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Issue Brief

Providing Underserved Patients with Medical Homes: Assessing the Readiness of Safety-Net Health Centers

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ABSTRACT: Enthusiasm for the patient-centered medical home model is growing, yet initial research is scant, showing that true transformation is challenging and that meaningful improvements in care delivery, efficiency, and health outcomes take time and sustained investment. This brief surveys safety-net health centers to determine their potential to become medical homes. Safety-net health centers that provide vulnerable and low-income populations with comprehensive primary care have unique opportunities for successful transformation, but also face challenges. For example, nearly half of the health centers surveyed do not have a process for scheduling patients with a personal provider or have an existing process that needs improvement; two-thirds do not have a process for same-day scheduling or have a process that needs improvement. Survey data also show that health centers that employed team-based care were more likely to have instituted patient access and communications processes, relative to those without team-based care.

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OVERVIEW

Despite widespread interest in the medical home model, it is often unclear how a practice becomes a patient-centered medical home (PCMH) or what a functioning PCMH looks like, particularly in the safety net. Implementing the PCMH model requires primary care practices to redesign how they interact with patients; organize care within the clinic; and coordinate care between their practice, other clinical settings, and the community. Public hospitals and clinics, federally qualified health centers (FQHCs), rural health centers, and free clinics for the medically underserved—collectively referred to here as safety-net health centers or practices—regularly deliver on some aspects of the medical home model. Many safety-net health centers have developed effective community partnerships to provide needed services, like behavioral health and dental care, as well as community exercise programs, Special Supplemental Nutrition Program for Women, Infants and Children (WIC) centers, and supportive housing services.

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Many health centers have a culture that emphasizes reaching out to and getting input from patients. In FQHCs, for example, more than half of the members of the board of directors must be current or past users of the health center. Other examples include the provision of after-hours or weekend care and colocation of health care services in public housing units and schools. Capitalizing on their strengths will be essential as these practices transform themselves into high-performing patient-centered medical homes.

Despite these assets, health centers face significant challenges. Continuity of care is difficult when transient patients with unstable insurance status are coupled with part-time providers. Health centers face a high demand for services, often from patients with limited English proficiency. In addition, finding referrals to specialty and inpatient services for uninsured patients is a major barrier to care coordination and safe transitions. Because of inadequate training of providers to work as part of care teams and the lack of financial support for care coordination, many health centers will require significant changes to transform into medical homes. Health centers also will need to work on updating their technology—insufficient health information systems hinder the efficient delivery of services, communication, sharing of health information, population-based measurement, and tracking of clinical outcomes.

This issue brief explores the potential of primary care safety-net health centers to become patient-centered medical homes. It includes information on current characteristics of safety-net health centers relevant to PCMH transformation, identifies areas for improvement, and proposes a set of strategies to assist health centers in becoming patient-centered medical homes.

ACTIONS FOR CHANGE

The Safety Net Medical Home Initiative—a national demonstration project sponsored by The Commonwealth Fund, cofunded by eight foundations, and led by Qualis Health and the MacColl Institute for Healthcare Innovation—was launched in May 2008. It is the first demonstration project to focus exclusively on safety-net practices. To guide the work of health centers participating in the initiative, Qualis Health and the MacColl Institute developed a set of change concepts for practice transformation. We worked with an expert panel that included patients, providers, researchers, and administrators to identify change concepts based on literature and experience that teams can use to guide improvement at the clinic level. We believe practices that tackle changes in these areas can strengthen their relationships with patients and families, delivering better, more satisfying patient care and improving health outcomes. The eight change concepts that have been adopted by the initiative to stimulate medical home transformation are:

1. **Empanelment**

- Determining and understanding which patients should be empaneled in the medical home and which require temporary, supplemental, or additional services.
- Using panel data and registries to contact, educate, and track patients by disease status, risk status, self-management status, community, and family need.
- Understanding practice supply and demand and balancing patient load accordingly.

2. **Continuous and team-based healing relationships**

- Establishing and supporting care delivery teams.
- Linking patients to a provider and care team so all parties recognize the others as partners in care.
- Ensuring that patients are able to see their provider or care team whenever possible.

A change concept is defined as a general idea with proven merit and a sound scientific or logical foundation that can stimulate specific ideas for changes that lead to improvement.

