Where Do We Go From Here?

The Value of *Sustaining* Practice Transformation

**Massachusetts League of Community Health Centers**

**Annual Clinical Conference**

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Qualis Health is a non-profit healthcare consulting and care management firm. We help practices implement the PCMH Model of Care and achieve PCMH recognition. We lead multi-state PCMH demonstration projects, regional collaboratives, and provide customized practice-level assistance for local networks.
Opening Questions

_handshake Who are you?

_handshake Based on your current knowledge and thinking about Patient-Centered Medical Home, where would you say your site or organization is on the journey toward transformation?

Not really begun  25% of the way  50% of the way  75% of the way  All the way
Agenda

1. *Changing expectations*: Preparing for the future of PCMH.
PCMH 1.0: Where it All Began

• Starfield’s seminal research on primary care
• *Crossing the Quality Chasm*, 2001
• *Joint Principles*, 2007
  – Pediatric Medical Home Model (1960s)
  – Chronic Care Model (MacColl Center)
• *Closing the Divide: How Medical Homes Promote Equity in Health Care*, 2007
• IHI’s Triple Aim, 2008
“Extraordinary Promise” Captured the Attention of the Nation

Best available vision for the future of primary care.

Improve quality and outcomes, reduce disparities, improve patient experience, improve efficiency, reduce healthcare costs, solve the workforce crisis.

Providers
Patient advocates
Researchers

Policymakers
Payers
Employers
Health Plans/TPAs
7 years later....Pilots and demonstrations abound and we have a new lexicon for primary care improvement.

Person-Centered Health Home (PCHH)
Medical Home Neighborhood
Person-Centered Primary Care Home (PCPCH)
Health Care Home
Community-Centered Health Home
Community Care Organization (CCO)
Accountable Care Organization (ACO)
Regional Community Care Organization (RCCO)
44 states and the District of Columbia have passed more than 330 laws relating to the medical home, or have executive level activity that references the PCMH.

All payers involved. All practice types.
Multi-Payer (as of 2013)

Medicaid/CHIP (since 2006)

Pursuing ACA 2703 Health Homes

Payments to Community-Based Teams/Networks
PCMH 2.0: Changing Expectations in a New Environment

• Medical Home Neighborhood: Comprehensive care...coordinated by primary care.

• Health Reform: New opportunities and new challenges:
  – ACA is providing traction in the payment arena
  – Medicaid expansion: Increased patient choice means increased competition
  – Insurance alone ≠ access
State ‘Accountable Care’ Activity Map (ACO, COO, RCCO)

Impact on Primary Care

- Population health
- Focus: Outcomes
- Shared cost-savings
- Risk-sharing

New Expectation: External Validation

- Self-assessment is no longer enough.
- Payers want some assurance they aren’t “paying more for the same thing.”
- Plans and patients want validation of PCMH capacity.
- 37 states have payment programs tied to NCQA Recognition.

2008: 38 practices recognized
Today: 6,000 practices—29,505 clinicians from 49 states
Plus: JCAHO, URAC, AAAHC
NCQA 2014 PCMH Recognition Program
It’s only 5 months away, and it’s tougher...by design.

<table>
<thead>
<tr>
<th>2011 Program</th>
<th>2014 Program*</th>
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<tbody>
<tr>
<td>HIT: MU Stage 1</td>
<td>HIT: MU Stage 2</td>
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<tr>
<td>Comprehensive primary care</td>
<td>Integrated care, e.g., behavioral health</td>
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<tr>
<td>Patient self-management support</td>
<td>Incorporate patient, family, <em>and</em> caregiver in self-care</td>
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<tr>
<td>Measurement for performance improvement</td>
<td>Document improved <em>outcomes</em> on a broad set of measures</td>
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<td></td>
<td>Resource stewardship: Cost and utilization</td>
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Selected examples only.* To see full proposed changes, visit NCQA Draft Standards: http://www.ncqa.org/Portals/0/PublicComment/PCMH2013/Appendix%202_All%20PCMH%20Documents_6.20.pdf.
Value Proposition for PCMH

• It will help your health center stay competitive in a changing marketplace:
  – Patient experience
  – Improve staff satisfaction and reduce turnover

• It will position your health center for participation in new models of care delivery (ACO) and prepare you for a variety of payment models:
  – Proactive, population health (empanelment)
  – QI and HIT required to improve and document outcomes
Value Proposition for PCMH

PCMH is here to stay.

