Project Summary: July 2013

Introduction

The Safety Net Medical Home Initiative has been widely recognized as a landmark demonstration of the Patient-Centered Medical Home (PCMH) Model of Care. This document provides a snapshot of the Initiative's achievements, describes a new library of free resources and tools on PCMH implementation, and describes what comes next.

About The Safety Net Medical Home Initiative

In May 2008, The Commonwealth Fund, Qualis Health, and the MacColl Center for Health Care Innovation at the Group Health Research Institute launched a five-year initiative to help primary care safety net sites become high-performing medical homes and achieve benchmark levels of quality, efficiency, and patient experience.

Our implementation was both faster and more effective because of the point-by-point delineation of the Key Changes and Medical Home Concepts.
Matilda Theiss Health Center, Pittsburgh, PA

Without this help, trying to implement PCMH transformation would be akin to attempting to learn a new language with no tools, textbook, etc.
East Liberty Family Health Center, Pittsburgh, PA

Learn more about the project at www.safetynetmedicalhome.org.

We created a replicable model for practice transformation…

A key goal of the SNMHI was to develop a replicable model for practice transformation. The SNMHI developed, and over the course of the Initiative tested and refined, technical assistance methods and an evidence-based framework for PCMH transformation. Our proven model has been adopted by other improvement initiatives nationwide.

The Change Concepts for Practice Transformation: An Evidence-Based Framework to Guide Practice Transformation at the Practice Site Level

A "change concept" is a general idea used to stimulate specific, actionable steps that lead to improvement. The SNMHI framework includes eight change concepts in four stages. Together they represent the key design features of a PCMH.
1. Laying the Foundation: Engaged Leadership and Quality Improvement Strategy.
2. Building Relationships: Empanelment and Continuous and Team-Based Healing Relationships.
3. Changing Care Delivery: Organized, Evidence-Based Care and Patient-Centered Interactions.
4. Reducing Barriers to Care: Enhanced Access and Care Coordination.

Each SNMHI Change Concept includes three to five "key changes." These provide a practice undertaking PCMH transformation with more specific ideas for improvement. Each practice must decide how to implement these key changes in light of their organizational structure and context. The Change Concepts were derived from reviews of the literature and discussions with leaders in primary care and quality improvement. They have been most extensively tested by the 65 safety net practices that participated in the SNMHI, but they are applicable to a wide range of primary care practice types.

Learn more about the Change Concepts for Practice Transformation.

We developed a library of resources and tools to guide transformation…

The SNMHI developed a comprehensive library of resources and tools to support the SNMHI Change Concept framework and help practices understand and implement the PCMH Model of Care. Resources were developed in partnership with practices that participated in the SNMHI and were informed by reviewers and contributors from across the country. The library was updated and expanded in June of 2013 to reflect the experience and learning of sites that participated in the Initiative. All resources are free and in the public domain. Together, these resources provide an invaluable legacy for others embarking on the PCMH journey or looking to improve their PCMH performance.

PCMH Resources

- Introductory materials describe how and where to begin PCMH transformation.
- Executive Summaries provide a concise description of each Change Concept, its role in PCMH transformation, and key implementation activities and actions.
- Implementation Guides provide a full introduction to each Change Concept, implementation strategies and tools, and case studies.
- Webinars with topics varying from "Optimizing the Role of Front Desk Staff" to "Care Coordination in Rural Communities." Webinars highlight the best-practices of SNMHI sites and other leading practices and many address specific implementation challenges.
- Policy briefs on medical home payment and health reform describe recognized PCMH payment models, the impact of patient/family social, behavioral, and environmental factors on the financial viability of safety net practices, and anoverview of the 2010 health reform legislation and impacts on safety net providers.

> The online resources, webinars, learning sessions, and community of peers were fantastic for offering implementation roadmaps, best practices, trouble-shooting, and collaboration.
>
> *Codman Square Health Center, Massachusetts*
>
> ---
>
> The resource materials…were very helpful in strengthening the understanding of core concepts.
>
> *Community Health Centers of Benton and Linn Counties, Oregon*

PCMH Tools

- Patient-Centered Medical Home Assessment (PCMH-A) is an interactive, self-scoring instrument that can be downloaded, completed, saved, and shared. The PCMH-A provides a detailed indication of the extent to which a practice functions as a PCMH, and if completed at regular intervals, can help practices track their progress toward practice transformation. PCMH-A results can also help collaborative sponsors plan and deliver relevant technical assistance.
- Key Activities Checklist is an excel workbook that provides examples of activities that have been tested by SNMHI sites.
- Tools that can be used to test or apply the key changes include an interactive Do-it-Yourself Run Chart, Patient Acuity Calculator, and a Secret Shopper Exercise to test the ease of scheduling an appointment from the patient's perspective.
- Change Concepts for Practice Transformation and 2011 NCQA PCMH™ Recognition Standard: A Crosswalk.
- A downloadable registry of tools and resources, which includes all resources and tools hosted on the site and those hyperlinked within documents on the site.

