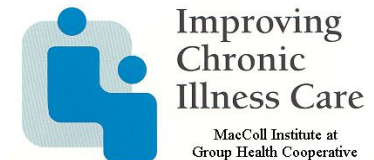


# The Singapore Disease Management & Primary Care Forum 2009

## Creating Patient Centered Medical Homes In US Safety Net Clinics

Brian Austin  
MacColl Institute for Healthcare Innovation  
Group Health Research Institute



# Presentation Overview

- Defining a medical home
- How do safety-net practices fit into the medical home movement?
- Commonwealth Fund Transformation Initiative
- Change concepts
- What about outside the safety net?
- Questions

# What are the key features of a Patient-Centered Medical Home? ACP, AAFP, AAP, AOA joint statement

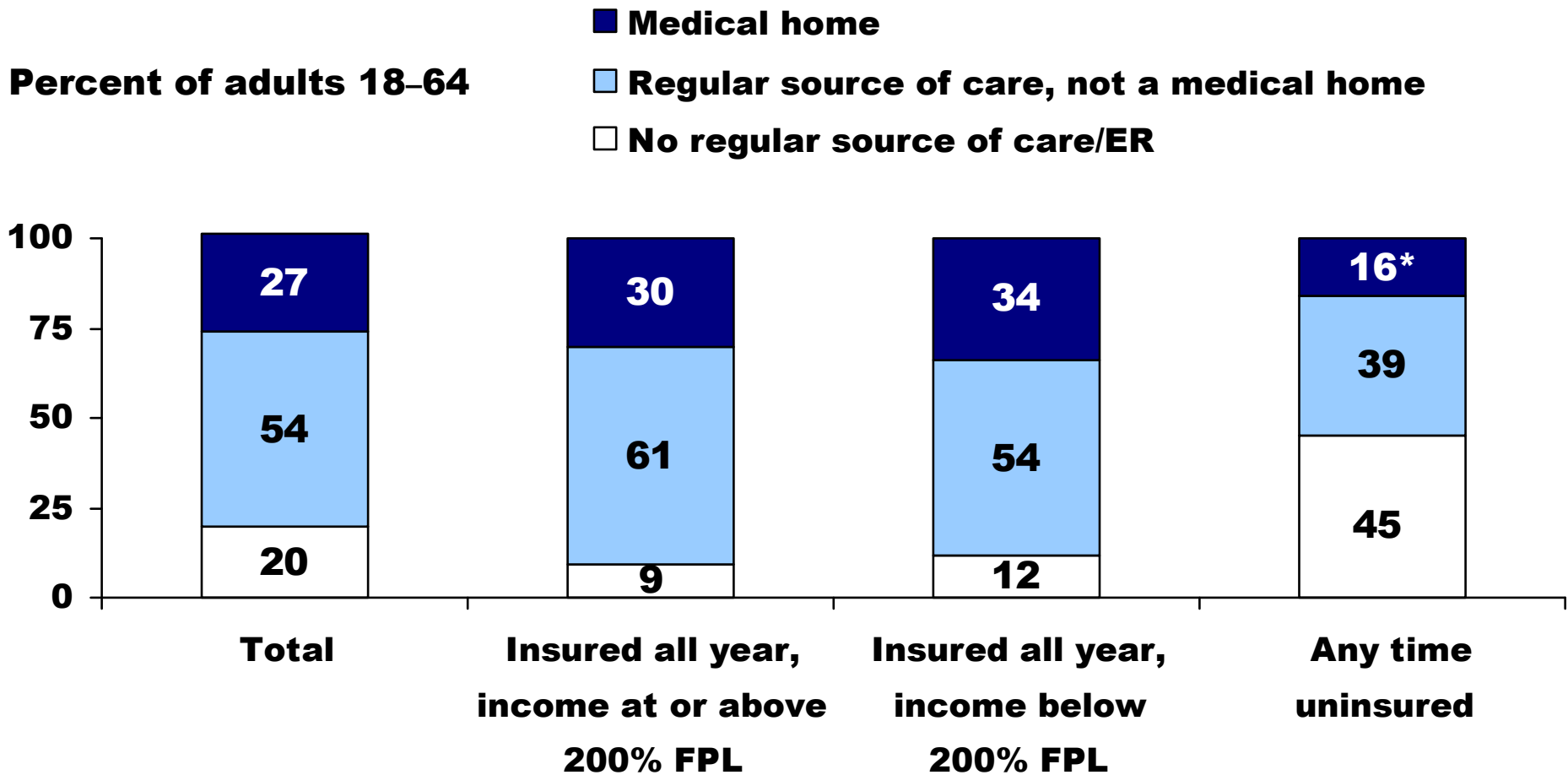
- **Personal Physician** – 1<sup>st</sup> contact, continuous, comprehensive care
- **Team Care** – collectively take responsibility for ongoing care
- **Whole Person Orientation** – take responsibility for all patient needs by delivering or arranging care
- **Coordinated Care** – across all elements of the healthcare system
- **Quality and Safety** – by implementation of CCM, continuous QI, and voluntary recognition process
- **Enhanced access** – via open scheduling, expanded hours and new options for communication
- **Payment** – recognizes value of the PCMH, pays for coordination and electronic communication with patients, supports IT use