- Defining roles and distributing tasks among care team members to reflect their skills, abilities, and credentials.
- Cross-training care team members to maximize flexibility and ensure patients' needs are met.

3. Patient-centered interactions

- Respecting patient and family values and expressed needs.
- Encouraging patients to expand their role in decision-making, health-related behaviors, and self-management.
- Communicating with patients in a culturally appropriate manner, in a language and at a level that the patient understands.
- Providing self-management support at every visit through goal-setting and action-planning.

4. Engaged leadership

- Providing visible and sustained leadership to lead overall culture change, as well as specific strategies to improve quality and spread and sustain change.
- Establishing and supporting a quality improvement team that meets regularly and guides the effort.
- Ensuring providers and other care team members have protected time to conduct activities beyond direct patient care that are consistent with the medical home model.
- Building the practice's values of creating a medical home for patients into staff hiring and training processes.

5. Quality improvement strategy

- Choosing and using a formal model for quality improvement.
- Establishing and monitoring metrics to evaluate improvement efforts and outcomes; ensuring all staff members understand the metrics for success.
- Obtaining feedback from patients and families about their health care experience and using this information for quality improvement.
- Ensuring that patients, families, providers, and care team members are involved in quality improvement activities.
- Optimizing the use of health information technology.

6. Enhanced access

- Promoting and expanding access by ensuring that established patients have continuous access to their care teams 24 hours a day, seven days a week via phone, e-mail, or in-person visits.
- Providing scheduling options that are patient- and family-centered and accessible to all.
- Helping patients attain and understand health insurance coverage.

7. Care coordination

- Linking patients with community resources to facilitate referrals and respond to social service needs.
- Providing care management services for high-risk patients.
- Integrating behavioral health and specialty care into care delivery through colocation or referral protocols.
- Tracking and supporting patients when they obtain services outside the practice.
- Following up with patients within a few days of an emergency room visit or hospital discharge.

Exhibit 1. Applicant Demographics (n=554) (averages)

Number of physicians	6
Number of unduplicated patients	9,436
Patients with limited English proficiency	28%
Percentage of patients covered by Medicaid	40%
Percentage of patients uninsured	36%

- Communicating test results and care plans to patients and families.

8. Organized, evidence-based care

- Using planned care according to patient need.
- Using point-of-care reminders based on clinical guidelines.
- Enabling planned interactions with patients by making up-to-date information available to providers and care teams at the time of visit.

These change concepts overlap and interrelate with one another. Together, they point the way to redesigned care that meets patients' needs and improves health outcomes and to policy changes that can tangibly support and sustain patient-centered medical homes in primary care.

Many of the changes listed above have already been the focus of quality improvement efforts by some safety-net health centers. However, despite exposure to specific change concepts like enhanced access, there is a high degree of variability among safety-net health centers in terms of their capacity and readiness to implement the medical home model in entirety. The next section outlines the strengths of safety-net health centers and opportunities for improvement as they strive to become medical homes. Data is organized by change concept, showing the areas in which technical assistance may be most beneficial.

Methods and Data

Data made available to us as part of the Safety Net Medical Home Initiative application process allow greater understanding about the readiness of health centers to become medical homes. Applications for participation in the initiative were received from 42 organizations across 31 states. Each applicant organization was required to function as a coordinating center and quality improvement provider to 12 to 15 health centers in their self-defined region. In total, 554 safety-net health centers applied to participate in the initiative.

The safety-net health centers represented in the applicant pool varied in type, size, and number of patients served. The health centers, on average, supported six physicians, three midlevel providers, and five registered nurses or health educators. The smallest health center saw 22 patients and the largest clinic saw 147,000 patients at least once during the previous year. In 2008, the average active patient population was 9,436. More than a quarter (28%) of patients served had limited English proficiency and the vast majority were either uninsured (36%) or insured through Medicaid or a Medicaid managed care plan (40%) (Exhibit 1). A small percentage of patients had coverage through Medicare (11%) or a commercial insurance plan (15%).

As part of the application process, each clinic site was required to complete a self-assessment based on the National Committee for Quality Assurance's Physician Practice Connections Patient Centered Medical Home (PPC-PCMH) recognition tool (RS version, 2006).[1] The survey asked clinics to provide information on current operations and policies regarding important medical home activities, such as care

coordination and advanced access. These data provide valuable insights on the capacity of safety-net health centers to become patient-centered medical homes and their needs relative to transformation. This information informed the change concepts, which provide the framework for the transformation efforts. Results are based on self-reported data from clinics applying for a grant to support medical home transformation. Though applicants were highly motivated and interested, and thus may not be representative of all safety-net health centers, the data provide an important window into the readiness of safety-net practices to become medical homes.

