

MEDICAL HOME DIGEST

NEWS FROM THE SAFETY NET MEDICAL HOME INITIATIVE

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



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In our final issue of the Medical Home Digest, we reflect on some of what we have learned during the SNMHI. Medical Home Facilitators from our five Regional Coordinating Centers share lessons they and their practices learned about setting the stage for successful transformation. Medical Home Facilitators also describe what is coming next for their organizations

and how they plan to spread and sustain PCMH. Also included in this issue is a reflection on the value of learning communities—a key component of collaboratives including the SNMHI. Specific examples of tailoring showcase the many ways organizations can harness the power of peer interaction to inspire and teach. Finally, we describe recent revisions to the *SNMHI Implementation Guide Series*, a comprehensive library of resources and tools intended to assist practices in understanding and implementing the SNMHI Change Concepts for Practice Transformation.

Summer 2013 - Lessons Learned

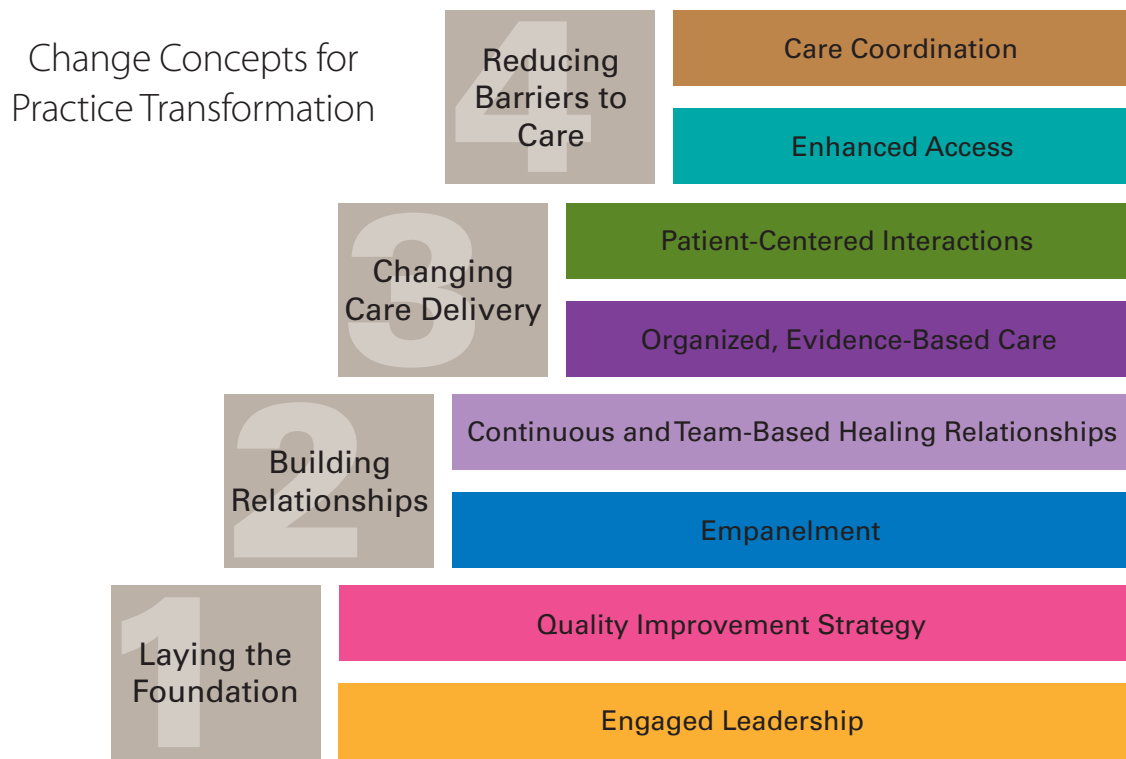
IN THIS ISSUE:

From the Principal Investigator	1
What Makes PCMH Transformation Succeed and Stick? Advice from SNMHI Sites	3
Looking Ahead: What Comes Next for the SNMHI Regional Coordinating Centers?	7
Transforming Together: The Importance of Learning Communities for PCMH Transformation	9
New PCMH Resource Alert.....	11

When we developed the eight Change Concepts for Practice Transformation as a framework for the SNMHI, we focused primarily on the universe of changes necessary to become a medical home, and less on the sequence in which those changes need to be implemented. Our experience leading the SNMHI has strengthened our impression that successful practices have focused on some fundamental changes before tackling others, and we recently developed a new graphic that calls attention to a recommended sequence for implementing the Change Concepts.

The Change Concepts for Practice Transformation are interdependent and mutually-reinforcing. Implementation of all eight is necessary for a practice to become a full PCMH. Our framework includes eight change concepts in four stages. Change Concepts in **laying the foundation**—“Engaged Leadership” and “Quality Improvement Strategy”—ensure that the foundation is in place to enable the practice to learn and implement change. If these foundational issues are not addressed first, meaningful transformation is difficult at best. Next, effective primary care depends upon solid, trusting

continued



relationships. The Change Concepts directed at **building relationships** among teams and between patients and providers—“Empanelment” and “Continuous, and Team-Based Healing Relationships”—prepare the practice to deliver personalized, patient-centered care effectively and efficiently. The next Change Concepts—“Organized, Evidence-Based Care” and “Patient-Centered Interactions”—focus on **changing care delivery** to increase the likelihood of productive interactions and improved clinical performance. The final two Change Concepts—“Enhanced Access” and “Care Coordination”—focus on reducing **barriers to care**. These changes are no less important than the Change Concepts addressed earlier, but they are often more difficult to implement.

The updated *SNMHI Implementation Guide Series* reflects this recommended sequence. It also includes many important content additions, case studies, and over 23 new tools and resources on PMCH transformation. Even if you have previously used the *Implementation Guide Series*, I encourage you to check out the recent updates.

Although technical assistance for SNMHI participating sites concluded in April of 2013, The Commonwealth Fund is supporting a rigorous evaluation of the SNMHI. The University of Chicago, the evaluation lead, expects to begin to publish the results of their findings in 2014.

Additionally, 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. A behavioral health integration Implementation Guide is underway and will be published on the SNMHI website in 2014.

While this is the last issue of the Digest, you can continue to learn about the initiative and its legacy by checking in at www.safetynetmedicalhome.org. Thanks for your interest in and support of the Safety Net Medical Home Initiative, and for working to accelerate primary care transformation among practices caring for the nation’s vulnerable and underserved populations.

What Makes PCMH Transformation Succeed and Stick? Advice from SNMHI Sites

Patient-Centered Medical Home (PCMH) transformation requires a concrete pathway, dogged persistence, and most importantly, patience. Partner sites benefited from investing time in transparent communication strategies, anticipating challenges such as change fatigue, and sequencing PCMH change. This preparation was critical to their success.

The 65 practice sites that participated in the SNMHI were diverse in terms of size, location, and population served. While no two practice sites had exactly the same PCMH experience, the challenges and solutions were similar across all five regions. The Qualis/MacColl project team asked the 14 Medical Home Facilitators and 65 practices to list their top recommendations and lessons learned that they would give to other primary care practices embarking on PCMH transformation. A selection of their responses is provided below. We hope these kernels of information both assist and inspire other practices on the PCMH journey.

