Gauging the Impact of the Safety Net Medical Home Initiative on Primary Care

The following are a list of selected question and answers from the July 9 webinar on this topic.

Medical Home Facilitators/Coaches

1. **What kind of training/background might a coach have? Were there any M.D.s or N.P.s?**
   Medical home facilitators, or coaches, typically had a background in quality improvement/process improvement. Some had experience with practice coaching in other areas (e.g., diabetes collaboratives, health disparities collaborative). Most had experience in primary care, which we found to be essential, ideally in a safety-net primary care setting. None of our medical home facilitators were M.D.s, although a few were R.N.s and one was an N.P. Most others had backgrounds/degrees in social work, public health, healthcare administration, etc.

2. **Was the training for your medical home facilitators internal to your program?**
   Our medical home facilitators/coaches received training and support internally from Qualis Health and MacColl, and from other sources such as the Institute for Healthcare Improvement and Dartmouth Microsystems. The Initiative provided funding for coaches to participate in training events and conferences to build specific skills such as motivational interviewing. Coaches also had access to a "coaches learning community," which allowed them to learn from one another, share resources and experiences, and troubleshoot.

3. **How many practices per medical home facilitator did you have? How often did they meet with the practice?**
   The medical home facilitators supported between two and 13 practices each, depending on the number of full-time employees in each practice and the number of coaches in their region. When asked, our medical home facilitators said that one full-time coach to five to 15 sites was about the right ratio. There were 10 to 15 practices per region. Coaches interacted with sites at different intervals (weekly, monthly, semi-monthly) and in different ways (in-person, phone, email, learning session) depending on the site's needs, progress, preferences, and geographic distance.

Evaluation

4. **Who is leading the independent evaluation?**
   The Commonwealth Fund is supporting Marshall Chin, MD, MPH, to conduct a rigorous evaluation of the Safety Net Medical Home Initiative that is examining impact of the initiative on clinical quality, patient experience, clinician/staff experience and utilization/cost outcomes. Several papers reporting baseline results have already been published. Outcome results are expected sometime in 2014 and 2015. Learn more about the Safety Net Medical Home Initiative evaluation and follow the outcomes.

Sustainability

5. **How do you maintain and sustain the patient-centered medical home model and changes? I often see practices become a patient-centered medical home and one year later, it seems like the medical home has somewhat fallen through the cracks...**
The patient-centered medical home transformation is a marathon, not a sprint. A robust quality improvement strategy and emphasis from practice leadership helps sites sustain patient-centered medical home changes. Some of the practices that did not do well did not have engaged leadership.

   Standardizing work processes is also a key way to sustain improvements. Standardization is a "Lean" tool that your practice can use to sustain improvement effort, even if you have not focused on using Lean. If practices are fundamentally rearranged, working in teams, having panels, staff won't go back to the old way of doing things. For more information on standard work and other quality improvement methodology, see the Quality Improvement Strategy Part 1 Implementation Guide: Tools to Make and Measure Improvement or the webinar, Spread and Sustainability in Medical Home Transformation.

Patient's Role

6. **What was the role of patients in the 65 sites in helping providers to change to a patient-centered medical home model?**
Patients were vital to the patient-centered medical home transformation process for the sites, but sites had variable success with this change. For many practices, it was easy because the board included patients; for others it was a major cultural shift. At Health West in Idaho, the patients who were on the board were very engaged. They would come to board meetings and say how connected they felt to their care teams.

   For information on engaging patients in patient-centered medical home transformation, measuring patient experience, communicating with diverse patients, and actively engaging and supporting patients and their families before, during, and after office visits, see the Patient-Centered Interactions Implementation Guide: Engaging Patients in Health and Healthcare and the Cambridge Health Alliance Practice Improvement Team (PIT) Development Toolkit. For an example of building patient and family advisory councils in the safety net medical home, see the webinar Establishing Patient and Family Advisory Councils in the Medical Home.

Communicating with All Staff

7. **What strategies do the practices participating in this initiative use to communicate the change concepts and principles in a language that ALL staff understood?**
The Safety Net Medical Home Initiative practices used many different strategies to communicate about the medical home model. Health West in Idaho held an all-day, all-staff meeting at the beginning of transformation process then emailed all staff a biweekly *Medical Home* newsletter about progress and held all-staff meetings. Engaged leadership was vital to communicate the change concepts and encourage staff to learn about PCMH.

For more information strategies, tips, and tools leaders can use to guide their practices through PCMH transformation see, the Engaged Leadership Implementation Guide: Strategies for Guiding PCMH Transformation.

Empanelment

8. **Could you please elaborate on the empanelment process?**

For many practices, empanelment was a cultural transformation. Providers and care teams shifted their focus from caring for individual patients to managing the health of a defined population of patients. Empanelment requires a shift from reactive to proactive care. See the Empanelment Implementation Guide: Establishing Patient-Provider Relationships step-by-step instructions for assigning and managing panels and strategies for sustaining the effort over time.

9. **What was the panel size of the PCMHs/teams, i.e. how many patients was each team responsible for?**
   Panel size for each provider/care team should be determined by the number of patients the provider can support based on current appointment supply and known patient demand. Size is not fixed and will vary for each provider. For a worksheet to run panel size calculations, see Determining the Right Panel Size.

