Coach Medical Home

Strategies & tools to support patient-centered medical home transformation



MODULE 3: Sequencing the Changes

GroupHealth

MacColl Center for Health Care Innovation

THE COMMONWEALTH FUND

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Learning objectives for this module

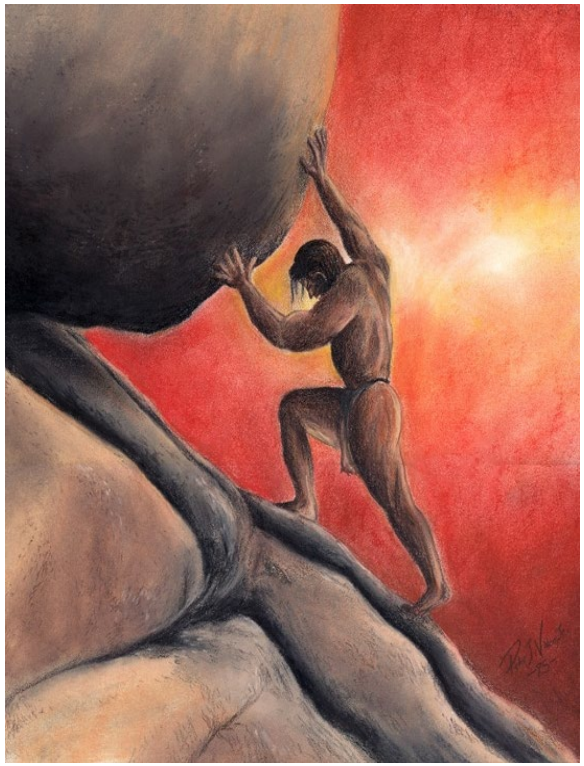
After completing this module, you will know how to:

- Explain the “change concepts”: the changes necessary to become a medical home as defined by the SNMHI Framework for Practice Transformation.
- Help practices test and implement changes in logical sequence.

What are we trying to achieve?

Benchmark performance in quality and efficiency

- Improve the operational efficiency of clinics
- Improve quality of care for patients
- Improve patients' health care experiences
- Improve clinician/staff experience
- Reduce disparities in access to care and quality of care
- Reduce costs



How do we get there: The SNMHI change package

8 Change concepts

- A general idea—with proven merit and a sound scientific or logical foundation—that can stimulate specific ideas for changes that lead to improvement

32 Key changes

- More detailed change ideas that sites can adapt and try in their practice

Activities

- Small changes that clinics can try to improve care

Grouping and sequencing the changes

Laying the Foundation	• Engaged leadership • QI strategy
Building Relationships	• Empanelment • Continuous, team-based healing relationships
Changing Care Delivery	• Organized, evidence-based care • Patient-centered interactions
Reducing Barriers to Care	• Enhancing access • Care coordination

Planning sequencing

Review the sequence of the eight change concepts,

Adapt sequence to the practice's existing processes, infrastructure, and goals:

- Build of the readiness assessment (See Module 1: Getting Started)
- Not all teams will work through the changes in the same sequence

Incorporate state or national-level PCMH initiative demands.

Use tools available at safetynetmedicalhome.org

- PCMH-A, Implementation guides, and more



Engaged leadership: PCMH practice key changes

- Visible and sustained leadership at many levels: board, senior leadership, office managers, medical staff .
- Leads overall cultural 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.

Engaged leadership: Implementation tips

Develop	**trust & open communication** with the Board or senior leadership.
Encourage	**ongoing leadership development** through training resources & learning communities.
Monitor	**level of engagement.** Practices that never get started have leadership that is either ineffective or opposed to change.
Look for	**“adaptive reserve”:** the ability to learn & change—vision for the future, strategy for getting there, support for staff involvement & time.

Quality improvement (QI) strategy: PCMH practice key changes



Choose & use formal models for quality improvement.



Establish & monitor metrics to routinely evaluate improvement efforts & outcomes—and ensure all staff members understand metrics for success.



Ensure that patients/families, providers, and care team members are involved in quality improvement activities.



Optimize use of information technology to meet Meaningful Use criteria.

Note: For practices pursuing NCQA recognition, this is a must-pass element.