“This is the kind of care that we would want for ourselves and for the persons we know and love. It is the right way to care for the whole person.”

*Stephen Weeg, Retired Director, Health West, Idaho*
“Welcome to My Neighborhood”

Will you be ready to meet the *new* expectations of PCMH?

- Are you ready to actively collaborate with specialists, hospitals, EDs, long-term care?
- Are you ready to provide/link to social services and supports?
- Will your health center be viewed as “provider of choice” by patients with new options?
Let’s Revisit...

Based on what you’ve just heard and your own current knowledge and thinking about Patient-Centered Medical Home, where would you say your site or organization is at on the journey toward transformation?

Not really begun  25% of the way  50% of the way  75% of the way  All the way

How will you continue *transforming* to meet the new expectations of PCMH?
Safety Net Medical Home Initiative: 2008-2013

• Helped 65 primary care safety net sites implement the PCMH Model of Care:
  ✓ All sites made significant progress; half implemented most or all PCMH “key changes” to a substantial degree
  ✓ 83% achieved recognition

• Led by Qualis Health and the MacColl Center with support from The Commonwealth Fund and local foundations.

• Regional Coordinating Centers employed practice coaches who provided direct technical assistance to sites and supported state-based learning communities.
Achievements and Contributions

• Developed and tested an operational, evidence-based framework to guide transformation.
• Published a comprehensive library of implementation resources.

We identified approaches, strategies, and “mental models” that facilitate transformative, sustainable change.

Consider which you can adopt to help your health center set the stage for success...
1. Use a Roadmap
A structured approach makes the work tangible and manageable.

The Change Concepts for Practice Transformation:

4 stages
8 concepts
32 “key changes”

2. Find Ways to Build and Sustain Energy for the Work Ahead
   (Because there is always more to do....)

• Effective practices:
  – Recognize that PCMH is a transformative process, not a series of discrete, incremental changes.
  – Connect PCMH to their organization’s mission, make it their vision, and embed it in their values. And they do it in tangible ways: Interview guides, job descriptions, patient orientation packets.
  – Harness staff’s intrinsic desire to do good.
  – Use change management techniques to protect against change fatigue.
3. Plan for Success
Engaged Leaders and a solid QI strategy provide the foundation for successful redesign.

• Engaged leaders:
  – Make PCMH the priority
  – Give staff time and resources to do the work
  – Invest themselves in the process

• Performance measurement is routine, inclusive, well resourced, and valued:
  – Meaningful involvement from patients and families
4. Use the Power of Relationship to Change Culture

People make and sustain change because of & for other people.

Relationships with patients (empanelment)

- Foundation for population management.
- Practices that do not make this jump do not become medical homes.
- Effective practices explicitly link patients and teams.

*When everyone is held accountable for the outcomes of patients they know ... everyone works together to improve the process of care.*
Relationships with staff (care teams)

- Team-based care is what allows the practice to meet the demands of the model.
- Practices that do not make this jump...can’t keep up.
- Effective practices:
  - Build teams around the specific needs of their patient population.
  - Make everyone a caregiver: Especially the receptionist.
  - Focus on core functions and activities, not credentials. Train-up.
  - Hire for, train, and reward teamwork.
Transformation vs. Recognition

- Accreditation doesn’t necessarily mean you are a PCMH: It means you passed the PCMH “test.”
- Transformational change is about the paradigm shift.

<table>
<thead>
<tr>
<th>FROM</th>
<th>TO</th>
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<tbody>
<tr>
<td>Acute reactive care</td>
<td>Proactive planned care</td>
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<tr>
<td>Solo provider mindset</td>
<td>Team-based care</td>
</tr>
<tr>
<td>Volume-driven</td>
<td>Value-based</td>
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<tr>
<td>Chaos</td>
<td>Control</td>
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<tr>
<td>Fragmented services</td>
<td>Full service integration</td>
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Recognition criteria can provide structure, motivation, and resources.
5. Use the NCQA PCMH Recognition Process to Anchor Changes

• When done well, transformation and recognition are synergistic and mutually reinforcing.

• Understand the difference. *And do both to stay competitive.*
  – Payers (in 37 states), plans, and patients expect it.

• Integrate efforts from the very beginning:
  – Use documentation requirements to develop written processes and standard work.
Questions
May your trails be crooked, winding, and challenging. The most astounding views often come from the steepest, most twisted and difficult paths.