Colorado

Start on the right foot by getting buy-in from all staff members

- To be willing to undertake the challenge of becoming a PCMH, staff must understand the benefits to them, their patients, and the practice as a whole.
- “[Buy-in] needs to be ideological, of course, but also in the form of practical support such as dedicated time for meetings, IT support, and training of staff at various levels.”
Inner City Health Center
- “Perhaps the most blatant change indicative of PCMH transformation is the incorporation of ‘patient-centered’ into the daily rhetoric of the clinic. . . the way in which staff think about and address problems. People are not only acting it and seeing it, they are saying it and owning it.”
Thornton Medical Clinic, part of Clinica Family Health Services

“...I think that completing periodic assessments (e.g., PCMH-A survey, checklists) within a team is a really powerful way to see where things are on the frontline: what’s working, what’s not working, what’s missing, what do we celebrate...”
Valley-Wide Health Systems, Alamosa

Use site-level data to inform your QI strategy

- “Use all the tools, resources, and support that you can because it is a lot of hard work—but work that is certainly worth doing. . . I think that completing periodic assessments (e.g., PCMH-A survey, checklists) within a team is a really powerful way to see where things are on the frontline: what’s working, what’s not working, what’s missing, what do we celebrate. . . . What was helpful for the sites was the ultimate compilation of data at the end of the project. To be able to see and understand data over a period of time certainly afforded sites the opportunity for analysis and improvement.”
Valley-Wide Health Systems, Alamosa

Take small steps

- “Begin with small changes; it is easy to become overwhelmed. It is important to realize that it is a journey. . . . It is helpful to create a PCMH workgroup, and to continuously employ the principles of PDSA to your PCMH transformation.”
Eastside Adult Clinic

continued

This is a journey, not a destination. Accept setbacks as you make the major changes needed to implement PCMH. *Terry Reilly Health Services*

Idaho

Encourage networking within and across sites

- “Through the learning sessions, webinars, and collaborations with the other [65 partner sites], we have moved to a level where our entire staff feels like a part of the team.” *St. Mary’s/Clearwater Valley Hospital and Clinics*

Work through setbacks with persistence

- “Rome wasn’t built in a day, and neither will your medical home.” *St. Mary’s/Clearwater Valley Hospital and Clinics*
- “This is a journey, not a destination. Accept setbacks as you make the major changes needed to implement PCMH.” *Terry Reilly Health Services*

Empower staff through increased trust

- “Most important was changing the culture of the clinic so that receptionists and nursing personnel were empowered to work at the top of their training. Instead of having a king (provider), a servant (nurse), and a slave (receptionist), we have a king, a queen, and a queen.” *HealthWest, Inc.*
- “I am so appreciative of the trust placed in us to work at the top of our licenses.” *Family Medicine Residency of Idaho*

Plan for delays in your PCMH efforts when simultaneously undertaking the challenge of EHR implementation

- There’s no two ways about it: electronic health record (EHR) implementation is difficult—but ultimately, an EHR can be a very powerful tool in service of quality improvement and PCMH efforts. Eight Idaho sites in the SNMHI implemented an EHR within the first two years.
- “Most of our processes in patient care—whether office visits, pre-visit planning, or phone care—center on the EHR. We experienced paralysis of our care... [and] it took about a year to find fixes to allow us to move forward with our transformation efforts.” *Family Medicine Residency of Idaho*

- “[Challenges related to EHR implementation were] addressed through teamwork and mutual learning and support.” *St. Mary’s/Clearwater Valley Hospital and Clinics*

Massachusetts

Engage staff at all levels of the organization in the transformation efforts so that those who are closest to the processes are involved and true culture change can be supported.

- “True transformation could not rest in the hands of one person.” *Joseph M. Smith Community Health Center*
- Harbor Community Health Center has started holding two all-staff meetings per month “so all staff can attend at least one meeting... includ[ing] all staff members from front desk staff to providers; topics include designing and following up on PDSAs for outcome measures and motivational interviewing.”

