The Medical Home Digest is a newsletter devoted to keeping you informed about medical home transformation in the safety net. This newsletter is brought to you by the Safety Net Medical Home Initiative, which is sponsored by The Commonwealth Fund. Each issue highlights critical aspects of patient-centered care and PCMH transformation.

From the Principal Investigator

As the 65 practice sites participating in the Safety Net Medical Home Initiative enter the fourth and final year of the national demonstration project, there is little doubt that the impact of the SNMHI will be sustained long after the direct support to the practices winds down in 2013.

Several factors give me confidence that the SNMHI will have a sustained impact. First, many of the participating practices have reached a tipping point—their efforts to transform have resulted in redesigned systems that are now firmly and irreversibly in place. This issue of the Medical Home Digest includes a number of reflections on the topic “What has transformation to a PCMH meant to you?”, and the optimism and enthusiasm in the responses of staff and providers reflect these changes in practice design and culture.

March 2012
Organized, Evidence-based Care

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We are also encouraged by data from the semiannual administration of the PCMH-A, the assessment tool developed to support SNMHI practices in understanding their progress and target areas for improvement. With each successive cycle of evaluation, the data show increased adoption of key changes that reflect implementation of all eight medical home change concepts that provide the framework for the SNMHI.

The eight change concepts¹ that serve as the framework for our efforts to accelerate PCMH transformation in the safety net have been widely adopted as the basis for a number of other efforts across the country. For example, technical assistance in support of the CMS Advanced Primary Care Practice Demonstration project will rely heavily on the change concepts to support the 500 Federally Qualified Health Centers participating in that effort.

Although achieving formal PCMH recognition was not a requirement for practices participating in the SNMHI, 29 of 65 sites have now been recognized either by NCQA or a state certification program, and we are on track for over 90% of practices to achieve recognition by the end of the initiative. It is of note that many practices have chosen to prioritize implementation of durable changes to the practice over efforts to focus on recognition per se, and have seen recognition more as an indicator of “job well done” than an end in itself.

We hope that the insights included in this issue of the Medical Home Digest will assist providers and practices not participating in the SNMHI accelerate their own journeys toward medical home transformation.

Transforming Safety Net Clinics into Patient-Centered Medical Homes

Delivering Organized, Evidence-based Care: The Heart of the Medical Home

The patient-centered medical home (PCMH) gives renewed emphasis to the basic principles of primary care that were enunciated 33 years ago in the Alma Alta Declaration, and re-confirmed by the Institute of Medicine 17 years ago. According to these principles, primary care should be comprehensive, accessible, continuous, and coordinated. To these principles, the PCMH includes additional elements derived in part from the Chronic Care Model that assure that the care delivered is patient-centered and evidence-based. The components of the Chronic Care Model are integrated into seven of the 8 Safety Net Medical Home Initiative Change Concepts.

The key changes that comprise the Organized Evidence-based Care Change Concept include three crucial features of high-quality practices—planned interactions, integrated decision support, and care management of high-risk patients.

Two key changes pertain to planned care:

- Use planned care according to patient need.
- Enable planned interactions with patients by making up-to-date information available to providers and the care team at the time of the visit.

Developing the capacity to plan and organize care for patients, especially those with chronic illness and those with preventive care needs, is a critical step in improving performance. Planned care depends on two practice characteristics: the availability of key information on patients that indicates what services they need, and a health care team organized and trained to consistently deliver those services. The information must be up-to-date and readily accessible prior to an encounter, whether that encounter is one initiated by the practice or by the patient. An EHR helps, but a registry or an EHR with registry functionality enables the practice to look across their panel, find folks needing to be seen, and set up a planned visit.

Providing clinicians with timely information to help them make decisions based on science (decision support) is another feature of evidence-based practice. The key change is: use point-of-care reminders based on clinical guidelines. Decision support provided at the time decisions are being made is most effective. This can be in the form of alerts or information provided at the time of an encounter, or linked to the ordering of a test or treatment.
To convince payers that PCMHs deserve to be paid more generously will likely require a demonstrated ability to achieve and maintain low rates of emergency room and hospital use. It is becoming accepted fact that more intensive management of high-risk populations by a care manager can improve health outcomes and contribute to reduced costs. So the second key change is: identify high-risk patients and ensure they are receiving appropriate care and case management services.

A careful review of the evidence reveals great heterogeneity in the design and execution of care management programs, and, not surprisingly, a mix of both positive and negative results. From this mixed bag, well-trained care managers supported by a multi-disciplinary team can improve the quality and reduce the costs of care for a limited number of carefully selected high-risk patients.

