Transforming Care for Vulnerable Populations:

Lessons from the Safety Net Medical Home Initiative

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Goals for this Session

• Describe the goals and outcomes of the SNMHI
• Share lessons and reflections from the frontlines of strengthening the primary care delivery system
• Offer ideas on topics to consider as you seek to improve care for vulnerable populations
Safety Net Medical Home Initiative
2008-2013

• 5-year demonstration project to help 65 primary care safety net sites in 5 states (OR, ID, CO, PA, MA) implement the PCMH Model of Care
• First national effort to focus on safety net practices
• Led by Qualis Health and the MacColl Center with support from The Commonwealth Fund and local foundations
Our Improvement Goal?

Organize care around the needs and preferences of patients and families

- Improve operational efficiency
- Improve quality of care for patients
- Improve patients’ health care experiences
- Enhance clinician/staff experience
- Reduce disparities
Additional Policy Goals

Build capacity for sustainable improvement

• Enhance regional capacity to support practice improvement:
  – Each state led by a Regional Coordinating Center
  – State Primary Care Associations and Regional Health Improvement Networks employed local practice coaches; now leaders in practice facilitation

• Involve Medicaid and other stakeholders in action toward appropriate reimbursement levels to sustain practice efforts
  – Ultimately informing the design of two state-wide multi-payer pilots
Practice Transformation
As described by Health West, FQHC (Idaho)

• A fundamental redesign of an organization’s:
  – Mission, vision, and strategic goals
  – Organizational responsibilities and roles
  – Policies and procedures
  – Care processes
  – Use of data
  – Relationships with patients and community

LPN from Aberdeen, Idaho:
“Before the medical home, I used to just room patients. Now, I’m a partner with my provider and responsible (especially for the preventative health care) of our patient panel. I feel like I’m making a difference now.”
Were we successful?

• External evaluation results available 2016-2017
• All sites (100%) made significant progress toward implementing the key design features of a PCMH and nearly half implemented most or all of the 32 “key changes” to a substantial degree
• 83% of sites achieved NCQA PCMH™ Recognition or a state equivalent
Average Change Concept Scores Across All Partner Sites*
Mar 2010 - Mar 2013
(Numbers in boxes contain the increase in Change Concept score from Mar 2010 to Mar 2013)

Mar-10  Sep-10  Mar-11  Sep-11  Mar-12  Sep-12  Mar-13

+2.1  +2.1  +3.1  +2.2  +2.3  +2.3  +1.7  +1.7  +2.2

**Change Concept**
- Engaged Leadership
- QI Strategy
- Empanelment
- Team-based Relations
- Org. Evid.-based Care
- Pt-centered Interactions
- Enhanced Access
- Care Coordination
- Overall Average
Multi-Modal Technical Assistance

• Practice coaching from local “Medical Home Facilitators”
• Access to national experts
• Workshops and training sessions
• Regional and national learning communities
• Feedback and data reports
• Targeted assistance for PCMH Recognition
• Limited financial assistance for special projects and site visits (*)

(*) Fewer than half of practices received enhanced payment from Medicaid or commercial insurers
A Blueprint for Practice Transformation

*Changed how we think about, teach, and coach primary care improvement*

- Developed and tested an operational, evidence-based framework to guide transformation
- Published a comprehensive library of implementation resources created by and for primary care practices
- Companion curriculum for practice coaches
Model Generalizable & Results Achievable in Diverse Settings

• SNMHI provides a platform for strengthening the primary care delivery system responsive to unique assets and needs of the safety net

• Adopted by >70 improvement initiatives and health systems nationwide

• Harvard Academic Innovations Collaborative
  – 19 academic medical centers and residency training programs in Boston metro area

• Arkansas Payment Improvement Initiative
  – 102 private practices serving Medicaid beneficiaries
Enhanced Capacity for Patient-Centered Care

PCMH-A Score

- Engaged Leadership
- Quality Improvement Strategy
- Empowerment
- Continuous Team-based Healing Relationships
- Patient-centered Interactions
- Organized Evidence-based Care
- Enhanced Access
- Care Coordination
- Overall Score

AIC: Jul-12  AIC: Jan-13  AIC: Jul-13  AIC: Jan-14
Evidence of Cost Impact

Risk-adjusted medical cost per capita, % trend, CY14 vs. CY13

| Benchmark trend       | 2.6 |
|-----------------------|--|--|
| Practices enrolled in PCMH | 1.5 |
| Practices not enrolled in PCMH | 3.2 |

Practices enrolled in Arkansas’ medical home program had lower cost growth than both benchmark trend and their unenrolled peers.

Source: Arkansas DHS, Division of Medical Services, ARS tables from CY10,11,12,13,Q2’15 reports. Preliminary data subject to change.
# Lessons and Implications for Policymakers

## Lessons

- PCMH Model effective pathway for achieving a stronger and more responsive primary care delivery system
- True transformation takes time (3-4 years)
- Improvement has a sequence
- Recognition is not synonymous with transformation

## Implications

- The need for improvement results is immediate
- Evidence for cost savings comes from enhancements to access and care coordination ("later" changes)
- Payers need a way to validate changes
## Lessons and Implications for Policymakers

**Lessons**
- Explicit change model is essential
- Practices benefit greatly from external coaching and peer-to-peer interactions

**Implications**
- Multi-modal technical assistance programs are resource intense
- The early adopters are already engaged; those remaining are likely to need (more or different) motivation and support

### What helps?
- States can partner with one another to accelerate improvement and spread innovations
- Practices can leverage local resources
Continued Evolution

• Removing silos and reducing fragmentation
  – Behavioral & oral health integration

• New access models: What works for vulnerable patients?
  – Phone, email; telemedicine
  – Home & community visits

• Moving upstream: How can we address the social needs of patients and families so they can engage in health?
Learn More About the SNMHI
ww.safetynetmedicalhome.org/resources-tools/snmhi-bibliography


• Practice coaching: Unlocking the Black Box: Supporting Practices to Become Patient-centered Medical Homes (2014) Medical Care. Katie Coleman, MSPH; Kathryn E. Phillips, MPH; Nicole Van Borkulo, MEd; et al.

• Provider perspectives: The Practice Perspective on Transformation: Experience and Learning from the Frontlines (2014) Medical Care. Somova Stout, MD, MS; Stephen Weeg, MEd

• Evidence for the Change Concepts: The Changes Involved in Patient-Centered Medical Home Transformation (2012) Primary Care Clinics. Edward H. Wagner, MD, MPH; Katie Coleman, MSPH; Robert J. Reid, MD, PhD; et al.
Access Tools & Resources

www.safetynetmedicalhome.org
www.coachmedicalhome.org

- **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](#)
- 38 webinars
- 3 policy briefs on medical home payment and health reform
Regional Partners

• Colorado Primary Care Association
• Idaho Primary Care Association
• Massachusetts League of Community Health Centers
• Oregon Primary Care Association
• Oregon Rural Practice-based Research Network
• Pittsburgh Regional Health Improvement Network

SNMHI practice site listing:
http://www.safetynetmedicalhome.org/about-initiative/rcc
Qualis Health

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Qualis Health is a non-profit healthcare consulting and care management firm. We help primary care practices implement the PCMH Model of Care and achieve PCMH Recognition.

We lead multi-state PCMH demonstration projects, regional collaboratives, and develop and disseminate PCMH implementation resources and tools.