The Safety Net Medical Home Initiative: Practice Results

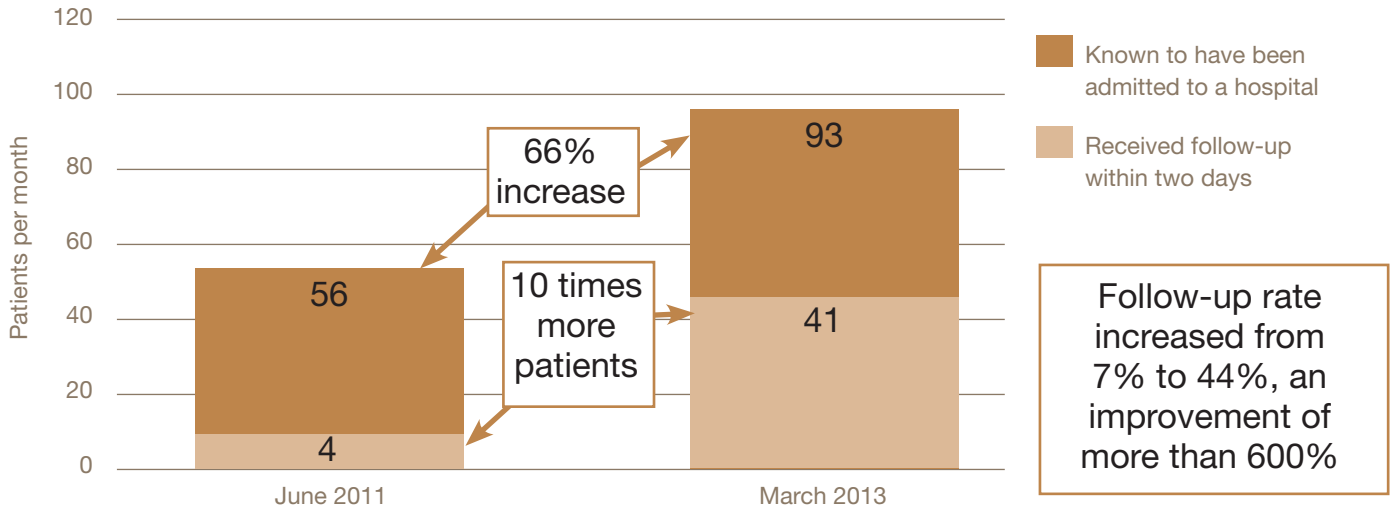
SPOTLIGHT: Dorchester House Multi-Service Center • Dorchester, MA

MEASURE: Contacting patients within two days of their hospital discharge

Timely follow-up has been shown to prevent rehospitalizations. Although widely accepted as important, few providers have a systematic method of ensuring it gets done.

For more information about the SNMHI's "Care Coordination" Change Concept, see www.safetynetmedicalhome.org/change-concepts/care-coordination.

Ten times as many patients are now contacted following a hospital discharge

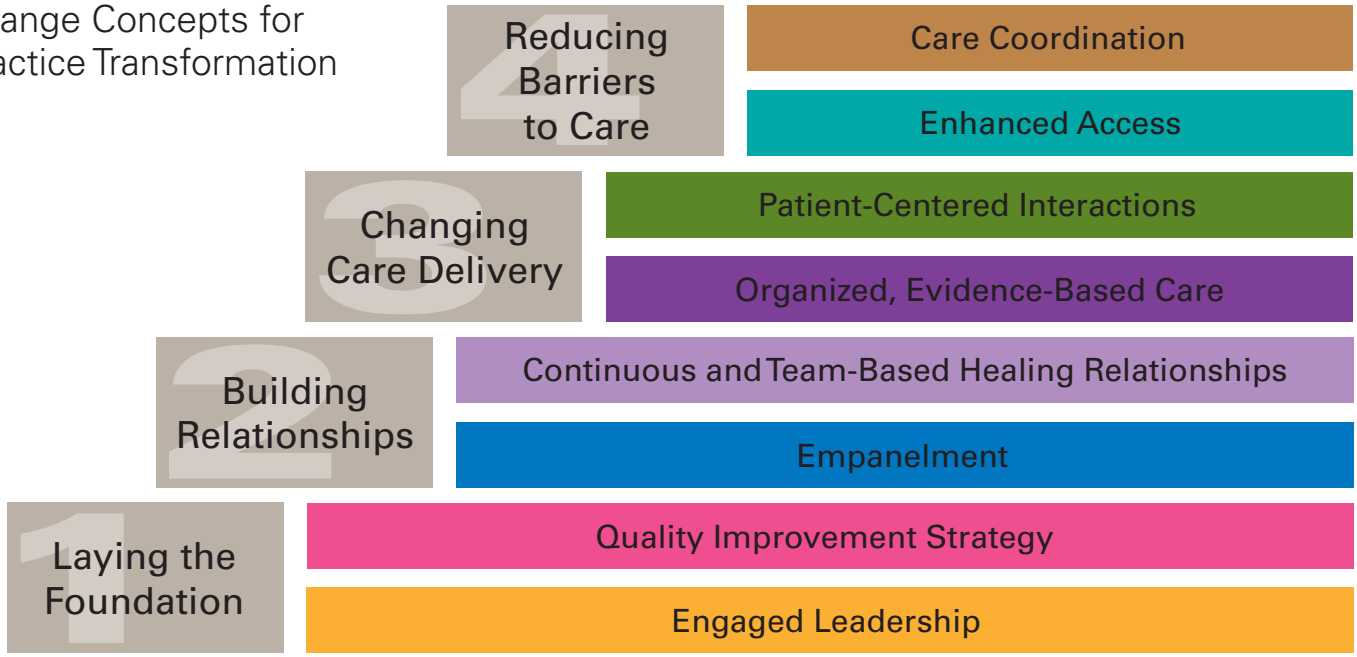


Dorchester House dramatically improved the proportion of patients contacted within two days of being discharged from the hospital. What's more, the clinic improved communication with the hospitals and payers so that they are more often being alerted when one of Dorchester House's patients is admitted.

Staff at Dorchester House report:

"By the time the patient is released from the hospital the Clinical Care Manager has performed a medication reconciliation, scheduled a follow-up visit, and made sure everything is in order for the patient to return home. The Clinical Care Manager has built ongoing relationships with many of our highest-risk patients and as a result we are better able to meet their needs, acting proactively to avoid further hospitalizations or readmissions."

Change Concepts for Practice Transformation



About the Safety Net Medical Home Initiative

It's no small undertaking to implement the Patient-Centered Medical Home (PCMH) Model of Care. The Safety Net Medical Home Initiative used a combination of coaching, assessment and change management tools, and peer-sharing communities to help move participants forward. The Initiative's sequential set of "Change Concepts" has been proven to streamline the path to full PCMH implementation, and our approach has been adopted by other improvement initiatives nationwide.

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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.

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MacColl Center for Health Care Innovation