## Indicators of a Medical Home by Usual Health Care Setting (adults 18–64)

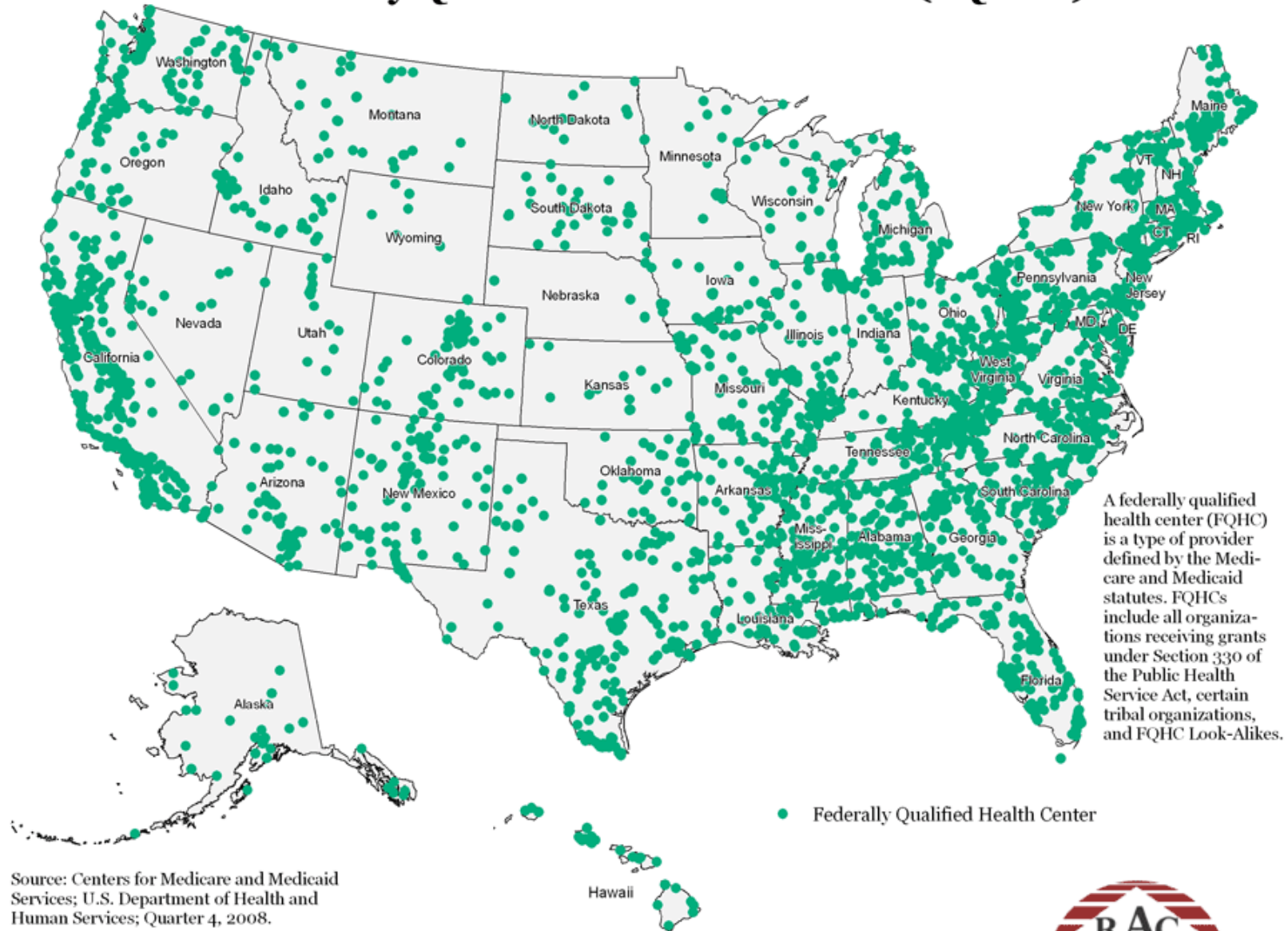
Indicator	Total	Doctors' office	Community health center or public clinic	Other settings*
<b>Regular doctor or source of care</b>	<b>80%</b>	<b>95%</b>	<b>78%</b>	<b>63%</b>
<i><b>Among those with a regular doctor or source of care . . .</b></i>				
<b>Not difficult to contact provider over telephone</b>	<b>85</b>	<b>87</b>	<b>77</b>	<b>77</b>
<b>Not difficult to get care or medical advice after hours</b>	<b>65</b>	<b>67</b>	<b>54</b>	<b>69</b>
<b>Always or often find visits to doctors' office well organized and running on time</b>	<b>66</b>	<b>68</b>	<b>56</b>	<b>60</b>
<b>All four indicators of a medical home</b>	<b>27</b>	<b>32</b>	<b>21</b>	<b>22</b>

\* Includes hospital outpatient departments and other settings.  
Source: Commonwealth Fund 2006 Health Care Quality Survey.

# Uninsured Are Least Likely to Have a Medical Home and Many Do Not Have a Regular Source of Care



# Federally Qualified Health Centers (FQHCs)



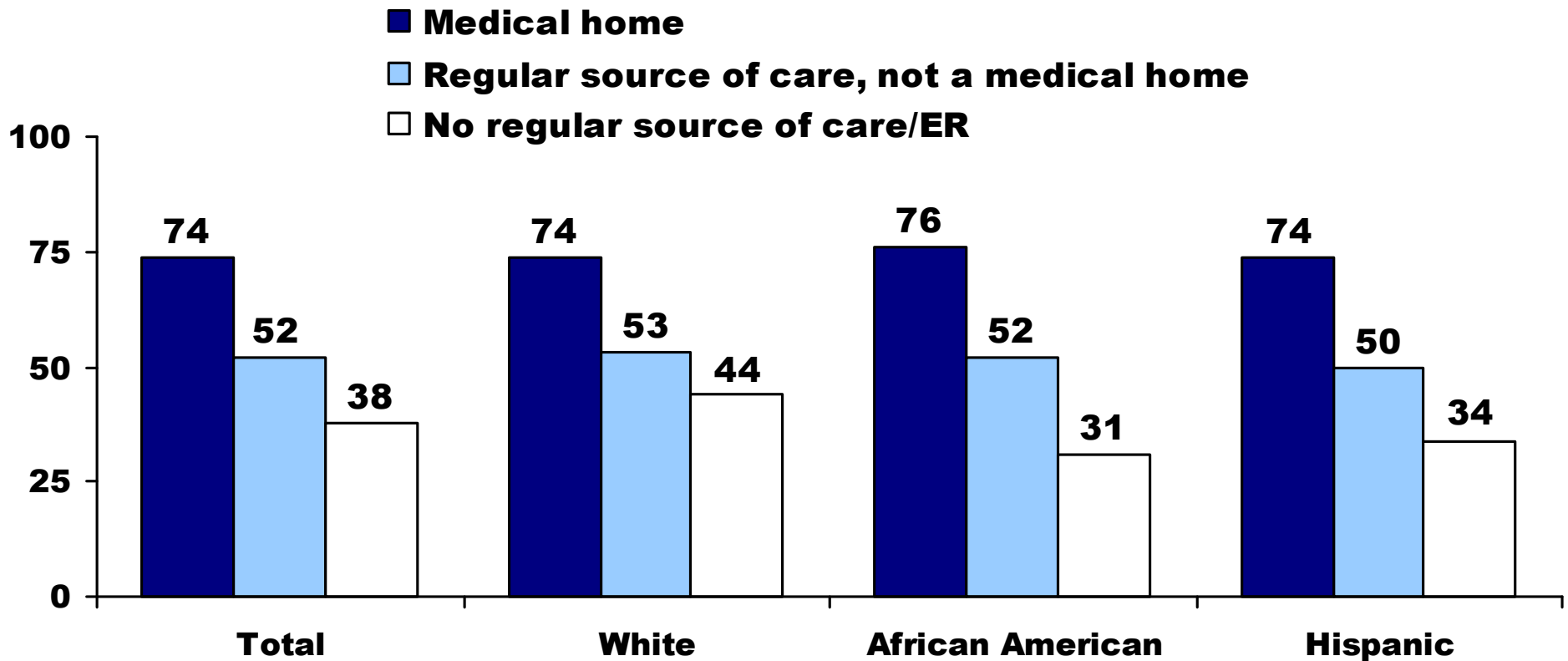
A federally qualified health center (FQHC) is a type of provider defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes.

Source: Centers for Medicare and Medicaid Services; U.S. Department of Health and Human Services; Quarter 4, 2008.

