INTRODUCTION TO THE SAFETY NET MEDICAL HOME INITIATIVE IMPLEMENTATION GUIDE SERIES

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A Framework to Guide Patient-Centered Medical Home Transformation

Becoming a Patient-Centered Medical Home (PCMH) is a journey. For some practices, transformation will require system-wide changes and an epic re-imagination[1] of care delivery; for other practices it will require implementation of a few important changes. In either case, practices often find it helpful to have a framework to guide the transformation effort.

The Safety Net Medical Home Initiative (SNMHI) developed a framework—The Change Concepts for Practice Transformation—to help guide primary care practices through the PCMH transformation process.[2] In this introduction, we describe this framework and how to navigate the library of resources and tools we created to help practices implement the PCMH Model of Care.

The Change Concepts for Practice Transformation

The Safety Net Medical Home Initiative's (SNMHI's) framework for PCMH transformation includes eight Change Concepts for Practice Transformation: Engaged Leadership, Quality Improvement Strategy, Empanelment, Continuous and Team-Based Healing Relationships, Organized, Evidence-Based Care, Patient-Centered Interactions, Enhanced Access, and Care Coordination. A "change concept" is a general idea used to stimulate specific, actionable steps that lead to improvement. Each SNMHI Change Concept includes three to five "key changes." These provide a practice undertaking PCMH transformation with more specific ideas for improvement. Each practice must decide how to implement these key changes in light of their organizational structure and context.

The Change Concepts were derived from reviews of the literature and discussions with leaders in primary care and quality improvement. They have been most extensively tested by the 65 safety net practices that participated in the SNMHI, but they are applicable to a wide range of primary care practice types. To date, the SNMHI framework and resources have been used by academic health centers, residency training programs, private practices, small community practices, and hundreds of health centers across the country. They have also been adopted by a number of other improvement initiatives, reflecting their generalizability in primary care.

LAYING THE FOUNDATION

ENGAGED LEADERSHIP

- Provide visible and sustained leadership to lead overall culture change as well as specific strategies to improve quality and spread and sustain change.
- Ensure that the PCMH transformation effort has the time and resources needed to be successful.
- Ensure that providers and other care team members have protected time to conduct activities beyond direct patient care that are consistent with the medical home model.
- Build the practice's values on creating a medical home for patients into staff hiring and training processes.

QUALITY IMPROVEMENT (QI) STRATEGY

- Choose and use a formal model for quality improvement.
- Establish and monitor metrics to evaluate improvement efforts and outcome; ensure all staff members understand the metrics for success.
- Ensure that patients, families, providers, and care team members are involved in quality improvement activities.
- Optimize use of health information technology to meet Meaningful Use criteria.

BUILDING RELATIONSHIPS

EMPANELMENT

- Assign all patients to a provider panel and confirm assignments with providers and patients; review and update panel assignments on a regular basis.
- Assess practice supply and demand, and balance patient load accordingly.
- Use panel data and registries to proactively contact, educate, and track patients by disease status, risk status, self-management status, community and family need.

CONTINUOUS & TEAM-BASED HEALING RELATIONSHIPS

- Establish and provide organizational support for care delivery teams accountable for the patient population/panel.
- Link patients to a provider and care team so both patients and provider/care team recognize each other as partners in care.
- Ensure 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.

CHANGING CARE DELIVERY

ORGANIZED, EVIDENCE-BASED CARE

- Use planned care according to patient need.
- Identify high risk patients and ensure they are receiving appropriate care and case management services.
- Use point-of-care reminders based on clinical guidelines.
- Enable planned interactions with patients by making up-to-date information available to providers and the care team at the time of the visit.

PATIENT-CENTERED INTERACTIONS

- Respect patient and family values and expressed needs.
- Encourage patients to expand their role in decision-making, health-related behaviors, 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.
- Obtain feedback from patients/family about their healthcare experience and use this information for quality improvement.

REDUCING BARRIERS TO CARE

ENHANCED ACCESS

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

CARE COORDINATION

- Link patients with community resources to facilitate referrals and respond to social service needs.
- Integrate behavioral health and specialty care into care delivery through co-location or referral protocols.
- Track and support patients when they obtain services outside the practice.
- Follow-up with patients within a few days of an emergency room visit or hospital discharge.
- Communicate test results and care plans to patients/families.