Create systems and structures that cultivate, focus on, and create momentum for change

- “Participation in the SNMHI gave us a structure, timeline, and goals as we implement the PCMH model—[which] helped place PCMH at the top of our priority lists.” *Dorchester House Multi-Service Center*
- “PCMH transformation is a complex and far-reaching process—no part of the organization is untouched... regular reporting [was] crucial for motivating all staff and leadership to participate in and facilitate the transformation process.” *Codman Square Health Center*

True transformation could not rest in the hands of one person. *Joseph M. Smith Community Health Center*

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Create strategies to minimize change fatigue

- “Change is the hardest part. Not only does it cause stress from unfamiliar roles, but communication is also a huge issue. Training needs to be frequent and regular.”
Hilltown Community Health Centers, Inc.
- “Remember to celebrate the successes and to build time to address change fatigue.” *CHA Revere Family Health*
- Take time to stop and reassess the new situation: “...Be prepared to use narratives that resonate with [staff]. It takes time to craft these stories, but it is well worth it.”
Codman Square Health Center

Working in a collaborative helped tremendously by providing a network of other clinics struggling together and celebrating success together.

Winding Waters Clinic

Oregon

Create opportunities for sharing best practices

- “Being able to meet with other clinics at various stages of the PCMH transformation and discuss what was or was not working at our own practices was very helpful...Meeting as a collaborative also allowed us to critically examine, as a group, the pros and cons of workflows we were looking to adopt.”
Old Town Clinic, Central City Concern
- “Working in a collaborative helped tremendously by providing a network of other clinics struggling together and celebrating success together.” *Winding Waters Clinic*

Steal successes from other practice sites shamelessly

- “Don’t try to be too original for the sake of being original – it’s okay to adopt work from other practices.”
Old Town Clinic, Central City Concern
- “Reinventing the wheel is a slow and cumbersome process and nearly impossible if you never even thought to use a wheel.”
Outside In

Sequence your steps

- “Do not try to tackle every element of the PCMH model from the outset—choose a single area for focus, and allow what you learn from that work to lead you to other areas to prioritize next.” *OHSU Family Medicine at Richmond*
- “The successful implementation of many medical home concepts depends on whether or not your clinic has other foundational PCMH concepts in place.”
Community Health Center, White City

Celebrate success

- “When things are tough, we try to remind each other to celebrate our successes, and let the staff know how much their efforts are appreciated!” *Old Town Clinic, Central City Concern*

Transformation takes a team

- “Work flows and processes can be developed but if the line staff does not participate in the development, and understand the rationale for the changes, there will not be a successful transformation.” *Community Health Center, White City*
- “Seek solutions from the FRONTLINE and from your PATIENTS.”
OHSU Family Medicine at Richmond
- “The transformations take a team effort. It is often difficult to get all team members to “embrace” the changes necessary for transformation. It is vital to include input from the members of the team involved in order to be successful in the implementation.” *Klamath Health Partnership*

Change is the hardest part. Not only does it cause stress from unfamiliar roles, but communication is also a huge issue. Training needs to be frequent and regular. *Hilltown Community Health Centers, Inc.*

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Expect to learn a lot about processes, implementing and evaluating where there is a fracture in the process...Someone needs to be allotted the time and the role to do QI and help drive the process.

University of Pittsburgh Medical Center, Matilda Theiss Health Center

Pittsburgh, PA

Create a culture of continuous quality improvement

- "The concept of transformation to a medical home provided new motivation to try new things and to be open to both failure and success in PDSA cycles."
University of Pittsburgh Medical Center, Matilda Theiss Health Center
- Beaver Falls Primary Care notes that their quality improvement team "Sees challenges and opportunities everywhere" and is constantly working to improve care processes and maintain the focus on the patient.

Prepare to address leadership turnover

- Leadership turnover can derail the momentum of PCMH transformation but can also be an opportunity for hiring staff committed to PCMH.
- Metro Family Practice recalled that leadership instability "in the early years...made it difficult to have time to work [on PCMH] or to gain the active involvement of others."
- University of Pittsburgh Medical Center, Matilda Theiss Health Center was able to overcome the disruption of leadership and staff turnover through "standardizing work, continuing to show improvement, and collaborating effectively on teams."