READINESS FOR TRANSFORMATION

Access and Communications

Enhanced access to a care team is a core component of patient-centered care; same-day access and access to a personal clinician are both important measures of a medical home.[2] According to results from the survey tool, half (52%) of the practices reported their process for scheduling patients with a personal clinician works well, but fewer than one-third (32%) felt their process for scheduling same-day appointments work well (Exhibit 2).

Small (1–2 physicians) and medium-sized (3–9 physicians) practices were more likely to report their processes to support patient access and communications worked well than were large (10–49 physicians) or very large (50–99 physicians) practices.

Organized, Evidence-Based Care

Quality and safety are hallmarks of patient-centered care and high-performing safety-net practices implement protocols to make certain their patients receive the right care at the right time. Clinicians use these protocols, which are derived from evidence-based guidelines, to ensure that appropriate medications, immunizations, screenings, and counseling services are delivered to all patients. Virtually all of the surveyed health centers have protocols in place for using evidence-based guidelines to inform care delivery. However, there is significant variation by condition. For example, 92 percent of surveyed health centers use evidence-based guidelines to inform diabetes care, but only 59 percent use guidelines for depression care. There was a similar degree of variation with preventive services: 95 percent of health centers have protocols in place for age-appropriate immunizations, but only 68 percent use them for counseling and health education services. Fewer than one-third of health centers reported using electronic or paper-based tools to remind providers about needed services at the point of care (e.g., pop-ups in an electronic medical record, paper notes attached to the front of a paper chart). This low use rate of clinician reminders held true across a wide variety of conditions, including asthma, diabetes, depression, cardiovascular disease, and age-appropriate immunizations.

Exhibit 2. Practices with Standardized Processes to Support Patient Access and Communications

Does your practice have standardized processes to support patient access and communications with the practice?	Yes, works well	Yes, could use improvement	No
Scheduling patients with a personal clinician	52.2%	46.1%	1.7%
Coordinating visits to multiple clinicians and/or diagnostic tests during one trip	29.9%	55.4%	13.7%
Scheduling same-day appointments based on patients' requests	32.0%	57.6%	10.3%
Providing telephone advice on clinical issues during office hours by physician, nurse, or other clinician within a specified period of time	35.9%	51.9%	11.3%

Exhibit 3. Team Functioning

Do the nonphysician members of your staff share responsibility for managing patient care?	Yes, works well	Yes, could use improvement	No
Reminding patients of appointments and collecting information prior to appointments	34.0%	61.2%	4.7%
Executing standing orders for medication refills, ordering tests, and delivering routine preventive services	36.7%	50.7%	12.7%
Educating patients about self-care	32.1%	62.6%	4.7%
Coordinating care with external disease management or case management organizations	29.4%	55.8%	16.9%

Continuous and Team-Based Healing Relationships

Well-functioning clinical teams are one of the most powerful interventions for improving health outcomes.[3] Practices that function as patient-centered medical homes use care teams to deliver personal, coordinated, well-organized care that makes good use of providers' and patients' time. One way to measure this characteristic is by looking at the degree to which nonphysician staff share responsibility for managing key components of patient care.[4] More than half of the health centers surveyed reported that their nonphysician staff members did not share responsibility for managing patient care or said their existing system for dividing responsibilities could use improvement (Exhibit 3).

Similarly, health centers often rely on physicians to perform care management functions that could be effectively performed by another member of the care team, such as a nurse or medical assistant. Recent studies have demonstrated the importance of providing care management services that are well integrated with the patient's regular source of care.[5] Using team members within the practice to provide clinical care management, care coordination, and patient self-management services frees up providers' time, enables staff to work at the highest level their licensure or certification allows, and improves health outcomes for patients.[6]

Proactive planning—before, after, and between visits—for patients with chronic illness can help patients stay healthy and ultimately improve health outcomes. Previsit planning can range from quick daily