Note: Alaska and Hawaii not shown to scale

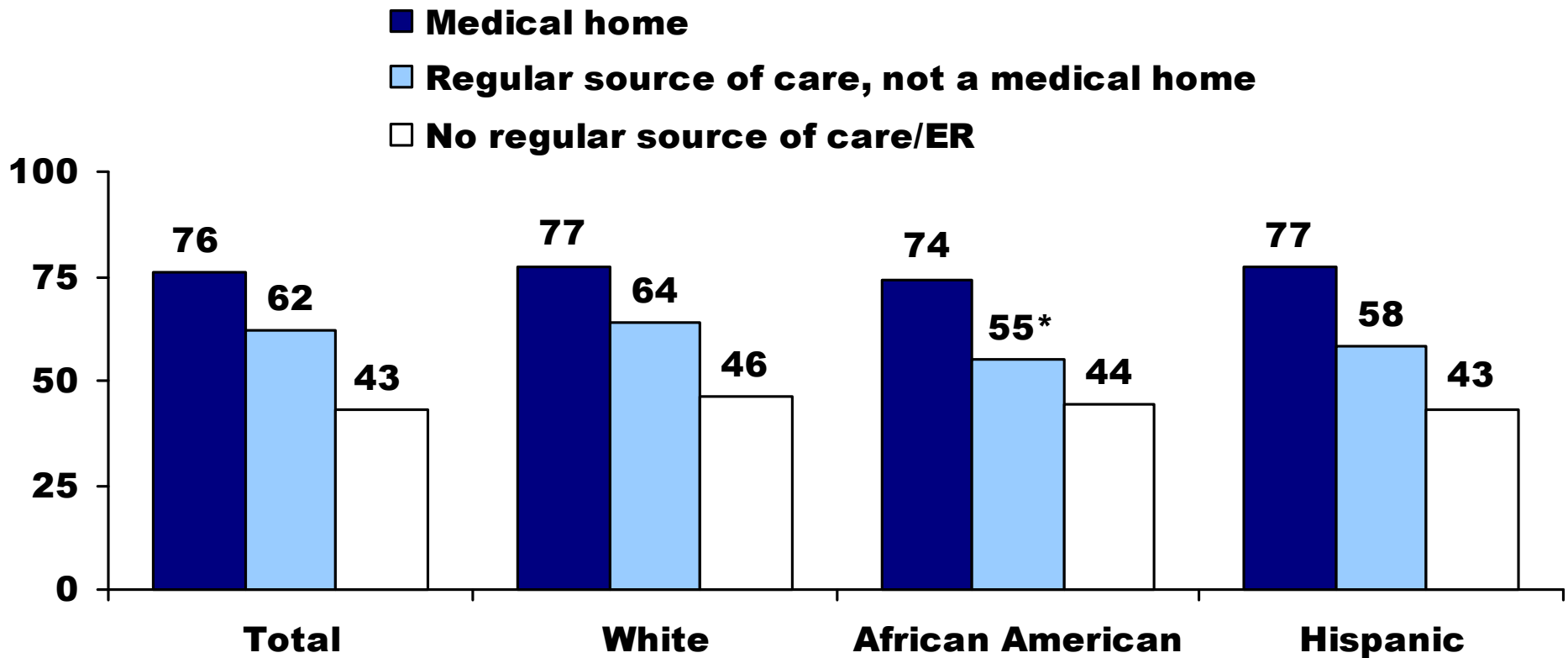
# Racial and Ethnic Differences in Getting Needed Medical Care Are Eliminated When Adults Have Medical Homes

Percent reporting always getting care they need when they need it



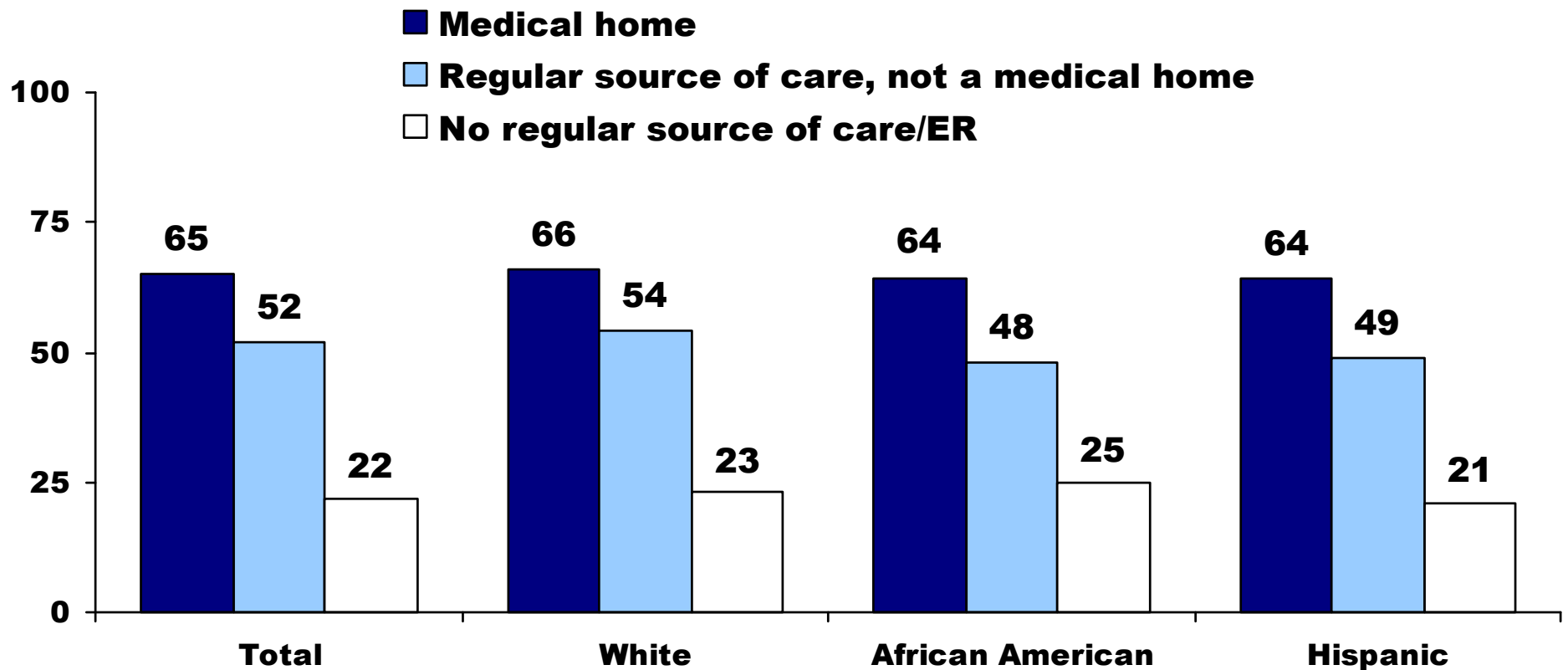
# African American and Hispanic Adults Who Have Medical Homes Have Rapid Access to Medical Appointments