Allocate sufficient time and resources

- "[QI and leadership must] commit adequate resources and build and maintain structure...Both our greatest successes and our biggest challenges were directly related to the degree to which we were able to garner resources and work within an organized structure." *North Side Christian Health Center*
- "Expect to learn a lot about processes, implementing and evaluating where there is a fracture in the process...Someone needs to be allotted the time and the role to do QI and help drive the process."
University of Pittsburgh Medical Center, Matilda Theiss Health Center

Invest time and resources into optimizing Health Information Technology

- The importance of optimizing Health Information Technology to support PCMH cannot be underestimated.
- Invest in training and support for staff and providers to be successful in using the electronic health record to support PCMH workflows.

Rome wasn't built in a day, and neither will your medical home. *St. Mary's/Clearwater Valley Hospital and Clinics*

Looking Ahead: What Comes Next for the SNMHI Regional Coordinating Centers?

Colorado Community Health Network

www.cchn.org

Colorado Community Health Network (CCHN) will continue their PCMH work with multiple grants focused on patient experience, data for quality, continued PCMH transformation, creation of the Patient-Centered Dental Home, social determinants of health, patient advisory councils, participation in the Kaiser Permanente ALL (Aspirin-Lisinopril-Lipid Lowering) program, and an increased emphasis on care coordination. These grants will investigate the patient's perspective on receiving care and how health center staff can relate to patients and patient barriers to care. Future transformation and spread efforts are geared primarily towards the sustainability of PCMH transformation. CCHN will continue to develop trainings, assist health centers in the development of a quality improvement infrastructure, and provide technical assistance around the development and use of reports and data to monitor progress towards goals.

Idaho Primary Care Association

www.idahopca.org

The Idaho Primary Care Association (IPCA) is going to continue PCMH transformation work with the support of three grants. The Cambia Health Foundation and Blue Cross of Idaho Foundation each awarded funds to continue and spread the work done during the SNMHI. Both cited the SNMHI as influential in awarding the grants to the IPCA and member health centers. IPCA also was a recipient of the Health Resources and Services Administration's Health Center Controlled Networks Technical Assistance grant, which has three components: PCMH development and advancement, achieving Meaningful Use of electronic health records, and data aggregation and exchange.

IPCA continues to be involved in the Idaho Medical Home Collaborative, a two-year pilot project including both private practice and community health center providers, private health insurers, Idaho Medicaid, and other healthcare providers.

Massachusetts Executive Office of Health and Human Services & Massachusetts League of Community Health Centers

www.massleague.org

www.mass.gov/eohhs

Massachusetts League of Community Health Centers (the League) and the Commonwealth of Massachusetts Executive Office of Health and Human Services (EOHHS) worked together to align the goals and processes of the SNMHI and the Massachusetts PCMH Initiative and to create health center-based teams and medical neighborhoods responsible for PCMH transformation.

The League will continue to balance technical assistance between NCQA PCMH™ recognition and PCMH practice transformation to its membership and in its role as the lead primary care association for the CMS Advanced Primary Care Practice Demonstration. The League will also provide support through IMPACT. This program is designed to provide health centers with both concrete tools and a shared language for developing and sustaining a culture of continuous quality and process improvement. By teaching health centers how to apply performance improvement models such as Six Sigma, Lean, and the Change Acceleration Process, the health centers will have the framework to guide their journey through the Change Concepts for Practice Transformation. Emphasis is placed on engaging all staff in a common goal of higher quality and more efficient patient-centered care. IMPACT is a phase-based capacity building initiative that engages senior leaders, middle managers, and frontline staff to work collaboratively in the creation of a culture of continuous quality and process improvement that is directly tied to the mission, values, and strategic objectives of the organization and the PCMH change concepts.