Exhibit 4. Care Management

Which of the following components of care management are routinely provided to your patients?	On site by M.D.	On site by ancillary staff	By contracted health plan or disease management organization	Not provided
Perform previsit planning to ensure that all needed information is available at the time of the visit	7.4%	59.1%	2.2%	31.2%
Review and individualize the care management plan with patients	70.1%	18.0%	1.1%	10.8%
Help patients set individualized treatment goals	69.7%	21.8%	1.9%	6.7%
Identify and review all prescribed and over-the-counter medications at each visit	69.9%	25.9%	0.6%	3.7%
Assess barriers when patients have not met treatment goals	69.2%	21.2%	1.5%	8.2%
Complete after-visit follow-up	8.0%	58.1%	2.4%	31.4%

morning huddles of the practice team to previewing charts to ensure tests are ordered and results are available before the visit. Previsit planning can help keep the day on track by ensuring up-to-date information is available when it is needed. After-visit follow-up, usually conducted by a member of the care team, can help ensure patients receive the important clinical information and self-management support they need to address their conditions. Despite the benefits of previsit and postvisit planning, about one-third (31%) of health centers surveyed do not provide these services (Exhibit 4).

The Importance of Team-Based Care

Many of the services and functions discussed, like previsit planning and follow-up, provision of care management services, and the use of evidence-based care, best occur within the context of a well-functioning clinical team. In fact, a recent review in the *Journal of the American Medical Association* showed that enhancing team-based care was the most effective intervention in improving intermediate health outcomes for patients with diabetes.[7] To better understand how team functioning and role assignments affect patient access and communications at participating health centers, we developed a composite index composed of questions related to sharing responsibilities. Health centers in which physicians are the only ones providing care management services were rated low on this "teamness index." Conversely, health centers that use nonphysician team members for care management received high ratings. To be rated as a high scorer, a practice had to confirm that its clinical staff shared responsibility for managing patient care in at least three of the four following areas:

- reminding patients of appointments and collecting information prior to appointments;
- executing standing orders for medication refills, ordering tests, and delivering routine preventive services;
- educating patients about self-care; and
- coordinating care with external disease management or case management organizations.

Data from these surveyed safety-net health centers affirmed earlier findings. Compared with practices that scored low on the "teamness index," high scorers were more likely to report they had processes in place to support patient access and communication and that those processes worked well (Exhibit 5).

Exhibit 5. "Teamness Index" Results for Patient Access and Communications

Does your practice have standardized processes to support patient access and communications with the practice?	Low scorer on "teamness index"		High scorer on "teamness index"	
	Percentage	Response	Percentage	Response
Scheduling patients with a personal clinician	42.2%	Yes, works well	84.8%	Yes, works well
	56.2%	Yes, could use improvement	14.4%	Yes, could use improvement
Coordinating visits to multiple clinicians and/or diagnostic tests during one trip	20.4%	Yes, works well	55.5%	Yes, works well
	63.1%	Yes, could use improvement	36.1%	Yes, could use improvement
Scheduling same-day appointments based on patients' requests	22.7%	Yes, works well	59.7%	Yes, works well
	66.8%	Yes, could use improvement	31.1%	Yes, could use improvement
Providing telephone advice on clinical issues during office hours by physician, nurse, or other clinician within a specified period of time	24.8%	Yes, works well	65.3%	Yes, works well
	59.6%	Yes, could use improvement	33.9%	Yes, could use improvement

Exhibit 6. Percentage of Practices with a System Outside the Paper Medical Chart for Tracking Tests and Referrals

Does your practice have a system outside of the paper medical chart for:	Yes, electronic system	Yes, paper	No
Tracking referrals until the consultation report returns to the practice	46.7%	29.3%	22.5%
Tracking all laboratory tests ordered or done, until results are available to the clinician, flagging overdue results	48.2%	31.4%	18.1%
Tracking all imaging tests ordered or done, until results are available to the clinician, flagging overdue results	33.0%	34.8%	27.6%
Flagging abnormal test results, bringing them to a clinician's attention	43.6%	47.1%	8.1%
Following-up with patients for all abnormal test results	36.3%	51.1%	11.7%

Sharing responsibilities also positively affected quality improvement activities. In particular, practices that scored high on the "teamness index" were nearly twice as likely to include a patient or consumer representative on their quality improvement committee than were low scorers (50% vs. 28%). Compared with practices that scored low on the index, practices that scored high were 23 percent more likely to connect patients with chronic conditions to self-management support programs. Practices with two to four physicians on staff scored highest on the "teamness index" overall and were most likely to report sharing responsibilities for patient management among staff members.