We built regional capacity for improvement…

Another key goal of the SNMHI was to build regional capacity for improvement by training practice coaches and developing learning communities. The Initiative selected five "Regional Coordinating Centers" (RCC) from 42 applicants. The selected organizations, mainly state Primary Care Associations (PCAs), received funding from the Initiative and employed "Medical Home Facilitators" who provided direct support for the sites in their region (Colorado, Idaho, Oregon, Massachusetts, and Pittsburgh, PA). Medical Home Facilitators received training and support and participated in a coaches' learning community. The majority of RCCs were able to build effective practice facilitation programs and have committed to maintaining and growing these programs in the future, spreading what they learned in the SNMHI to other safety net sites in their communities.

Learn more about the SNMHI Regional Coordinating Centers.

Evidence of practice redesign…

With support from the SNMHI Medical Home Facilitators, the Project Team, and their peers, SNMHI practices made significant achievements, which we believe will result in improved health outcomes, patient experience, and provider and staff satisfaction. Sites completed a self-assessment that measured the degree of implementation of the Change Concepts for Practice Transformation at regular intervals throughout the Initiative. At the final administration, 100% of SNMHI sites demonstrated some level of implementation of all of the key design features of a PCMH and nearly 50% demonstrated full implementation. Examples of improvement include:

- Use of registries for pre-visit planning and outreach.
- Policies and procedures that ensure continuity of care (patients see their provider and care team whenever possible).
- Non-physician practice team members now perform key clinical service roles that match their abilities and credentials (a measure of team-based care).
- Principles of patient-centered care are consistently used to guide changes and care interactions.

> Being a part of the Initiative challenged us to improve, track, and report on the things we said we were doing. It also challenged us to meet all of the items in the model of care instead of maintaining the status quo.
>
> *High Plains Community Health Center, Colorado*

> Participation in this Initiative was vital to our moving this care model. Having a chance to hear what others were doing, what worked or didn't work helped us formulate our plans to move forward.
>
> *St. Mary's Hospital and Clinics, Idaho*

PCMH recognition…

PCMH recognition was an important goal for many sites. The SNMHI provided coaching and financial support for recognition. Eighty-one percent (81%) of participating sites achieved PCMH recognition, either from NCQA or their state. Recognition qualifies practices in some states for enhanced payments and is a cornerstone goal of supporting agencies such as the Health Resources and Services Administration (HRSA).

What Comes Next?

Evaluation: Technical assistance for participating sites concluded in April of 2013. The Commonwealth Fund is supporting a rigorous evaluation of the Safety Net Medical Home Initiative. The University of Chicago, the evaluation lead, expects to begin to publish the results of their findings in 2014. Learn more about the SNMHI evaluation. Follow the outcomes of the SNMHI.

Dissemination: Qualis Health and the MacColl Center for Health Care Innovation have been awarded a grant from The Commonwealth Fund to identify and publish the primary lessons of the SNMHI experience to help inform implementation efforts and policy.

Additional resources and tools: A behavioral health integration Implementation Guide is underway and will be published on the SNMHI website in 2014.

Safety Net Medical Home Initiative

This is a product of the Safety Net Medical Home Initiative, which was supported by The Commonwealth Fund, a national, private foundation based in New York City that supports independent research on health care issues and makes grants to improve health care practice policy. The views presented here are those of the author and not necessarily those of The Commonwealth Fund, its directors, officers, or staff. The Initiative also received support from the Colorado Health Foundation, Jewish Healthcare Foundation, Northwest Health Foundation, The Boston Foundation, Blue Cross Blue Shield of Massachusetts Foundation, Partners Community Benefit Fund, Blue Cross of Idaho, and the Beth Israel Deaconess Medical Center. For more information about The Commonwealth Fund, refer to www.cmwf.org.

The objective of the Safety Net Medical Home Initiative was 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 was administered by Qualis Health and conducted in partnership with the MacColl Center for Health Care 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.