MEDICAL HOME DIGEST

NEWS FROM THE SAFETY NET MEDICAL HOME INITIATIVE

October/November 2009

IN THIS ISSUE:

UPCOMING EVENTS AND CONFERENCES:

MGMA and TransforMED

National Conference on the Patient-centered Medical Home

Fort Worth, TX; Nov. 12-14, 2009

Register at: www.mgma.com

National Medical Home Summit

Philadelphia, PA; Feb. 28-Mar. 2, 2009

Register at: www.medicalhomesummit.com

RESOURCES:

Want to learn more about the Safety Net Medical Home Initiative's **Change Concepts for Practice Transformation?**

A 10-minute video that explains the eight Change Concepts is now available, click here to view. To download a PDF copy of the Change Concepts, click here.

This is the first issue of 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. This initial issue focuses on the importance of leadership in medical home transformation efforts. Future issues will highlight other critical aspects of patient-centered care and PCMH transformation.

From the Principal Investigator

Jonathan Sugarman, MD, MPH
President & CEO
Qualis Health

Much of the energy surrounding the patient-centered medical home model has come from the mainstream of American medicine, and from large employers and health plans. Many of the more than 100 medical home pilot projects have not included settings—for example, community health centers—that primarily serve uninsured, vulnerable, and underserved populations. Indeed, some think that the population characteristics and resource constraints associated with care delivered in the safety net make it unlikely that vulnerable populations can have a true medical home. The skeptics are wrong.

The Safety Net Medical Home Initiative (SNMHI)—a national demonstration project sponsored by The Commonwealth Fund, co-funded by eight foundations, and led by Qualis Health and the MacColl Center for Health Care Innovation—has revealed a deep reservoir of commitment to medical home transformation among safety net providers across the country. Earlier this year, following a national request for proposals and a rigorous review process, five "Regional Coordinating Centers" (RCCs) associated with 68 sites in the safety net were selected to participate in the SNMHI. More information about the Initiative can be found at: www.safetynetmedicalhome.org.

We recently completed a series of kickoff meetings in the five participating states (Colorado, Idaho, Massachusetts, Oregon, and Pennsylvania), and found ample evidence that the medical home model has taken root in Federally Qualified Health Centers, rural health clinics, homeless clinics, and other community health settings, and that these efforts are bearing fruit.

At the kickoff meetings, we learned about a broad range of innovative approaches to developing medical homes to meet the special needs of vulnerable populations. For instance, we heard how one system developed a model of patient panels that greatly increased continuity of care—even in a setting where many providers work part-time. The foundation of their model was an organization-wide commitment to the primacy of patient needs. At other sites, we heard about exciting ways of engaging patients in system redesign activities so that services and changes truly meet patients' expectations.

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Yet even in the face of exciting advances in some areas, all of the participating practices identified numerous opportunities for progress in their journey to become patient-centered medical homes.

In the Medical Home Digest, we hope to harvest the learning from practices participating in the SNMHI, and to share this learning with the broader community of safety net providers. We begin with some comments by Dr. Ed Wagner on the importance of engaged leadership as a core concept for medical home transformation, and in future issues will provide additional thoughts on eight key "Change Concepts" for medical home transformation.

This issue also includes insights from Alicia Eng, Practice Team Manager for the Factoria Clinic – the site of Group Health Cooperative's first medical home demonstration. While Group Health is not a safety net provider, its early experience with PCMH transformation provides important lessons for all. The results of their initial demonstration, published in the September 2009 issue of the *American Journal of Managed Care*, show that implementation of patient-centered care does in fact improve patient experience, reduce provider burnout, and improve certain quality measures. Based on these initial results, Group Health has committed to spreading the PCMH model to all of its owned and operated facilities. I encourage you to read the evaluation results and see for yourself the impressive outcomes of PCMH transformation.

Please contact us at info@qhmedicalhome.org to let us know what you think!

Reference: Reid RJ et al. Patient-centered medical home demonstration: A prospective, quasi-experimental before and after evaluation. *Am J Managed Care* 2009; 15(9):e71-e87 .

Knowledge From the Field

Engaged Leadership

Ed Wagner,
MD, MPH, FACP
Director, MacColl Center for Health Care Innovation
Group Health Research Institute

Leadership support of any initiative is obviously helpful, but it appears to be critical when the initiative involves major transformation and culture change. Implementing the Patient-centered Medical Home Model constitutes major change. Wang and colleagues (RAND; Santa Monica, CA) asked experts in clinical system redesign what factors were most critical to success. Top of the list was: "Direct involvement of top- and middle-level leaders". We use the word "engaged" to indicate that leaders must be visibly promoting transformation and a supportive culture, building QI capacity, securing resources, and helping staff address barriers. Providing newsletter messages and pats on the back aren't enough. The engagement of leaders at both senior and middle levels is essential as the former influence culture and strategy while the latter make implementation happen.