Care Coordination

Patient-centered practices ensure the timely communication of test results to patients and other care team members, and implement mechanisms to manage referrals when specialty care is needed. While most practices have a system in place to track referrals, flag abnormal laboratory or imaging results, and follow-up with patients regarding abnormal results, a number of clinics rely on a paper-based system for these functions and some health centers have no system in place at all (Exhibit 6).

Patient-Centered Interactions

Engaged patients are more likely to manage their chronic diseases and take advantage of needed preventive services.[8] Patient-centered practices encourage and support patient education and engagement by making patients active members of their care teams and encouraging patients to self-manage their conditions (Exhibit 7).

Targeted patient information that includes both patient-specific information and national guidelines or

Exhibit 7. Activities to Encourage Self-Management

For patients with chronic conditions (e.g., diabetes), does your practice routinely use the following activities to encourage patient self-management?	Yes	No	Don't know
Provide educational resources in the language or medium that the patient understands	95.8%	3.9%	0.4%
Instruct patients in self-management techniques and periodically observes their techniques	80.7%	13.0%	6.3%
Provide or connect patients to self-management support programs	74.4%	20.8%	4.8%
Offer patients the opportunity to include family members at visits, if preferred by patients	93.7%	4.1%	2.2%

averages can be a powerful tool in helping patients better understand and manage their conditions. More than half of the health centers surveyed provide patients with copies of their laboratory, imaging, or diagnostic procedure results (62%); a medication list (66%); or allergy information (56%). Yet half or fewer provide patients with a problem list (50%), visit notes (42%), or a written care plan (45%).

Quality Improvement Strategy

PCMH practices continually strive to improve care delivery processes and health care outcomes, strengthen relationships with their patients and communities, and increase the job satisfaction of their staff. Survey results show all the clinics have some type of quality improvement infrastructure in place: 94 percent set goals based on measurement results and 77 percent work to improve performance (Exhibit 8). However, quality improvement meetings occur less than once a month for more than half the sample, and 65 percent do not have patient representation on their quality improvement committees. There is significant room for improvement in these areas. As noted previously, teams that shared responsibility for managing patient care, rather than relying solely on providers, were more likely to report robust quality improvement activities, particularly the inclusion of patients on quality improvement committees.

Opportunities for Improvement

The safety-net health centers included in this study have a strong foundation on which to build and demonstrate capacity for high performance. As clinics interested in applying for a major, multiyear improvement initiative, most have formal quality improvement processes and many report regularly providing patient self-management support. Yet even these clinic teams have room for improvement in care coordination, team functioning, and access. With technical assistance, resources, and continued motivation, these clinics can become fully functioning, patient-centered medical homes. However, full transformation will require significant change and meaningful effort. In order for transformative efforts to be sustained over time, the reimbursement environment must change and new payment mechanisms will need to be implemented.

One clear area for improvement is access: Nearly half (48%) of the surveyed health centers do not have a process for scheduling patients with a personal provider or believe their process needs improvement, and two-thirds (68%) of health centers do not have a process for same-day scheduling or believe their process could be improved. While most of the clinics surveyed use evidence-based guidelines to direct chronic disease care and immunizations, depression care remains highly variable. Like their private-sector counterparts, safety-net clinics also have room for improvement in the provision of counseling, health education, and other critical preventive services. Two-thirds of the clinics surveyed do not provide their clinicians with reminders about evidence-based guidelines at the point of care. Reminders have been shown to increase the delivery of needed services and also offer an important opportunity for patient education and engagement.[9]

Exhibit 8. Quality Improvement Activities

Do your quality improvement activities include:	Yes	No	Don't know
Setting goals based on measurement results	94.3%	5.0%	0.7%
Taking action to improve performance of individual physicians	77.2%	20.6%	2.2%
Patient/consumer representatives on quality improvement committee	32.6%	64.8%	2.6%
Monthly (or more frequent) quality improvement meetings	46.7%	52.2%	1.1%
Involvement of clinicians on quality improvement committee	73.6%	24.7%	1.7%

The implementation of effective care teams is another key area for improvement. With a shrinking primary care workforce and an aging population with ever-increasing health care needs, the appropriate division of roles and responsibilities among physicians and other staff members is becoming increasingly important. Overburdened health centers could benefit from using nurses, health educators, and medical assistants to support critical patient care functions, particularly previsit and postvisit activities. Test and referral tracking also pose a challenge to safety-net health centers. These functions are important to ensure care is coordinated across time and place and that the primary care provider has an accurate record for point-of-care service delivery.