Percent of adults 18–64 able to get an appointment same or next day



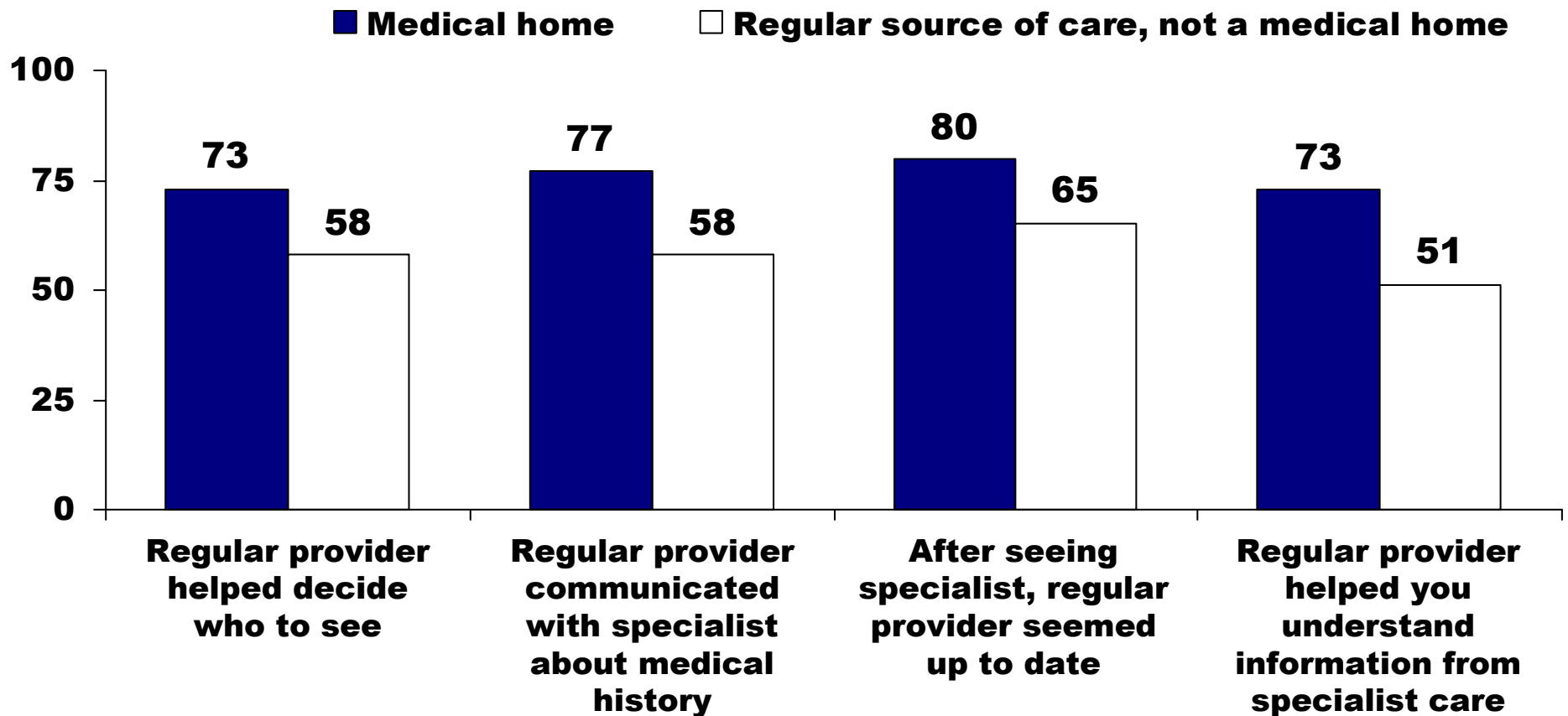
# When African Americans and Hispanics Have Medical Homes They Are Just as Likely as Whites to Receive Reminders for Preventive Care Visits

Percent of adults 18–64 receiving a reminder to schedule a preventive visit by doctors' office



# Figure 27. Patients with a Medical Home Report Better Coordination Between Their Regular Provider and Specialist

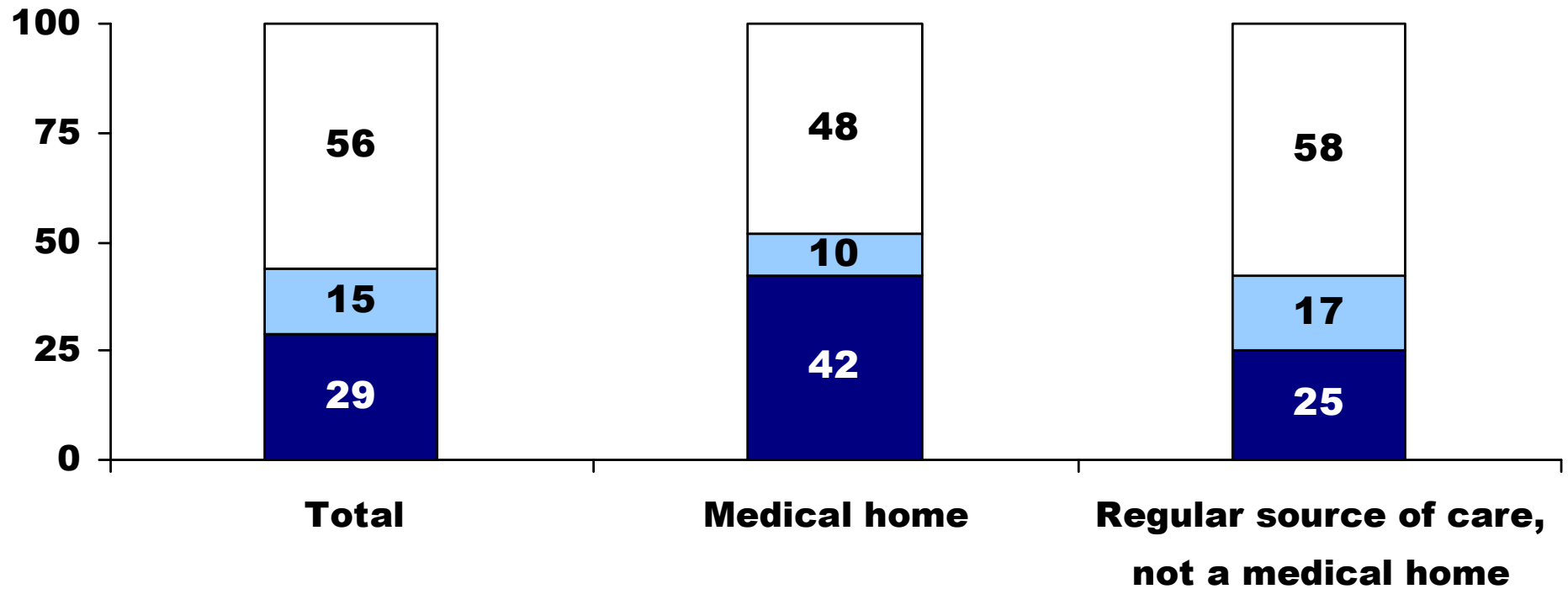
Percent of adults ages 18–64 who have seen a specialist in past two years



