



You're committed to making primary care work better—and so are we. Learn from the Safety Net Medical Home Initiative

October 2013

In 2008, we launched a five-year initiative to help safety net clinics dramatically improve quality, efficiency, and patient experience through the implementation of the patient-centered medical home (PCMH) Model of Care.

Widely recognized as a landmark demonstration, the Safety Net Medical Home Initiative developed a roadmap proven to help others navigate PCMH transformation.

If safety net providers—who arguably are tasked with some of the most constrained budgets and challenging patient populations—can achieve PCMH recognition, your organization can do it too.

The essence of a medical home is about patients having a team who knows them and cares for them. I now feel that I am working to improve the health of my whole population of patients—not just the patients who happen to show up that day.

Virginia Garcia Memorial Health Center—Cornelius, OR



MacColl Center for Health Care Innovation



Work has become much more efficient and I am no longer charting at 8:00 pm in the evening. I would never want to go back to the old way.

Terry Reilly Health Services—Homedale, ID

Results

By the end of the project, the majority of participants had made substantial progress.

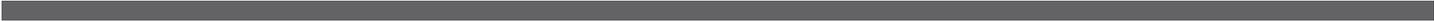
- All 65 participating safety net clinics (located in Colorado, Idaho, Massachusetts, Oregon, and Pennsylvania) demonstrated some level of implementation for each of the key PCMH criteria.
- More than 80% of participating clinics earned PCMH recognition—in many cases qualifying them for enhanced payments from various payors.

Process changes ranged from simple (but impactful) adjustments to complete overhauls of existing workflows, team responsibilities, and the dynamic between patient and provider. For example:

- Clinics created care teams—typically a physician, one or two MAs, and perhaps an RN or care coordinator—who always work together and prepare for their day with a brief morning huddle.
- Improved patient access. Some clinics streamlined their call management system to direct patients to specific care teams and developed processes to ensure the patient’s concern was answered directly or via a return call within 24 hours.
- Many implemented open access scheduling, which in turn reduced no-show rates (in some cases by more than 50%) and greatly improved patients’ ability to secure office visits within two days.
- One clinic created a Clinical Care Manager position to follow patients at risk for complications or readmission after a hospital visit. Over the course of two years, the percent of patients who received a telephonic or face-to-face appointment within two days of discharge rose from 7% to 44%.
- Others used health IT to create team-specific reports that stratify patients based on key clinical indicators and diagnoses—identifying the high-risk patients who would benefit most from care management.
- Some clinics either hired or better coordinated with in-house specialty care providers—behavioral health providers, nutritionists, etc.—to improve integration and provide whole-person care.
- Practices adopted registries to track patients with specific conditions and those in need of preventive services. Care teams used registries for proactive outreach and to help make sure every patient had his or her needs met.

The impact of transformation on the providers has been astounding.... This is what medical care should be like—taking care of a patient’s health and wellness and addressing their needs.

Outside In—Portland, OR



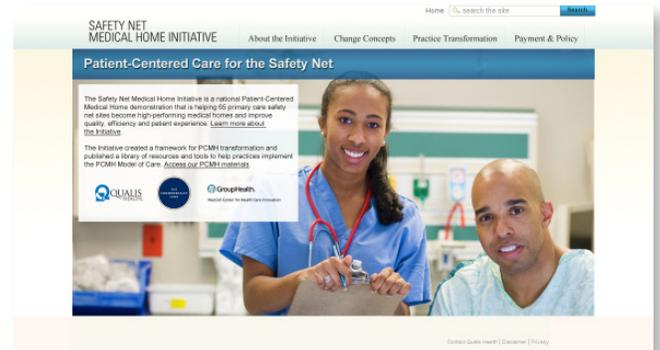
Free Resources

We developed a comprehensive set of resources and tools to help primary care practices understand and implement the PCMH model. Archived online, this legacy of the Safety Net Medical Home Initiative can help you achieve PCMH transformation.

The full library of practical tools is available, free of charge, at www.safetynetmedicalhome.org/resources

- Introduce frontline staff, board members, community partners, and others to the PCMH model via the Executive Summaries.
- Get practical tools and strategies for undertaking each of the sequential Change Concepts from the Implementation Guides.
- Monitor progress using the PCMH-A (Version 3.1), an interactive, self-scoring practice assessment.
- Access a wide variety of other downloadable tools and resources.

Ready to help others succeed?
Our PCMH coaching curriculum is accessible at www.coachmedicalhome.org



Our implementation was both faster and more effective because of the point-by-point delineation of the Key Changes and Medical Home Concepts. Without this assistance, we would have spent much time defining these and attempting to depict how they should look in our primary care setting.

North Side Christian Family Health Center—Pittsburgh, PA



About the Safety Net Medical Home Initiative

It's no small undertaking to implement the PCMH model. 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.



MacColl Center for Health Care Innovation