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Oregon Primary Care Association, CareOregon, & Oregon Rural Practice-Based Research Network

www.orpca.org

www.careoregon.org

www.ohsu.edu/orprn

The Oregon Primary Care Association (OPCA) will continue to support statewide PCMH transformation and sustainability within health centers and lead the nation in Federally Qualified Health Center payment reform. OPCA is committed to continuing and expanding upon the work of the Safety Net Medical Home Initiative by supporting all its community health centers in achieving the quadruple aim – cost, quality, access, and equity.

OPCA continues to lead a coalition of stakeholders in development of an alternative payment methodology that moves Medicaid reimbursement away from the FQHC's fee-for-service-oriented payment system to a capitated payment methodology. Health centers will now have the flexibility under a capitated financial model to robustly implement core components of the medical home. Built on the foundation of the national SNMHI, Oregon's community health centers have an opportunity to lead the country in advanced understanding and implementation of true, engaged patient-centered care. OPCA hopes to redefine patient-centered care so that it is untethered to reimbursement for face-to-face encounters. To this end, OPCA hopes to improve population quality of care; quantitatively enhance patient-centeredness and engagement; contain total costs of care; and ensure outstanding staff retention and engagement among safety net providers.

Pittsburgh Regional Health Initiative

www.prhoi.org

Looking forward, the Pittsburgh Regional Health Initiative (PRHI) is expanding its PCMH work to a number of primary care practices with which they are working through PA REACH, Western Pennsylvania's Regional Extension Center. Building on experiences of the SNMHI, PRHI has developed a 12-module training course in PCMH and meaningful use for practice managers, physicians, practice leadership and other frontline staff. PRHI is also working with PA SPREAD, an AHRQ-funded initiative to develop a primary

care extension center in Pennsylvania with plans to spread to three other states. PRHI's work in integrating behavioral and physical health care continues through a multistate collaborative funded by CMMI. Regionally sustainable efforts for federally qualified health centers include building a shared network of services to support continued PCMH transformation.

Qualis Health and the MacColl Center for Health Care Innovation

www.qualishealth.org

www.grouphealthresearch.org/maccoll/maccoll.html

www.coachmedicalhome.org

www.safetynetmedicalhome.org

Technical assistance concluded in April of 2013. The Commonwealth Fund is supporting a rigorous evaluation of the Initiative, led by the University of Chicago. Baseline data has been published and final results are expected in 2014 and 2015. The Commonwealth Fund's website provides more information about the [SNMHI evaluation](#). Follow the [outcomes](#) of the SNMHI.

In addition, Qualis Health and the MacColl Center for Health Care Innovation have been awarded a grant by The Commonwealth Fund to identify and publish the primary lessons of the SNMHI to help inform other implementation and policy efforts. Results will be submitted to a journal as a special supplement. A behavioral health integration Implementation Guide is also underway and will be published on the SNMHI website in 2014. We believe that lessons from the Initiative have and will continue to improve the way we think about, teach, and coach PCMH, and will inform the next generation of primary care improvement programs.

Transforming Together: The Importance of Learning Communities for PCMH Transformation



Judith Schaefer, MPH
MacColl Center for
Health Care Innovation

Adults learn best when learning is purposeful, when it builds upon past experience and skills, and when it is shared with other learners in an environment of respect. This is an apt description of the environment of the Safety Net Medical Home Initiative (SNMHI) learning communities.

Focused on the lofty goal of transforming healthcare delivery in their systems, SNMHI partner clinics valued the learning communities as a crucial infrastructure for change. Because much of their work involved innovation, the sites particularly depended on the learning communities to assist them in connecting with other learners and innovators—and not only for exchange of knowledge. The learning community’s technical assistance program also:

- Set expectations for change,
- Clarified the importance of the foundational Change Concepts (Engaged Leadership and Quality Improvement Strategy), and
- Provided guidance about sequencing of change activities.