# Adults with a Medical Home Are More Likely to Report Checking Their Blood Pressure Regularly and Keeping It in Control

Percent of adults 18–64 with high blood pressure

- Does not check BP
- Checks BP, not controlled
- Checks BP, controlled



# Closing the Divide

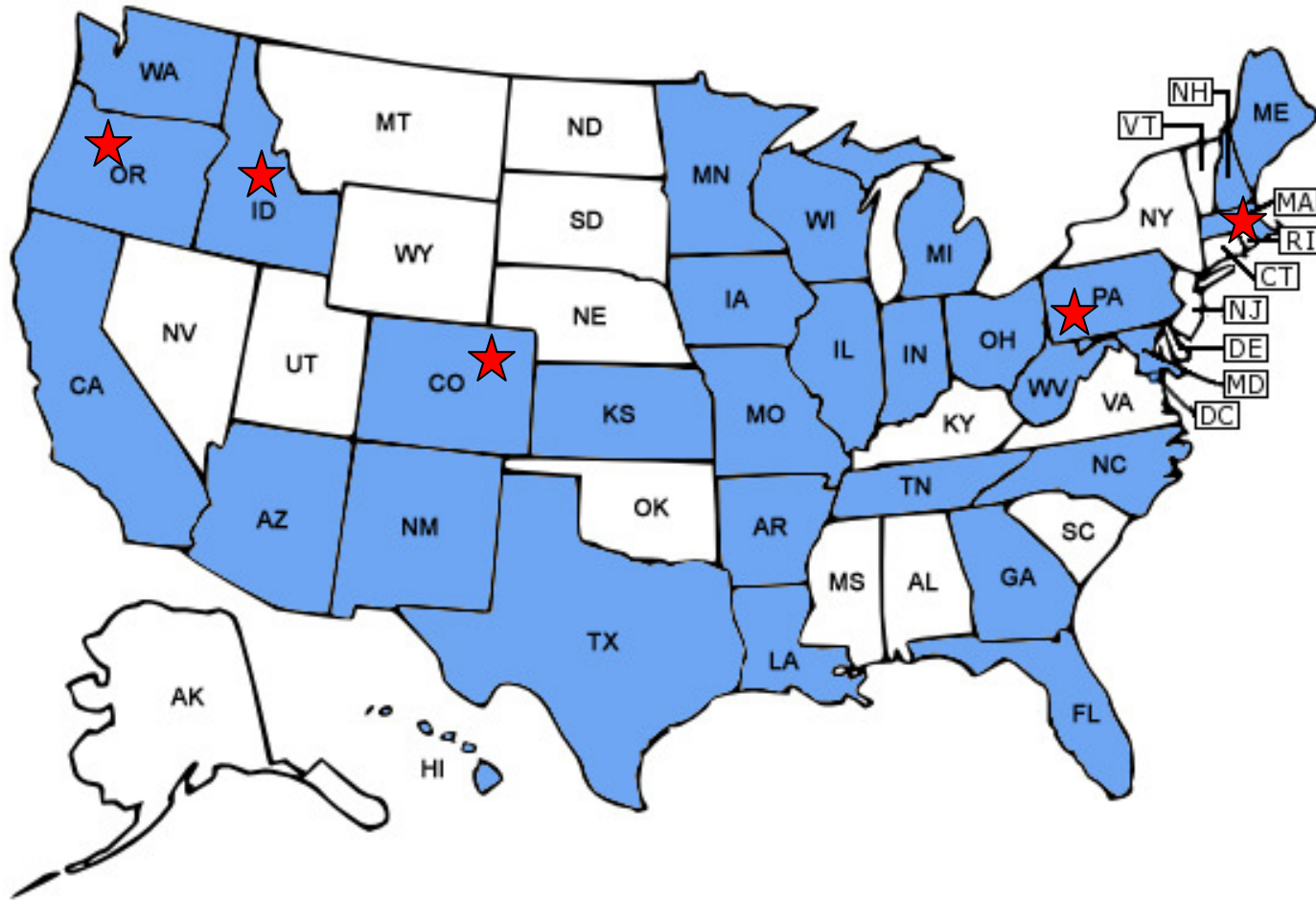
- Safety net clinics are less likely than private doctors' offices to be medical homes
- Medical homes can reduce or eliminate racial and ethnic disparities in access to and quality of health care
- “Community health centers and other public clinics, in particular, should be supported in their efforts to build medical homes for all patients.”

*Anne Beal et al. The Commonwealth Fund, June 2007*

# Commonwealth Fund Medical Home in the Safety Net Program

- Work with 5 Regional Coordinating Centers of the country to help 12-15 safety net practices in their area become medical homes
- Early step was to develop a “change package” that defines the attributes of a PCMH, and the system changes needed to get there.
- Assembled national experts to review and amend draft changes.
- Amended change package reviewed and edited by an additional multi-stakeholder group.

