THE CHANGE CONCEPTS FOR PRACTICE TRANSFORMATION: OVERVIEW

May 2013

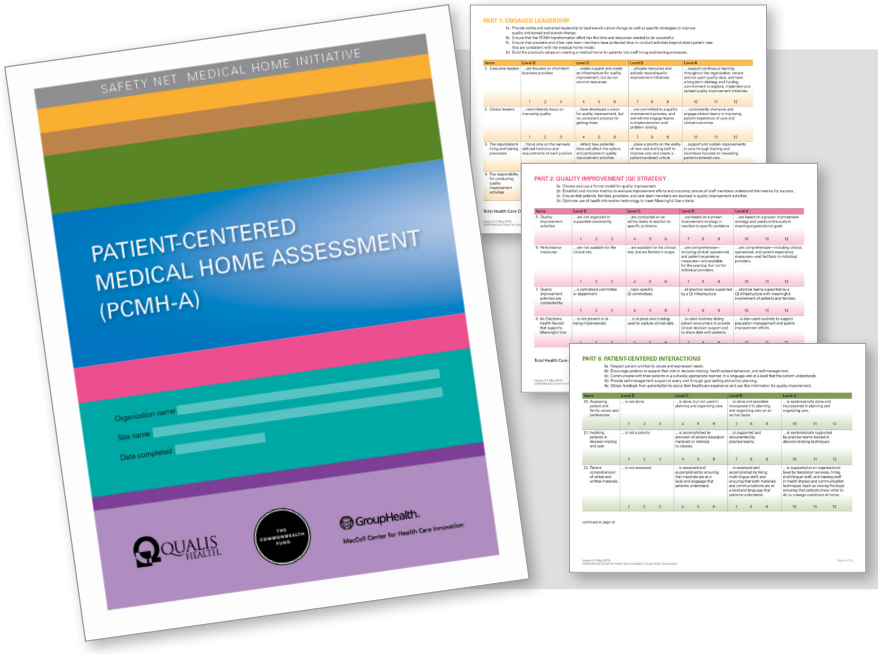
The Safety Net Medical Home Initiative (SNMHI) developed a framework to help guide primary care practices through the PCMH transformation process—The Change Concepts for Practice Transformation.[1]

"Change concepts" are general ideas used to stimulate specific, actionable steps that lead to improvement.

The Change Concepts were derived from reviews of the literature and discussions with leaders in primary care and quality improvement. Each 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 for Practice Transformation 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. The Change Concepts have been adopted by a number of other improvement initiatives, reflecting their generalizability in primary care regardless of patient population or practice structure. They are supported by a comprehensive library of resources and tools that provide detailed descriptions and real examples of transformation strategies. These resources are free and publicly available.

To learn more about the Change Concepts for Practice Transformation and the Safety Net Medical Home Initiative, visit: www.safetynetmedicalhome.org.



Practices beginning the PCMH transformation journey often have questions about where and how to begin. We recommend that practices start with a self-assessment to understand their current level of "medical homeness" and identify opportunities for improvement."

The SNMHI's self-assessment, the Patient-Centered Medical Home Assessment (PCMH-A), is an interactive, self-scoring instrument that can be downloaded, completed, saved, and shared.

Change Concepts and Key Changes

LAYING THE FOUNDATION

ENGAGED LEADERSHIP

- Provide visible and sustained leadership to lead overall culture 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 improvement efforts and outcome; 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, educate, 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 accountable for the patient population/panel.
- Link patients to a provider and care team so both patients and provider/care team recognize each other as partners in care.
- Ensure 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.

THE CHANGE CONCEPTS FOR PRACTICE TRANSFORMATION: OVERVIEW

CHANGING CARE DELIVERY

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 at the time of the visit.

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 their 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/family about their healthcare experience and use this information for quality improvement.

REDUCING BARRIERS TO CARE

ENHANCED ACCESS

- Promote and expand access by ensuring that established patients have 24/7 continuous access to their care team via phone, email 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 protocols.
- 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/families.

Suggested citation: Safety Net Medical Home Initiative. Change Concepts for Practice Transformation. 4th ed. Seattle, WA: Qualis Health and the MacColl Center for Health Care Innovation; May 2013.

References

1. Wagner EH, Coleman K, Reid RJ, Phillips K, Abrams MK, Sugarman JR. The changes involved in patient-centered medical home transformation. *Prim Care*.2012;39(2):241-259.

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.

QUALIS HEALTH™

THE COMMONWEALTH FUND

GroupHealth®

MacColl Center for Health Care Innovation