The learning community peers shared continuously and routinely—comparing ideas and building confidence in their ability to make changes when provided with the example of others like themselves. By learning from peers specific, tangible steps and by building and rebuilding their energy over the five years of the project, sites were able to vent frustrations and solve problems. They did not have to feel isolated when they hit the wall from hard work.

Role of Qualis Health and MacColl Center for Health Care Innovation

Qualis Health and the MacColl Center for Health Care Innovation (the project team), played a central role in learning communities as planners, presenters, and facilitators of meeting sessions. The SNMHI operated seven learning communities:

- One for each of the five regions’ practice staff.
- One devoted solely to medical home facilitators (MHFs) from all regions (coach-specific).
- One for the overarching community of practice staff and MHFs across all regions.

The MHF learning community, which included technical assistance staff from Qualis and MacColl, supported each of the individual regional learning communities for practice staff. This learning community aided the rapid spread of innovations, identification and sharing of content experts, development of effective learning activities, and creation of various team recognition methods. For example, the MHF learning community built on work done in the Oregon region to develop an important stratification tool that assesses a site’s progress and momentum toward PCMH transformation in one of five separate tiers. This tool supported the design of appropriate technical assistance for each tier.

Regional Adaptations

The five regions were diverse in size, rural/urban mix, distance from the MHFs to each site (geographic dispersion), longevity of activities and engagement around PCMH transformation. All regions created learning communities that met face-to-face at least annually, communicated electronically, supported the spread of innovation, and engaged their coaching staff.

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The varied environments generated novel adaptations in each learning community. The following are some of the best ideas from each region:

- Colorado excelled in the development of peer-specific learning groups, and organized opportunities (e.g., learning sessions, breakouts, webinars) that allowed these peers to learn from each other. For example, the Colorado Community Health Network (CCHN) designed webinars specifically for medical assistants whose roles were expanding rapidly. This mini medical assistant-specific learning community developed competencies in members and created opportunities to identify issues needing technical assistance and/or follow up.
- Idaho, whose teams were geographically widespread and predominantly rural, perfected the monthly round table conference call—identifying topics and engaging sites to share experiences and start problem-solving discussions. For their yearly in-person meetings, MHFs queried teams for input on topics and needs, then focused on drawing in expert and engaging speakers with first-hand experience on their topic.
- Massachusetts deftly aligned SNMHI and the statewide, multi-payer PCMH initiative to create a broader learning community with common goals, transformation framework, and activities. By tackling alignment early on, they were able to create efficiencies through aligned measurement and reporting expectations, shared learning sessions, and use of faculty in a way that supported multiple PCMH initiatives.
- During learning sessions, Oregon used a very thoughtful approach to connect people or sites at various points in the PCMH transformation journey. They set up sessions that were structured opportunities for more experienced teams to mentor less experienced teams. Oregon helped teams prepare for structured, facilitated conversations so that issues could be brought to the group for problem solving “in the round.” These powerful conversations helped sites that may have been struggling regain momentum.
- Pittsburgh, PA’s strength lay partly in their ability to be closely involved in the development of clinic sites and their changes. The region is geographically small (being the only city-specific region)—allowing frequent visits and quarterly learning sessions, which were sometimes held onsite at one of the

participating clinics. Frequent and short meetings allowed time for focused topical presentations, sharing and mutual problem solving, and feedback from MHFs. Sharing frequently across sites in real time was a benefit.

In-Person Contact Was Crucial

Listserves, conference calls, and webinars can all be effective in sharing information, but responses from SNMHI participants and MHFs show that nothing takes the place of face-to-face contact. In March 2011, halfway through the four years of technical assistance support, the SNMHI brought together staff from all 65 sites, MHFs, regional executive sponsors, and our Technical Expert Panel for a national summit. This two-day event proved to be a tremendous motivator, sparking networking contacts that were sustained for the life of the project. The coaching learning community took on new life when regular in-person meetings forged working relationships across regions. These in-person meetings proved the key to facilitating trust and generating partnerships between coach and site, among coaches, among sites, and among the executive sponsors.