# Participating Regions



# What are we trying to achieve?

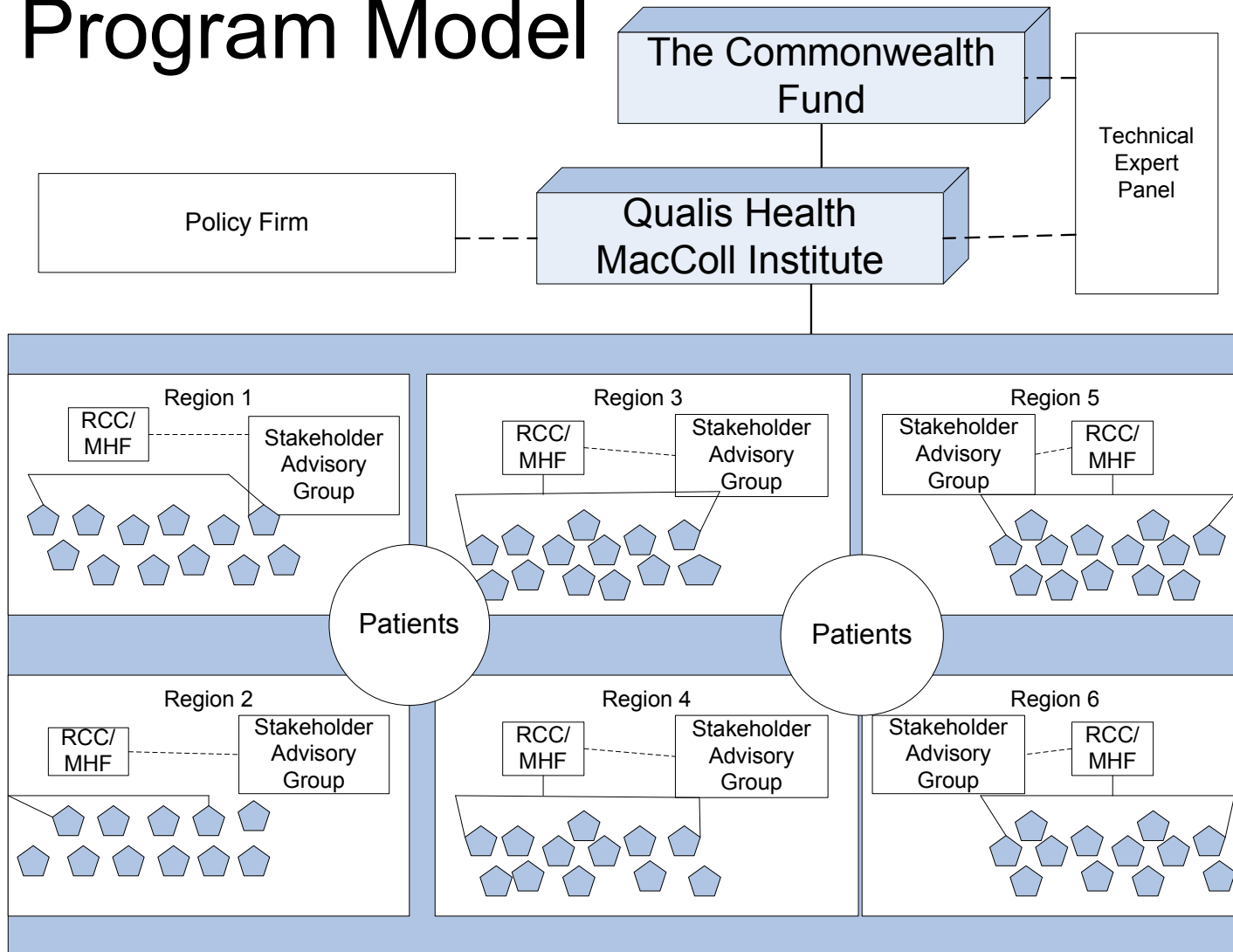
## Clinical Aims

- Improve the operational efficiency and quality of care in primary care safety net clinics.
- Improve patients' healthcare experiences.
- Reduce disparities in access to care and quality of care.

## Regional Aims

- Enhance capacity to support and sustain practice improvements.
- Influence health policy by involving Medicaid and other stakeholders in action towards appropriate reimbursement levels to sustain practice efforts.

# Program Model



# Evaluation Domains

1	Do the clinics become medical homes?
2	Do they provide better clinical quality, better patient experience, more efficient care?
3	What is associated with successful implementation?

# Change concept

*n.*, 1. A general idea – with proven merit and a sound scientific or logical foundation – that can stimulate specific ideas for changes that lead to improvement

# What are the key features of a Patient-Centered Medical Home? Commonwealth Project

- Engaged leadership
- Quality improvement strategy
- Empanelment
- Patient-centered interactions
- Organized, evidence-based care
- Care coordination
- Enhanced access
- Continuous, team-based healing relationships

# Technical Assistance Mechanisms

- Facilitation of “community of practice”: sharing best practices among RCCs/sites
- Support of regional Medical Home Facilitators
- Webinars, electronic and telephonic communication with sites
- Technical consultation from experts in specific domains of the change concepts

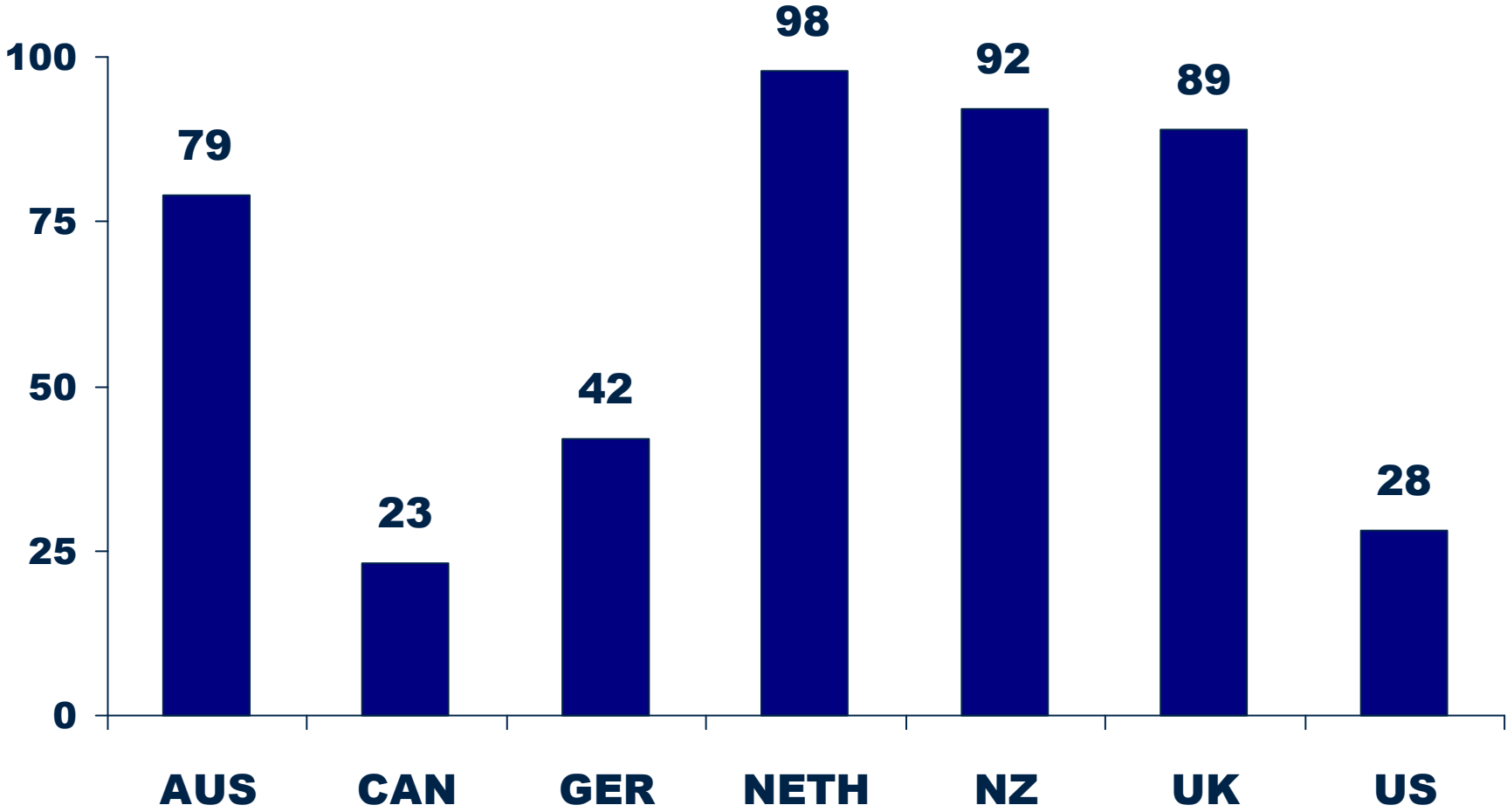
# Outside of the safety net, don't we already have medical homes— What's new?



Do Providers think Medical  
Home-style Care is Already  
Occurring?