Edward Abbey
## Key Activities List

<table>
<thead>
<tr>
<th>CONTINUOUS &amp; TEAM-BASED HEALING RELATIONSHIPS</th>
<th>Key Changes</th>
<th>Key Activities</th>
<th>Examples of Activities that Have Been Tested</th>
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</table>
| Developing staff buy-in for changing roles and responsibilities | 4a. Establish and provide organizational support for care delivery teams that are accountable for the patient population/panel. | • Visible support from clinical leadership to support PCMH teamness  
• Provide training for all staff/providers on the PCMH  
• Rewriting job descriptions to support PCMH  
• PCMH measures presented at staff meetings where leadership are present  
• Leadership delivers regular, consistent messaging about PCMH and medical home progress, (e.g., updates at meetings on a regular basis across the entire organization, in newsletters, etc.)  
• Follow patients or simulate the patient experience as a way to engage staff in thinking about new roles  
• Use senior leadership meetings to identify and include “champions” from staff when implementing training or changing care team roles  
• Hold monthly all-team meetings to inform, recognize, reward and appreciate staff | |
| Ensure teams have time to meet regularly | | • Allocate time for team huddles to ensure the care team is prepared for each visit  
• Hold quarterly department meetings to discuss PCMH goals  
• Ensure that people at all levels have the opportunity to meet as a PCMH or QI team to plan and organize changes that affect the clinic systems  
• Build time into daily work, pre- and post-session, for teams to meet at an established time  
• Hold routine “problem-solving” meetings  
• Co-location of care team members supports ability to meet and communicate | |
| Identify who should be on the care team | | • Use volunteers, ancillary staff (e.g., pharmacy) or others to support care delivery teams  
• Include behavioral health and health educator(s) in teams  
• Assign everyone in the health center to at least one care team  
• Solicit staff suggestions for role changes  
• Pilot new care team structures with one or two care teams then spread to others  
• Use patient panels to identify the ideal care team structure/staffing model | |
| Develop a staffing plan that addresses staff turnover or staff leave | | • Have clear job descriptions  
• Develop workflows to ensure continuous cross-training | |
Patient-Centered Care for the Safety Net

The Safety Net Medical Home Initiative was a national Patient-Centered Medical Home (PCMH) demonstration to help 65 primary care safety net sites become high-performing medical homes and improve quality, efficiency and patient experience. Learn more about the initiative.

The initiative created a framework for PCMH transformation and published a library of resources and tools to help practices implement the PCMH Model of Care. Access our PCMH materials.

NEW RESOURCES NOW AVAILABLE

The second edition of the SNMHI Implementation Guide Series is now available. This includes updated implementation guides, an executive summary for each PCMH Change Concept and new tools. See Resources & Tools to learn more.

www.safetynetmedicalhome.org
PCMH Implementation Resources

- **Patient-Centered Medical Home Assessment (PCMH-A)**
- 13 **Implementation Guides** provide implementation strategies, tools, and case studies
- 23 tools that can be used to test or apply the key changes, including an [NCQA PMCH Recognition Crosswalk](#)
- Downloadable **registry of tools and resources**
- 38 webinars
- 3 policy briefs on medical home payment and health reform
Change Concepts and NCQA PCMH™ Recognition

- All 6 NCQA standards crosswalk to the 8 Change Concepts.
- All NCQA elements (28) are reflected in the Change Concept elements (32), and a majority of Change Concept elements (all but 3) are reflected in the NCQA elements.

<table>
<thead>
<tr>
<th>NCQA PCMH Recognition</th>
<th>Change Concepts</th>
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<tbody>
<tr>
<td>1: Enhance Access and Continuity</td>
<td>Empanelment, Enhanced Access, CTBHR, PCI, Engaged Leadership, Quality Improvement Strategy, OEBBC</td>
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<tr>
<td>2: Identify and Manage Patient Pop.</td>
<td>Empanelment</td>
</tr>
<tr>
<td>3: Plan and Manage Care</td>
<td>OEBBC, PCI</td>
</tr>
<tr>
<td>4: Provide Self-Care and Comm. Support</td>
<td>PCI, Care Coordination</td>
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<tr>
<td>5: Track and Coordinate Care</td>
<td>Care Coordination</td>
</tr>
<tr>
<td>6: Measure and Improve Performance</td>
<td>Quality Improvement Strategy, PCI</td>
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Follow State Activity
(source for maps on slides 9 and 11)

National Academy of State Health Policy: State Medical Home Activity Map

National Academy of State Health Policy: ACO State Map