Practice Transformation: Where to Begin?

Practices beginning the PCMH transformation journey often have questions about where and how to begin.

Assess

We recommend that practices begin with a self-assessment to identify opportunities for improvement and understand their current level of "medical homeness." In addition to a careful review of the practice's data regarding clinical performance, patient experience, and staff satisfaction, the SNMHI's self-assessment, the Patient-Centered Medical Home Assessment (PCMH-A), provides a detailed indication of the extent to which the practice functions as a PCMH. The PCMH-A is an interactive, self-scoring instrument that can be downloaded, completed, saved, and shared. If completed at regular intervals, the PCMH-A can also help practices track their progress toward practice transformation. We strongly recommend that the PCMH-A be completed by a multidisciplinary group (e.g., physicians, nurses, medical assistants, residents, other operations and administrative staff) in order to capture the perspectives of individuals with different roles within the practice and to get the best sense possible of "the way things really work." We recommend that each staff member complete the assessment individually, meet together to discuss the results, produce a consensus version, and develop an action plan for priority improvement areas.

Implement

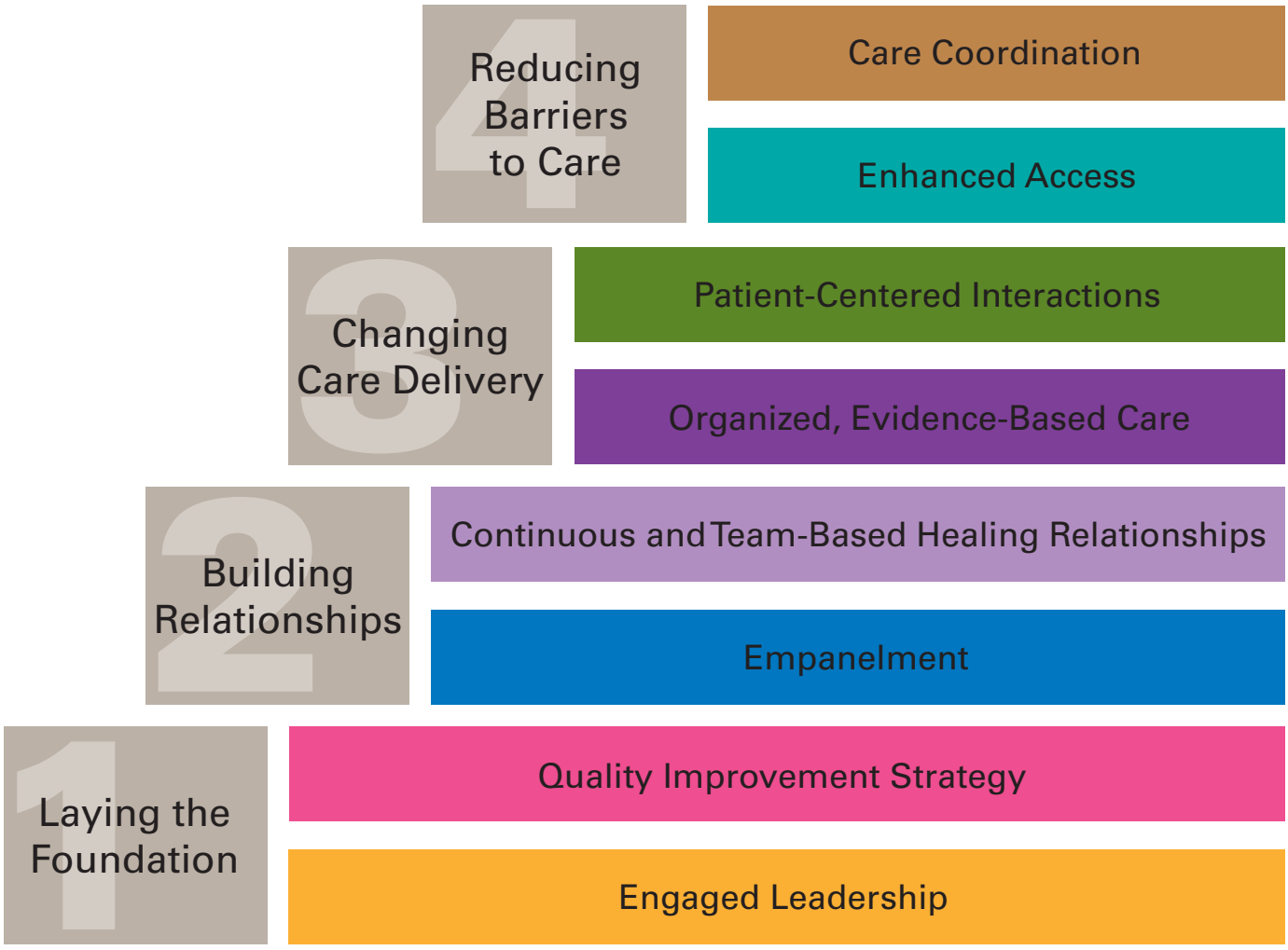
The Change Concepts for Practice Transformation are interdependent and mutually-reinforcing. Implementation of **all** eight is necessary for a practice to become a full PCMH. However, the experience of the SNMHI suggests sequenced implementation in four stages (refer to Figure 1):