The Affordable Care Act posits that transformed primary care, specifically the patient-centered medical home, will improve the care and reduce the costs of patients with complex chronic illness. It will likely only happen if practices can effectively reorganize their care delivery systems to ensure adherence to guidelines, planned interactions, and more intensive care management for its most fragile patients.


What has transformation to a Patient-Centered Medical Home (PCMH) meant to you?

SNMHI teams share how PCMH transformation has impacted the organized, evidence-based care that they provide for their patients.

Although initially slow, we began to make progress and individual patient outcomes improved. We made medical diagnoses of diabetes, heart disease and even cancer that had gone untreated. The medical and mental health clinicians began to see the value in caring for patients collaboratively. The medical providers joined case management meetings with the mental health providers allowing for formal, as well as informal, coordination of care. A little over two years later, we have over 600 shared patients. –CEO (CHC Lane County)

Before the standardization, it was easier for chronic pain patients to get their refills without being seen as often as necessary. With the standardization project, everyone is on the same page with refills so our patients are being called and brought in for their regular pain management appointments and getting the care they need. –Medical Assistant (Klamath)

Patients are getting refills on time and with less of a delay than before. I am taking less time to do paperwork and EHR refills and spending more time with my patients. –Physicians’ Assistant (Klamath)

In assisting in the shared medical appointments, I have seen how patients have improved their A1C results. The patients encourage one another by sharing their A1C results and comparing if the numbers have gone up or down and perhaps getting into friendly competition over it! They share recipes for healthier food and tips on cooking and, in listening to others, improve their eating habits. –Medical Assistant (Inner City Health Center)

The patient is now a permanent part of the healthcare team, empowered to act and interact with the rest of us. By improving communication between ourselves, we have also improved communication with the patient. The change? Now we’re working with an informed patient, ready to participate in a meaningful way in his or her own care. –Medical Director (Health West Pocatello)

I fully expected patient-centeredness to improve the care we offer to our patients, but what has impressed me is the impact I see on the staff. Patient-centeredness as a constant theme has the power to change our culture. In implementing the EHR, we have had to revise every clinical workflow. This has afforded us the opportunity to ask, at every juncture, ‘How will this change impact the patient’s experience?’ When we successfully keep this consideration at the forefront, there is a palpable change in the way we evaluate alternative work flows. It seems to bring out the best in all of us. –(CHC Inc)

The teams are meeting in the providers’ offices, looking at schedules. I hear the words ‘I’ll help,’ ‘Oh, that’s for me,’ ‘Great job, glad we were able to get them scheduled!’ I see the papers in the in boxes move back and forth after each team member has completed their part of the task. I don’t have complaints from patients related to I can never get ahold of my doctor. I see the patients come to the clinic and smile as they are individually recognized by ‘their’ clerk. –RN, Program Manager (Denver Health La Casa)

Before forming our practice improvement committee and involving the medical assistants from the beginning of any project, it was very difficult to drive change. There was a lack of enthusiasm and resistance to changing workflows or job duties. With the PIC meeting regularly, as a manager, I present a challenge then step out of the way so the team can come up with a solution – and they do! They review and track team metrics, and they have friendly competitions with other teams. They suggest solutions that make perfect sense. It’s wonderful to witness. Having change occur from the bottom up has changed our clinic to an engaged culture. –Practice Manager (OHSU Scappoose)
Case Study:
East Boston Neighborhood Health Center Reduces ED Readmissions; Improves Care for Newly Diagnosed Diabetics

East Boston Neighborhood Health Center is successfully partnering with its onsite Emergency Department (ED) to offer real-time care management for newly-diagnosed diabetes patients presenting in the ED. The result has been fewer ED readmissions, fewer laboratory re-tests, better communication with the ED and smoother schedules for the health center.

East Boston Neighborhood Health Center is the largest community health center in Massachusetts, and its onsite Emergency Department diagnoses many new cases of diabetes. Previously, upon diagnosis, a patient was referred to the health center for follow-up visits, education, and management at a later date. However, by the time patients arrived at the health center for their follow-up visit, their sugar was often high enough to require additional lab testing and/or a readmission to the ED for IV fluids and insulin.

To address this care gap, the health center’s care management team started an on-call service for the ED. For any newly-diagnosed diabetic, the ED now calls a nurse from the health center’s care management team to immediately meet with the patient, teach them how to use a glucometer, conduct nutritional counseling, check on medication orders and make sure all the proper orders are placed.

