread and sustain change.
- Ensure that the PCMH transformation effort has the time and resources needed to be successful.
- Ensure that providers and other care team members have protected time to conduct activities beyond direct patient care that are consistent with the medical home model.
- Build the practice's values on creating a medical home for patients into staff hiring and training processes.

QUALITY IMPROVEMENT (QI) STRATEGY

- Choose and use a formal model for quality improvement.
- Establish and monitor metrics to evaluate routinely improvement efforts and outcomes; ensure all staff members understand the metrics for success.
- Ensure that patients, families, providers, and care team members are involved in quality improvement activities.
- Optimize use of health information technology to meet Meaningful Use criteria.

BUILDING RELATIONSHIPS

EMPANELMENT

- Assign all patients to a provider panel and confirm assignments with providers and patients; review and update panel assignments on a regular basis.
- Assess practice supply and demand, and balance patient load accordingly.
- Use panel data and registries to proactively contact and track patients by disease status, risk status, self-management status, community and family need.

CONTINUOUS & TEAM-BASED HEALING RELATIONSHIPS

- Establish and provide organizational support for care delivery teams that are accountable for the patient population/panel.
- Link patients to a provider and care team so both patients and provider/care teams recognize each other as partners in care.
- Assure that patients are able to see their provider or care team whenever possible.
- Define roles and distribute tasks among care team members to reflect the skills, abilities, and credentials of team members.

CHANGING CARE DELIVERY

PATIENT-CENTERED INTERACTIONS

- Respect patient and family values and expressed needs.
- Encourage patients to expand their role in decision-making, health-related behaviors, and self-management.
- Communicate with patients in a culturally appropriate manner, in a language and at a level that the patient understands.
- Provide self-management support at every visit through goal setting and action planning.
- Obtain feedback from patients/families about their healthcare experience and use this information for quality improvement.

ORGANIZED, EVIDENCE-BASED CARE

- Use planned care according to patient need.
- Identify high risk patients and ensure they are receiving appropriate care and case management services.
- Use point-of-care reminders based on clinical guidelines.
- Enable planned interactions with patients by making up-to-date information available to providers and the care team prior to the visit.

REDUCING BARRIERS TO CARE

ENHANCED ACCESS

- Promote and expand access by ensuring that established patients have 24/7 continuous access to their care teams via phone, e-mail, or in-person visits.
- Provide scheduling options that are patient and family-centered and accessible to all patients.
- Help patients attain and understand health insurance coverage.

CARE COORDINATION

- Link patients with community resources to facilitate referrals and respond to social service needs.
- Integrate behavioral health and specialty care into care delivery through co-location or referral agreements.
- Track and support patients when they obtain services outside the practice.
- Follow up with patients within a few days of an emergency room visit or hospital discharge.
- Communicate test results and care plans to patients.

Safety Net Medical Home Initiative

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The objective of the Safety Net Medical Home Initiative is to develop and demonstrate a replicable and sustainable implementation model to transform primary care safety net practices into patient-centered medical homes with benchmark performance in quality, efficiency, and patient experience. The Initiative is administered by Qualis Health and conducted in partnership with the MacColl Institute for Healthcare Innovation at the Group Health Research Institute. Five regions were selected for participation (Colorado, Idaho, Massachusetts, Oregon and Pittsburgh), representing 65 safety net practices across the U.S. For more information about the Safety Net Medical Home Initiative, refer to: www.safetynetmedicalhome.org.

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