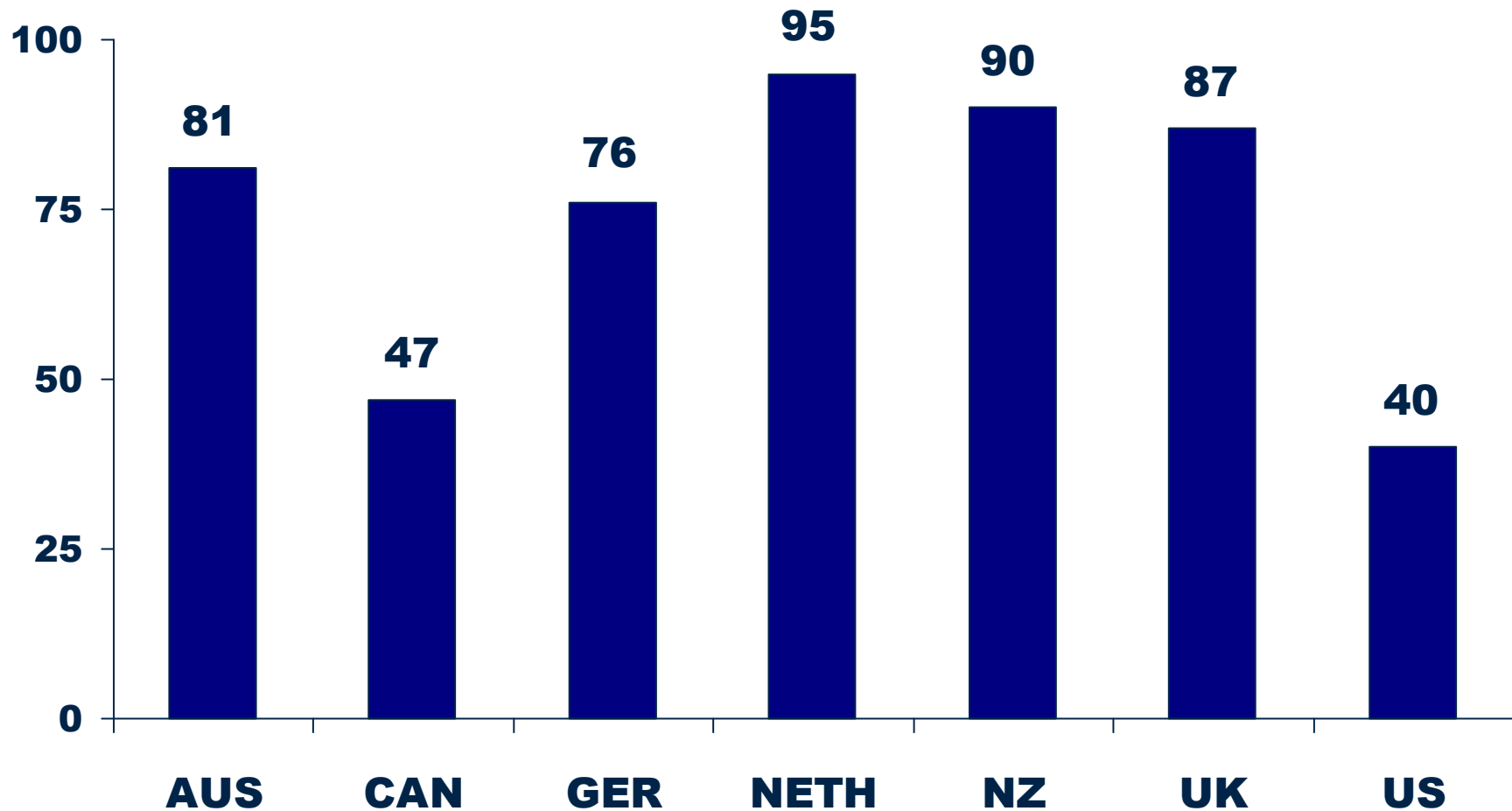
# Commonwealth Survey of Primary Care MDs: Use of Electronic Medical Records, 2006

Percent

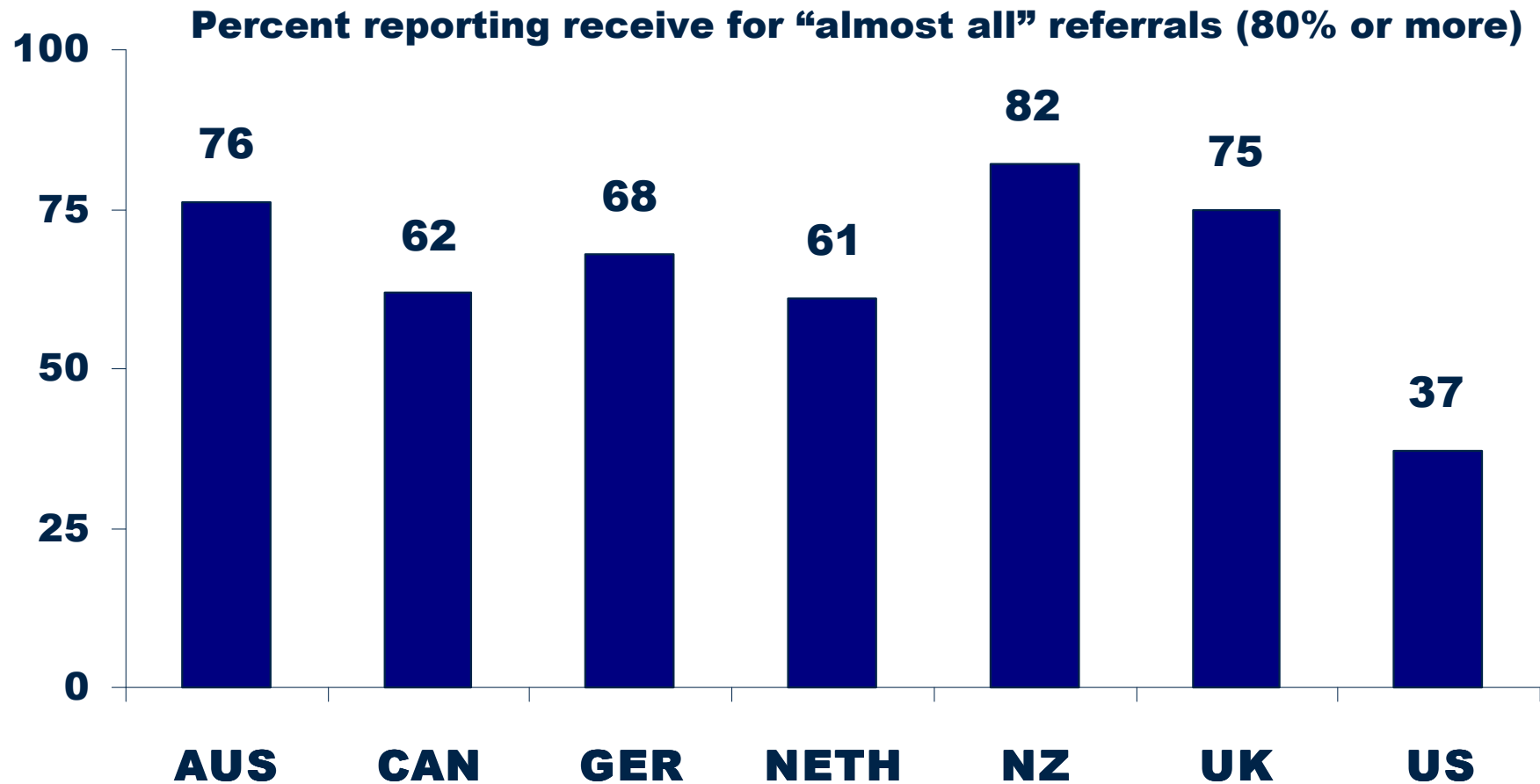


Source: 2006 Commonwealth Fund International Health Policy Survey of Primary Care Physicians.