The result of this process change is that more patients arrive at their follow-up appointment with an acceptable glucose level, ability to test their own glucose and a basic understanding of their diagnosis. Patient education and self-management support have led to improved health and fewer ED readmissions.
Knowledge from the Field

Risk Stratifying a Population to Provide Targeted, Evidence-Based Care

Multnomah County Health Department clinics provides low-cost family healthcare to underserved, low-income and uninsured residents of Multnomah County. Two of the eight clinics are participating in the Safety Net Medical Home Initiative.

In 2010, Multnomah County Health Department (MCHD) began implementing a chronic disease management program for patients with diabetes and depression. These two diseases were chosen because they were prevalent in the population, there were historical efforts to build on and best-practice guidelines were available. The program, a partnership with CareOregon and four local safety net clinics, focuses on enhancing condition-specific standards of care, standardizing routine care and providing targeted nursing care management. In order to better understand the needs of the population, and to target clients eligible for nursing care management, the clinics needed to develop a process to risk-stratify patients with diabetes and depression.

Previously, Multnomah Health Department had developed condition-specific registries used to identify patients at risk and close gaps in care (for example, a diabetes registry was used for outreach to clients overdue on HbA1c tests). While the frequency of screening tests increased, patient outcomes did not. In order to provide targeted, individualized interventions to these sub-populations of clients, the population needed to be stratified by co-morbidities or by risk in addition to merely by condition. The process of risk stratification allowed teams to understand patients that are appropriate for care management and also to begin to quantify the complex population in each panel.

By partnering with other safety net clinics using the same electronic health record (EHR) and the Oregon Community Health Information Network (OCHIN), the health information network that hosts that EHR, MCHD and CareOregon (Medicaid managed care plan) were able to identify existing functionalities for documentation and tracking of risk levels for each condition in a patient’s record. This foundation made it technically possible to risk-stratify the population in a way that was useable and reportable by clinic staff.

Figure 1. Risk Stratification Levels
Once the risk criteria were identified, it was possible to generate reports for each team to determine which patients might fall into Routine Care. They quickly realized, however, there was no reliable way to identify Complex Care clients from the remaining pool of care management "eligibles." In order to fully implement the risk stratification process, the medical home teams had to be engaged. This step required input from the teams that know the patients best at an individual level.

During the staff training on Diabetes and Depression Disease Management, each team received a list of patients with diabetes and depression on their panel and were asked to risk stratify their population. The teams weighed a variety of information to categorize their panel into care management eligible and complex care categories, including involvement with specialty care, active substance abuse, and other psycho-social challenges that can prevent patients from engaging in self-management activities. By engaging teams in this process, the true needs of the population were identified and the teams were able to target clients for nursing care management, while building a pool of eligible clients to draw from for enrollment.

Early results indicate that the combination of an updated Standard of Care for all patients and targeting a sub-population of patients for RN self-management coaching is improving outcomes across the whole population. MCHD clinics that have implemented this program have seen an average 8% increase in the percentage of diabetes patients meeting all D3 bundle targets (A1c < 8, LDL < 100, and BP under control) and a 10% improvement in the percentage of diabetic patients with a 50% reduction in their PHQ-9 score.

Note: Mindy Stadtlander has recently taken a position with CareOregon as the Clinical Systems Innovation Program Manager working on development and support of clinics moving to a PCMH model.

Figure 2. Diabetes Risk-stratification

<table>
<thead>
<tr>
<th>Title</th>
<th>Depression Criteria</th>
<th>Diabetes Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine Care</td>
<td>PHQ-9 &lt; 15</td>
<td>HbA1c &lt; 8 AND One or both BP and LDL at target</td>
</tr>
<tr>
<td>Care Management</td>
<td>PHQ-9 ≥ 15 or PCP discretion based on diagnosis</td>
<td>HbA1c ≥ 8 OR</td>
</tr>
<tr>
<td>Both BP and LDL not at target</td>
<td>h-need population. MCHD clinics that have implemented this program have seen</td>
<td>h-need population. MCHD clinics that have implemented this program have seen</td>
</tr>
<tr>
<td>Complex Care</td>
<td>Depression diagnosis with evidence of complex psychosocial and/or medical factors (team discretion)</td>
<td>Diabetes diagnosis with evidence of complex psychosocial and/or medical factors (team discretion)</td>
</tr>
</tbody>
</table>
Safety Net Medical Home Initiative

This is a product of the Safety Net Medical Home Initiative, which is 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 receives 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 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.