The following are the specific activities and changes we recommend under Engaged Leadership:

- Provide visible and sustained leadership in overall culture change as well as specific strategies to improve quality and spread and sustain change.
- Establish a QI team that meets regularly and guides the effort.
- Ensure that team members have protected time to conduct activities beyond direct patient care that are consistent with the medical home model.
- Incorporate the practice's values on creating a medical home for patients into staff hiring and training processes.

The first specific change emphasizes the importance of culture change, and leadership's critical role in the process. The IHI document, *Seven Leadership Leverage Points for Organization-Level Improvement in Health Care*, provides valuable detail about what helps with culture change (e.g., bringing the Board along, involving patients and clinicians in improvement, using stories and data to gain support). Culture change is sustained and enhanced by inculcating it in the hiring and training of staff. Identifying specific QI and spread strategies, and establishing and supporting a QI team(s) are essential to success, and critical functions of effective leadership. Successful QI teams not only need protected time to do their work, but need to meet at regular intervals with their leadership. QI teams that are a designated subset of key clinical and administrative staff may be important in guiding change in larger organizations, but experience suggests that there is great value in involving everyone on clinical teams in the improvement process.

References: Wang MC et al. Redesigning health systems for quality: lessons from emerging practices. Joint Commission Journal on Quality and Patient Safety. 2006; 32:599-611. Reinertsen JL et al. Seven leadership leverage points for organization-level improvement in health care. 2nd Edition, Institute for Healthcare Improvement, 2008. http://www.ihi.org/IHI/Results/WhitePapers/SevenLeadershipLeveragePointsWhitePaper.htm

In the News

Creating a Medical Home

Group Health Cooperative's PCMH demonstration, featured in the September 2009 issue of the *American Journal of Managed Care*, showed impressive results. Below is an interview with clinic leader and change agent Alicia Eng, RN, MBA. To learn more about Group Health's medical home efforts, visit: http://www.ghc.org/GettingCare/MedicalHome.jhtml.

Tell us a little about the medical home transformation at Factoria – what & who did it entail?

The effort really began in May 2006 when then Medical Director for Primary Care, Michael Soman, saw the need for change. He believed we had to do something about the increasing burden on primary care physicians and teams, less-than-perfect clinical quality, and increasing costs. In order to address these three issues, he believed we had to re-envision the future of primary care; the Patient-centered Medical Home was the place to start.

Where did you start?

We had to start with a common vision and goal – and it was essential that vision was shared by the medical staff. We also had to develop the capacity within the team to change. That meant we had to have a stable enough group that could buy in to this work, had the ability to try new things, and could learn from what worked and what didn't and improve. We weren't handed instructions, so it was important that as a group we were committed to a process of continuous improvement.

How does the care provided now, as part of the medical home, look different than before?

Our medical home implementation included making changes in four main areas:

1. Reduction in physician panel size: In order to enhance the relationship between the patients and their doctors, we reduced and leveled physician panel size from an average of about 2,300 individual patients to 1,800 patients, lengthening standard visit time from 20 to 30 minutes. Physicians see fewer patients per day and have more robust staff support and tools that enable them to be proactive in caring for all of their patients' needs.
2. Increased use of virtual medicine: We redesigned our phone system to enable patients to reach their own clinical team directly and carved out an hour per day of 'desk time' for physicians to answer phone calls and respond to email inquiries from patients.
3. Enhanced visit preparation and chronic disease management: We developed new tools and protocols for patient activation and treatment planning, and instituted daily huddles. These huddles enable us to address not just each patient's acute need, but also his or her chronic and preventive care needs, too.
4. Outreach: We knew we also had to proactively engage those patients that did not come in regularly for preventive care and health maintenance checks. Now we contact patients who had been admitted to the hospital or within 24 hours of discharge to link them back to the primary care home. We also send out birthday letters to engage patients in their care.

How important was it to involve the whole team?

The team varied depending on the work we were tackling, but it was really important to get everyone involved. Our main goal was to make our teams transparent to each other and to the patient. Because the medical home is all about strengthening the patient relationship with the doctor, a lot of planning and scripting went into organizing the care teams and making it clear to patients that they were there to support that relationship . We put pictures of the team members in the waiting room, and now, every time a team member contacts a patient, they identify themselves in relation to the patient's personal physician.

How long did this transformation take?