QI strategy: Implementation tips

Choose

a QI model if there is not already one in place. Lean has some advantages for PCMH transformation:

- focuses on reducing waste to create capacity.
- focuses on embedding and sustaining change through systematic use of linked measures.
- emphasizes engagement of the whole practice.

Use

a measurement & reporting strategy:

- Practices that don't routinely measure & review performance are unlikely to improve.
- PCMH-A scores help identify where to start.

Ensure

team meetings are effective.

Empanelment: PCMH practice key changes



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 and track patients by disease status, risk status, self-management status, community and family needs.

Note: For practices pursuing NCQA recognition, **using data for population management** is a must-pass element.

Empanelment implementation tips

Engage

teams to trouble-shoot challenges.

- assumes stability of providers and patients
- changes workflow

Emphasize

empanelment as a pivotal step in PCMH progress.

- population management is critical for clinical improvement
- lays the ground work for NCQA recognition.
- strengthens patient-provider relationships
- makes clinical operations smoother by matching provider supply and patient demand

Continuous & team-based healing relationships: PCMH practice key changes

- Establish and provide organizational support for care delivery teams that are accountable for the patient population/panel.
- Link patients to a provider and care team so both patients and provider/care teams 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.

Continuity and team-based care: Implementation tips

To routinely measure & improve continuity:

Build

on empanelment.

Include

continuity measures on dashboards, for example:

- % of patients empanelled to a primary care team
- % of patients in a day/week/month who saw the provider team to which they were empanelled

Remember

that continuity improves outcomes & quality:

- reduced disparities
- improved prevention, chronic care management, attention to mental health

Organized, evidence-based care: PCMH practice key changes



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 prior to the visit.

Note: For practices pursuing NCQA recognition, **care management** is a must-pass element.

Organized, evidence-based care: Implementation tips

System changes that improve clinical performance

- Reviewing data on patient needs prior to encounters. Pre-session huddles involve the entire team in assuring that patients leave the clinic with guidelines met.
- Providing regular follow up to patients whose condition is not under control. Useful follow up need not involve office visits or a provider.
- Intensifying treatment for patients whose condition is not under control.

Care management is a major part of organized, evidence-based care

- Usually provided by a nurse or other health professional.
- Effective for attaining disease control but less so for reducing costs in complex, high-risk patients.
- More effective when the care manager:
  - is an integral member of the PCP practice team.
  - can influence medications.
  - is supported by relevant medical specialist(s).
  - has some face-to-face patient contact.

Patient-centered interactions: PCMH practice key changes



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 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/families about their health care experience and use this information for quality improvement.

Note: For practices pursuing NCQA recognition, **self-care process** is a must-pass element.

Patient-centered interactions: Implementation tips

Empower

and help patients become better self managers:

- motivational interviewing
- self-management

Ask

for patient feedback:

- focus groups and surveys on care in general
- Patient Activation Measure (PAM) and Patient Assessment of Chronic Illness Care (PACIC) assess patient activation and role in decision making

Benefits of patient-centered interactions include better meeting patient needs and improving clinical performance measures.

Enhanced access: PCMH practice key changes



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 that are patient- and family-centered and accessible to all patients.



Help patients attain and understand health insurance coverage.

Note: For practices pursuing NCQA recognition, **same-day access** is a must-pass element.

Enhanced access: Implementation tips

Powerful way to improve care and reduce costly and stressful visits to the ER.

Improving access means different things to different people	Solicit team and patient input on what matters most
• In-person visits during regular business hours (for example, same day access)? • Phone or email communication? • After hours care?	• For patients, likely to mean ensuring a way to get care from someone who knows them or their health records 24/7.

Care coordination: PCMH practice key changes



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 agreements.



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.

Note: For practices pursuing NCQA recognition, **referral tracking and follow up** is a must-pass element.

Summary

Remember foundational changes	• Change is difficult without committed leadership and an effective, trusted QI strategy. • The practice should understand and use rapid cycle small tests of change.
Track and monitor the progress your teams are making	• Nothing is more encouraging than seeing improvement in clinical performance measures. • PCMH-A • Green-Yellow-Red Tool
When teams get stuck	• Try the techniques in the tiering tool. • Consider patient and family input.