Finally, as health centers redesign care delivery processes, it is essential that patients be involved in key decisions. Patients are at the heart of patient-centered care. Safety-net clinics should work to ensure that patients have a strong presence on quality improvement committees to ensure care delivery processes are responsive to patients' needs.

CONCLUSIONS

The patient-centered medical home model has garnered support from a wide variety of stakeholders, including state legislatures, commercial payers, public payers, employers, provider groups, and consumer groups. Enthusiasm is growing, yet initial research, namely from the private sector, shows that true transformation is challenging.[10] Redesigning practices—whether private practices or safety-net health centers—takes time, dedication, willingness to change, and a substantial investment of resources. Safety-net health centers have a unique opportunity to redesign their care processes, but they also face unique challenges and barriers.

The Safety Net Medical Home Initiative seeks to provide important lessons about changes at the clinic level, as well as policy and payment changes that will encourage and sustain patient-centered care. As our nation continues to engage in health care reform, we must remember that it will take both macro-level changes to health financing and micro-level transformation in care delivery to improve health access and health outcomes. Wholesale and prolonged changes are necessary to ensure the sustainability and spread of patient-centered care, and visible improvements in health outcomes and patient experience will be needed to continue the momentum.

The Safety Net Medical Home Initiative and other demonstration projects taking place across the U.S. will provide insight into the process of practice-level transformation and identify strategies for change and best practices that will be useful to a wide variety of practice settings.

Notes

1 National Committee for Quality Assurance, *Physician Practice Connections–Patient-Centered Medical Home Recognition Tool Readiness Survey* (Washington, D.C.: National Committee for Quality Assurance, 2006).

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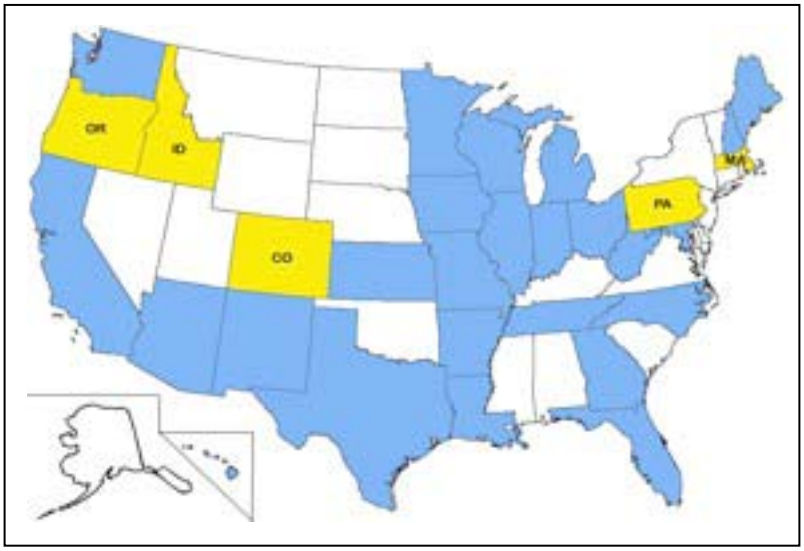
Appendix. Regional Coordinating Centers for the Safety Net Medical Home Initiative

Five regions (Colorado, Idaho, Massachusetts, Oregon, and Pittsburgh) were selected for participation in the initiative. These regions partnered with 65 safety-net health centers.

Figure. Map of Regional Coordinating Centers (yellow) and Other Applicants (blue)

- Colorado Community Health Network
- Idaho Primary Care Association
- Massachusetts League of Community Health Centers and the Massachusetts Executive Office of Health and Human Services
- Oregon Primary Care Association and CareOregon
- Pittsburgh Regional Health Initiative



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The initiative is administered by Qualis Health, conducted in partnership with the MacColl Institute for Healthcare Innovation at the Group Health Research Institute. For more information on the Initiative, visit: www.qhmedicalhome.org/safety-net.

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.

About the Authors

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