# Commonwealth Survey of Primary Care MDs: Doctor's Practice Has Arrangement for Patients' After-Hours Care to See Nurse/Doctor



# Commonwealth Survey of Primary Care MDs: Practice Receives Information Back After Referrals of Patients to Other Doctors/Specialists



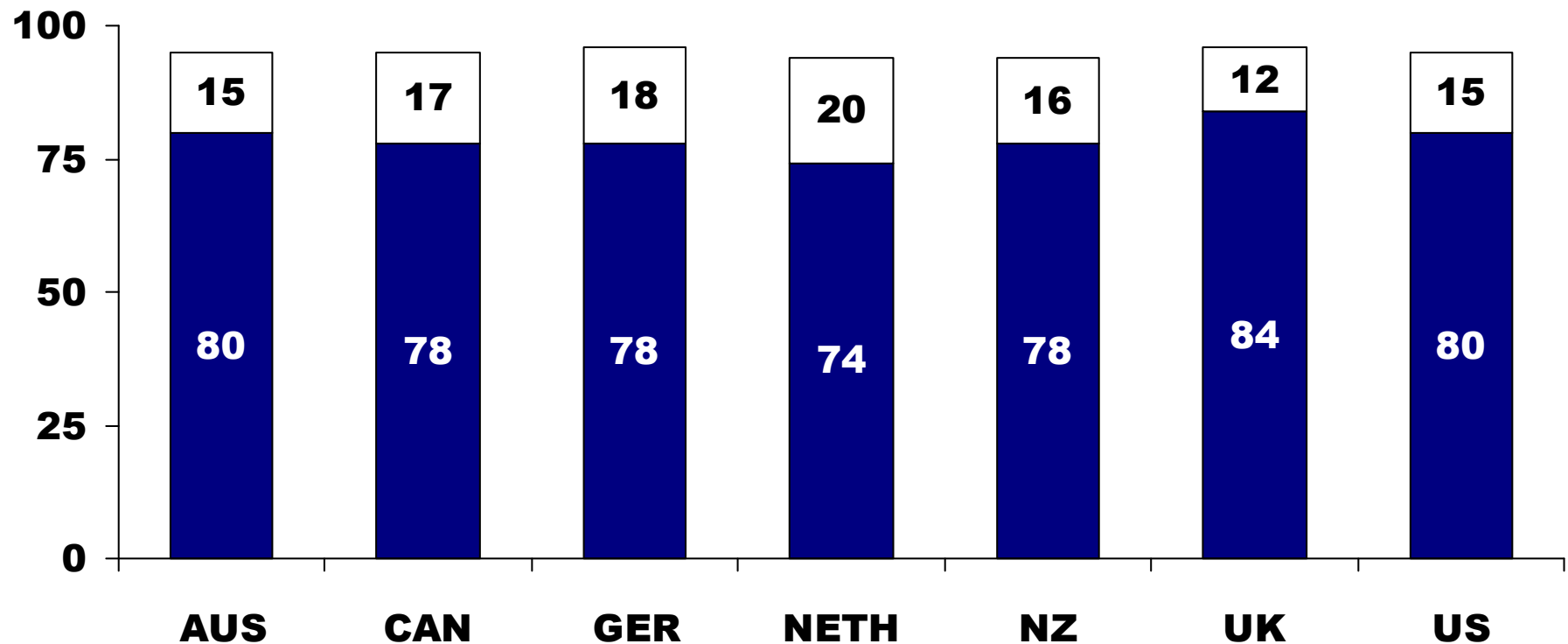
# What do Patients Think?

# When you need care, how important is it that you have one practice/clinic where doctors and nurses know you, provide and coordinate the care that you need?

Percent saying very or somewhat important

□ Somewhat important

■ Very important



# Are Medical Homes:

- A fad?
- A rationale for better payment?
- Life support for primary care?
- What patients want and need?

To learn more:

•[\*\*www.qhmedicalhome.org\*\*](http://www.qhmedicalhome.org)

•[\*\*www.improvingchroniccare.org\*\*](http://www.improvingchroniccare.org)

Thanks

# Appendix – Supplemental Materials

# Engaged Leadership

PCMH leaders:

- Provide visible and sustained leadership in overall culture change as well as specific strategies to improve quality and spread and sustain change.
- Establish a QI team that meets regularly and guides the effort.
- Ensure that team members have protected time to conduct activities beyond direct patient care that are consistent with the medical home model.
- Incorporate the practice's values on creating a medical home for patients into staff hiring and training processes.

# Quality Improvement (QI) Strategy

PCMH practices:

- Choose and use formal models for quality improvement
- Establish and monitor metrics to evaluate improvement efforts and outcome and provide feedback
- Obtain feedback from patients/family about their healthcare experience and use information for quality improvement.
- Ensure that patients/family, providers, and care team members are involved in quality improvement activities.
- Optimize use of information technology

# Empanelment

PCMH practices:

- Determine and understand which patients should be empanelled in the medical home.
- Use panel data and registries to proactively contact, educate, and track patients by disease status, risk status, etc.
- Understand practice supply and demand, and balance patient load accordingly.

# Patient-Centered Interactions

PCMH practices:

- Assess and respect patient/family values and expressed needs.
- Encourage patients to expand their role in decision-making, health-related behavior change, and self-management.
- Communicate with their patients in a culturally appropriate manner, in a language and at a level that the patient understands.
- Provide self-management support at every visit through goal setting and action planning.

# Organized, Evidence-Based Care

PCMH practices:

- Use planned interactions according to patient need.
- Enable planned interactions with patients by having available, up-to-date patient information and “standing orders” for the care team before any interaction.
- Use point-of-care reminders and other decision support based on clinical guidelines.
- Assure access to care management resources to provide more intensive support to high risk patients

# Care Coordination

## PCMH practices:

- Link patients with community resources to facilitate referrals and respond to social service needs.
- Provide care management services for high risk patients.
- Have referral protocols and agreements in place with an array of specialists to meet patients' needs.
- Proactively track and support patients as they go to and from specialty care, the hospital, and the ED
- Follow-up with patients within a few days of an emergency room visit or hospital discharge.
- Test results and care plans are communicated to patients/families.

# Enhanced Access

PCMH practices:

- Promote and expand access; ensure that established patients have 24/7 continuous access to their care teams via phone, email, or in-person visits.
- Scheduling options are patient- and family-centered and accessible to all patients.
- Help patients attain and understand health insurance coverage.

# Continuous and Team-Based Healing Relationships

PCMH practices:

- Clearly link patients to a provider and care team so both patients and provider/care team recognize each other as partners in care.
- Assure that patients are able to see their provider or care team whenever possible.
- Define roles and distribute tasks among care team members to reflect the skills, abilities, and credentials of team members.
- Cross-train care team members to maximize flexibility and ensure that patients' needs are met.