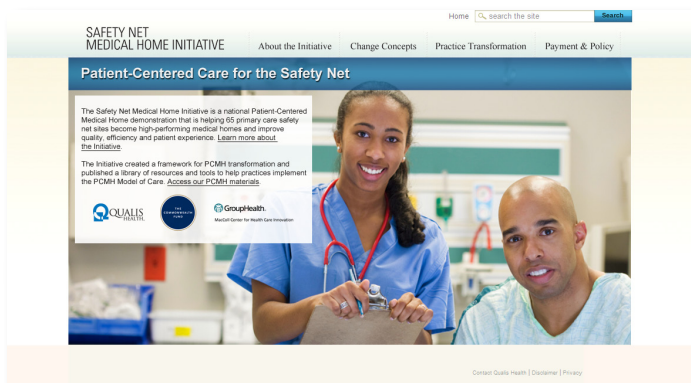
The most influential and inspiring strategy to promote new learning opportunities was the field trip or site visit. During site visits, a team from one primary care clinic visits another site to see “how it’s done.” The purpose of the site visit can range from learning how to expand role of the medical assistant to what empanelment really looks like in a medical home. The site visits offered invaluable first-person experience for site staff as well as MHFs to help spread improvements across sites. Site visits helped visitors understand the vision of PCMH as operationalized in ways that even well articulated descriptions or case studies could not do. Site visits were especially successful when there were common elements between the sites, such as a residency training program, serving a large migrant, homeless, or transitory population, or even use of the same electronic health record.

Conclusion

Through field trips, learning sessions, conference calls, and the project-wide summit, SNMHI participants and MHFs co-created robust learning communities that supported primary care practice transformation. We are hopeful the relationships developed will serve sites and MHFs as their PCMH journey continues in the months and years ahead.

New PCMH Resource Alert

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.



- **NEWLY REVISED!** The [PCMH-A](#) (Version 3.1), an interactive, self-scoring instrument to monitor practice transformation, can be downloaded, completed, saved, and shared.
- [Change Concepts for Practice Transformation and 2011 NCOA PCMH™ Recognition Standards: A Crosswalk.](#)
- **NEW!** Downloadable [registry of tools and resources](#), which includes all resources and tools hosted on the site and those hyperlinked within documents on the site.

PCMH Resources

- **NEW!** [Introductory materials](#) describe how and where to begin PCMH transformation.
- **NEW!** Executive Summaries provide a concise description of each Change Concept, its role in PCMH transformation, and key implementation activities and actions. These documents are a good starting place for frontline staff, board members, community partners, and others learning about PCMH transformation.
- **NEWLY UPDATED!** [Implementation Guides](#) (updated May 2013), provide an introduction to the Change Concepts, implementation strategies, and practical tools to facilitate real-world transformation. New additions include: the role of health information technology (HIT) and case studies that describe what change looks like.
- **NEW!** Twenty three independent and downloadable tools that can be used to test or apply the key changes. Tools include an interactive [Do-it-Yourself Run Chart](#), [Determining the Right Panel Size Worksheet](#), and a [Secret Shopper Exercise](#) to test the ease of scheduling an appointment from the patient’s perspective.

All materials are free and available on the SNMHI website: www.safetynetmedicalhome.org. We encourage you to use and share these materials widely. We welcome your feedback and hope the second edition series will prove to be a valuable and useful resource to you and your colleagues. Please contact us with questions or comments at info@qhmedicalhome.org.



Coach Medical Home

This website includes a curriculum for medical home facilitators or coaches who want to support practices through the medical home transformation process. Visit www.coachmedicalhome.org to learn more. More information can be found in the Medical Home Digest profile, [New Guide for Practice Facilitators: Coach Medical Home](#).

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.cmf.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.qhmedicalhome.org/safety-net.



MacColl Center for Health Care Innovation