1. Laying the Foundation: Engaged Leadership and Quality Improvement Strategy.
2. Building Relationships: Empanelment and Continuous and Team-Based Healing Relationships.
3. Changing Care Delivery: Organized, Evidence-Based Care and Patient-Centered Interactions.
4. Reducing Barriers to Care: Enhanced Access and Care Coordination.

Change Concepts in **laying the foundation**—"Engaged Leadership" and "Quality Improvement Strategy"—ensure that the foundation is in place to enable the practice to learn and implement change. If these foundational issues are not addressed first, meaningful transformation is difficult at best. Next, effective primary care depends upon solid, trusting relationships. The Change Concepts directed at **building relationships** among teams and between patients and providers—"Empanelment" and "Continuous, and Team-Based Healing Relationships"—prepare the practice to deliver personalized, patient-centered care effectively and efficiently. The next Change Concepts—"Organized, Evidence-Based Care" and "Patient-Centered Interactions"—focus on **changing care delivery** to increase the likelihood of productive interactions and improved clinical performance. The final two Change Concepts—"Enhanced Access" and "Care Coordination"—focus on **reducing barriers** to the seamless delivery of care. These changes are no less important than the Change Concepts addressed earlier, but they are often more difficult to implement.

Figure 1 shows how the eight Change Concepts for Practice Transformation build on and support one another.

Figure 1: Sequenced Change Concepts for Practice Transformation



How to Use the Implementation Guide Series: Resources to Guide Your Journey

We created a library of resources and tools to help practices understand the framework and implement each of the eight Change Concepts. These resources were developed in partnership with practices that participated in the SNMHI and were informed by reviewers and contributors from across the country. All resources are free and publicly available on the SNMHI website. A companion series, Coach Medical Home, provides PCMH transformation resources and tools specifically for practice coaches.

How to Navigate

You can access *SNMHI Implementation Guide Series* resources by Change Concept topic (e.g., Engaged Leadership) or by resource type. A comprehensive list of resources is available on the All Resources page of the SNMHI website. You can also download a registry of tools and resources, which includes all resources and tools hosted on the site and those hyperlinked within documents on the site.

Each Change Concept (e.g., Empanelment) is supported by an executive summary, Implementation Guide(s), tools, and webinars.

- The **Executive Summary** provides a concise description of the Change Concept, its role in PCMH transformation, and key implementation activities and actions.
- **Implementation Guides** include a detailed introduction, list relevant key changes, and provide strategies and case studies to guide implementation.
- **Tools** can be used to test or apply the key changes. They include, for example, an interactive "Do-it-Yourself" run chart tool, patient acuity calculator, and a secret shopper exercise to test the ease of scheduling an appointment from the patient's perspective.
- **Webinars** provide additional examples and tips and highlight the best-practices of SNMHI sites and other leading practices. Many webinars address specific implementation challenges.

References

1 Nutting PA, Miller WL, Crabtree BF, Jaen CR, Stewart EE, Stange KC. Initial lessons from the first national demonstration project on practice transformation to a patient-centered medical home. *Ann Fam Med.*2009;7(3): 254-260.

2 Wagner EH, Coleman K, Reid RJ, Phillips K, Abrams MK, Sugarman JR. The changes involved in patient-centered medical home transformation. *Prim Care.*2012;39(2):241-259.

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Safety Net Medical Home Initiative

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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.