The reality is our work with the medical home is not over. We want to continually improve. That said, when we were about one year into the work, we felt like we were really starting to make headway.

Any advice for others wanting do this kind of work?

Change is hard and there will be times that it feels like it is not working. That is a normal part of the change process. As leaders, we have to be able to step back and recognize what is normal and what is not, and have the will to persevere.

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Ask the Experts

Registries

By Brian Austin, Associate Director, and Katie Coleman, MSPH, Research Associate, from the MacColl Center for Health Care Innovation at the Group Health Research Institute

The arguments for using registries to organize care are very solid. They allow care teams to be proactive, easily identify when patients are due or overdue for visits or services, and identify when there are potential problems that need to be addressed (e.g. abnormal lab values). At an organizational level they can also provide valuable information about how the care team is doing with regard to chronic illness management, and may highlight systemic problems that interfere with optimal care provision. Below are frequently asked questions about disease registries.

Question: What kinds of challenges have you encountered in working with busy practices to implement and maintain accurate registries? What have you found to be successful strategies for overcoming those challenges? Are there common pitfalls to avoid?

Answer: Registries certainly provide the capability to organize information to improve the care of individual patients and whole panels. They are useful from both a care and an improvement perspective. They are a great aid in getting a practice to focus not only on the patients making their way into the office, but also those who haven't been in who could benefit from an interaction. But there are issues practices should consider as they contemplate adopting a registry. Here are four to start:

1. Do you want a registry or a clinical information system? Registries are often seen as an interim product, a stopgap until a practice fully commits to an Electronic Health Record (EHR), but many EHRs lack the population-based functionality of a modern registry. Both require an investment of time, training, and funding by the health system, but a registry can be implemented without the wholesale changes to the office that an EHR requires. The California Healthcare Foundation has put together a quick comparison of EHRs and registries to help with the decision, and it can be found here. We recommend that practices think about what functions they want to support with their technology, and use that as the basis for their shopping.

2. Don't underestimate the human engineering required to start and maintain a registry. Think from the beginning about who will be responsible for getting data into the system, and who will review the registry to proactively plan care. Roles should be explicit, and the practice should work together to find the best way to take action based on the data. Duplicate data entry should be avoided if it is at all possible because it is very hard to sustain. Can links be created to automatically input lab or pharmacy data, for instance?

3. Do use the registry for individual care as well as population health. Routinely entering self-management goals, for instance, and having that information during the visit is a step toward a more patient-centered encounter, and can lead to conversation that wouldn't otherwise occur.

4. Don't make the mistake of thinking any information system is a panacea. A recent study of 20 primary care clinics across South Texas found that the presence of a clinical information system made it ***less*** likely that patients with diabetes had good control of modifiable risk factors for cardiovascular disease. What did help? Strong community linkages and delivery system design. So explore and utilize registries, but don't forget they are a tool, and not a solution in and of themselves.

Question: What is the evidence for using registries?

Registries are a fundamental tool for practices interested in improving the quality of care they provide. In an article published in JAMA, Dr. Shojania and colleagues attempted to rank the most effective quality improvement strategies in reducing HbA1c values in diabetics. They found that patient registries are in the top Continued on page 5

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5 most effective interventions along with team-based care and effective care management. Bu and colleagues found something similar when they looked among IT-enabled quality improvement strategies: registries, more so than disease management protocols or remote monitoring, were associated with declines in HbA1c, blood pressure, and cholesterol among persons with diabetes. In fact, Flemming and colleagues went so far as to demonstrate that you could distinguish high-performing Medicare Managed Care plans from lower performing ones by examining what kinds of infrastructure they had in place. The vast majority of Medicare Managed Care plans that perform well on diabetes quality (78%) use registries, while only 40% of low-performing plans had registries in place. We should note that registries are not the same as use of an EMR. In fact, in Flemming's study, use of an EMR did not differentiate high-performing plans from low-performing plans the way registries did.

References: Shojania, K. G. et al. *JAMA* 2006; 296:427-440,
Bu et al. *Diabetes Care* 2007; 30:1137,
Fleming et al. *Am J Managed Care* 2004; 10: 934.

Have a question of your own?

Send your PCMH queries to info@qhmedicalhome.org and our experts will respond. Select questions will be published is each issue of the Medical Home Digest.

About the Initiative

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 Center for Health Care Innovation at the Group Health Research Institute. Five regions were selected for participation (Colorado, Idaho, Massachusetts, and Pittsburgh), representing 67 safety net practices across the U.S.

The Initiative 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. For more information about the Safety Net Medical Home Initiative, refer to: www.safetynetmedicalhome.org.

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