Continuous and Team-Based Healing Relationships (Staffing/Training)
10. **Could we have examples of some of the team members?**
    A care team is a small group of clinical and non-clinical staff who, together with a provider, are responsible for the health and well-being of a panel of patients. The members of the care team and their specific roles will vary based on patient needs and practice organization, but typically a care team includes a provider who leads the team (may be M.D., N.P., P.A.), one or more medical assistants, reception/front-office, care coordinator/referral manager, nurse, and support staff specific to patient need (community health workers, behavioral health, oral health, social workers). For more information on forming care teams, including how to redesign care team roles, address staff concerns, and ensure sustainability, see the Continuous and Team-Based Healing Relationships Implementation Guide: Improving Patient Care Through Teams.

11. **Do you see any new or existing jobs that will be in higher demand due to the rise in patient-centered medical homes?**
    New or existing jobs that will be in higher demand due to an increase in medical homes include: community health workers, patient navigators, panel managers, medical receptionists, medical /clinical assistants, R.N. care managers, and referral coordinators/care coordinators. See the webinar Optimizing the Role of the Front Desk Staff for other examples of expanded roles. To learn more about the enhanced role of medical assistants in the medical home and access training materials, refer to the Continuous and Team-Based Healing Relationships Supplement: Elevating the Role of the Medical/Clinical Assistant webinar.

12. **You noted that one of the change features was new roles among the team members. Whose roles changed, how did they change, and what training assistance were they given to change their roles? How did they learn to become a "team"?**
Everybody's role changed at the practice. Non-professional staff such as community health workers saw their roles expand—they were increasingly involved in patient care. Providers' roles changed in that they now were members of teams and had to both trust and delegate major responsibilities to other members of the team, a very difficult transition. Training for non-professional staff was a major undertaking. Many of the better practices developed internal training programs to make sure staff could perform their new roles.

At Health West, at the very first meeting, the medical director created a strong visual, the receptionist (low), the nurse (medium), and the physician (high) in a hierarchy, then a second image of them all standing at the same height to show they are a team. They also created a new position by taking a supervisor position and creating a care coordinator position.

An example of new roles for the medical receptionist include being engaged as a member of the team caring for individuals in the community, educating all team members on the importance of care continuity, and ensuring continuity whenever possible. Receptionists must balance these demands with the need to provide access to care, schedule appointments when patients want them, and coordinate referrals.

Recognition
13. **What percentage of participating practices have achieved any level/kind of patient-centered medical home recognition?**
Patient-centered medical home recognition was an important goal for many sites. The initiative provided coaching and financial support for recognition. Eighty-one percent of participating sites achieved patient-centered medical home recognition, either from the National Committee for Quality Assurance or their state. Recognition qualifies practices in some states for enhanced payments and is a cornerstone goal of supporting agencies such as the Health Resources and Services Administration.

Vulnerable Populations
14. **What are some innovative ways in which safety-net medical homes are managing patients with chronic disease?**
Some sites focused on enhancing patient engagement with care to address chronic disease. For a presentation of the tools used to engage patients, see the webinar Tools to Enhance Patient Engagement. Other sites integrated self-management strategies into the electronic health record. For a presentation on using the care plan for documentation of self-management strategies across team members and follow-up, as well as the role of each team member and team workflow in this process, see the webinar Using a Patient-Centered Care Plan and Teamwork to Support Self-Management. Other sites are using

group visit models to encourage better chronic disease management through peer education and support. See the webinar, Planned and Mini-Group Medical Visits for more information. For examples of how safety-net sites can communicate with diverse patients and actively engage and support patients and their families before, during, and after office visits, see the Patient-Centered Interactions Implementation Guide: Engaging Patients in Health and Healthcare.

Payment and Policy

15. **Much of what is talked about involves the need for a financial model that can allow implementation of changes and still pay the bills. How about practices that do not have anything to go on but the current traditional payment model?**
    Most Safety Net Medical Home Initiative practices did not have access to enhanced payment, incentives, or alternate payment models during the course of the demonstration, yet were still able to successfully transform. It is possible for practices operating under the traditional fee-for-service model to transform, although payment reform is critical for long-term sustainability of patient-centered medical home practice changes. Patient-centered medical home transformation is an investment in your practice. For transformation to be successful, practice leaders need to devote time and resources to the process. To learn more about the business case for patient-centered medical home transformation, see the Engaged Leadership Implementation Guide: Strategies for Guiding PCMH Transformation.

16. **What was the amount of the incentive payment for achieving patient-centered medical home recognition?**
    The Safety Net Medical Home Initiative itself did not provide enhanced payments or incentives for participating practices. However, some practices were eligible for enhanced payment/incentives from one or more payers. Each region had a policy group that worked with payers in each state to discuss the sustainability and spread of the patient-centered medical homes and the need for payment reform. In some of these programs, payment was contingent upon reaching patient-centered medical home recognition; in other programs; eligibility for enhanced payment was based on other/additional factors including quality metrics, patient experience, or cost reduction.