Introduction

The Patient Protection and Affordable Care Act (ACA) and California's Section 1115 Waiver (Bridge to Reform Medicaid Demonstration Waiver) are accelerating the push for quality improvement and practice transformation efforts in local health care delivery systems. Provisions in the ACA include **Patient Centered Medical Homes (PCMH) or** *health homes* for the millions of additional persons eligible for health coverage in 2014. Health delivery system practice transformation requires complex system redesign to realize the ultimate goal of achieving the Triple Aim with improved population health outcomes, enhanced patient experience, and lowered overall costs of care.

NCQA PCMH 2011 Standards

Levels

- PCMH 1: Enhance Access and Continuity
- PCMH 2: Identify and Manage Patient Populations
- PCMH 3: Plan and Manage Care
- PCMH 4: Provide Self-Care Support and Community Resources
- PCMH 5: Track and Coordinate Care
- PCMH 6: Measure and Improve Performance

Nationally, the National Committee for Quality Assurance (NCQA) PCMH 2011 standards provide the primary method for practices to evaluate the implementation of core components of the PCMH.[1] NCQA standards have emerged as the basis for practice recognition and certification as a PCMH.[2] In California, the California Primary Care Association (CPCA) has complimentary working principles for patient-centered health homes (PCHH) and actively encourages clinic members to pursue certification.[3]

HHIF Initiative Overview

Launched in 2011, the **Health Home Innovation Fund** (HHIF) supports partnerships among safety net institutions to build patient-centered, integrated systems of care and explores options for payment reform to sustain health home implementation. In partnership with The California Endowment, the Center for Care Innovations (CCI) funded eight geographically diverse collaborative projects for two years to facilitate health home transformation.

Participating collaboratives implemented various strategies to promote system transformation toward person-centered health homes.

This brief highlights the experiences of the HHIF Collaboratives in implementing the core PCMH components in participating clinics to inform future pilot efforts on health home transformation in California.

The HHIF Collaborative Projects* include:

1. **Coalition of Orange County Community Clinics**
2. **Health Improvement Partnership of Santa Cruz & Central CA Alliance for Health**
3. **Health Plan of San Joaquin**
4. **Inland Empire Health Plan**
5. **North Coast Clinic Network**
6. **Redwood Community Health Coalition & Partnership Health Plan**
7. **San Diego Community Clinics Health Network**
8. **San Francisco Community Clinic Consortium**

These 8 HHIF Collaborative Projects are fully funded. (Additional HHIF projects include: (A) Health Alliance of Northern California (HANC) and (B) California School Health Centers Association.)

Clinic Consortia and Health Plans Play Important Roles in Facilitating PCMH

Practice transformation efforts are supported and motivated by the expectations under health reform, incentives connected to NCQA recognition, and meeting the goals of the IHI Triple Aim. A primary focus for the majority of HHIF collaborative projects has been the implementation of PCMH components at the clinic level. Although the participating clinics started at various stages of readiness for transformation, most are working towards NCQA certification. The health plan and clinic consortia partners provided resources and technical assistance to facilitate this process and build capacity within clinics to strengthen the safety net system of care. Activities include:

- Conducting PCMH readiness assessments with clinics to understand elements that need work
- Sponsoring provider trainings on various PCMH components
- Convening clinics to share implementation lessons learned and outcomes of quality improvement activities, including PDSA cycles
- Developing resources and tool-kits with policies, procedures, and standard protocols needed to meet NCQA standards

Implementing the PCMH Core Components

HHIF grantees and participating clinics engaged in a variety of activities to achieve health home transformation and ultimately build capacity to meet the requirements for NCQA certification as a PCMH. Key activities included: patient empanelment, establishing care teams, panel management for target populations, using data and QI metrics to inform practice, and patient-centered care.

PCMH Core Components

- Empanelment
- Team-Based Care
- Panel Management
- Use of Data & Technology for Quality Improvement
- Patient-Centeredness

1. Empanelment

Empanelment, or the assignment of patients to specific providers or a care team, is the primary driver of the PCMH and a foundational element to PCMH transformation.[4] Empanelment enables population management by changing practice responsibility from the care of individual patients to proactive and planned care for a population of patients.[5]

Empanelment is a pre-requisite for panel management, which is critical in improving access to care and conducting proactive outreach to engage patients who need to come in for care. Many clinics chose to take an incremental approach to empanelment by targeting sub-populations, (e.g., diabetic patients) before eventually expanding to the entire clinic population. Consistent with any practice transformation, leadership support and thorough training for staff were key factors in clinic success.

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Lessons Learned:

- **TRAINING NEEDS.** Clinics need support on how to use empanelment as an ongoing tool and not just an initial process. Most empanelment training focuses on understanding patient supply and demand and how to assign patients using the "4-cut method," but clinics need to build in ongoing coaching and training after implementation to understand how to maximize patient empanelment for outreach, prevention and chronic disease management. Operationally, it is also important to review the assignment process and panel size regularly to ensure equitable distribution of patients across clinic providers.

- **CONTINUITY.** Patient assignment is challenging when clinics have a high percentage of part-time providers or residents. In these cases, clinics that assign patients to a care team are in a better position to maintain patient engagement and continuity when patients see the same nurse or MA, even when the physician assignment may fluctuate.

- **PATIENT INVOLVEMENT.** To establish meaningful relationships between patients and providers, panel assignment needs to be sensitive to patient and family member preferences. HHIF clinic partners endeavor to involve patients when making operational changes, but this continues to be a challenge. While it takes more time at the outset, incorporating patient needs and preferences in the empanelment process is more successful when implemented in a proactive rather than retrospective manner.

2. Team-Based Care

Team-based care is considered a more effective strategy for delivering patient-centered, coordinated care to panels of patients.[6] In this approach, clinicians work with a small group of medical assistants (MAs) who have enhanced responsibilities and clearly defined roles for patient care.[7] Specific patient care tasks are assigned to the team members with the most appropriate training to perform them well.

Across the HHIF clinic sites, physicians have embraced the strengths of a team-based care model and recognize that inter-professional teams embedded in primary care are more effective in addressing the needs of complex patients. Team composition varies across clinics. However, most clinic teams are comprised of PCP, RN, MA, and front desk clerk. Some clinics have dedicated "teamlets", where primary care providers work consistently with the same medical assistant each shift. To meet the needs of complex patients, other providers on the team can include, for example, a behavioral health provider, health educator, registered dietician nutritionist, and benefits enrollment specialist.

> **In team-based care, specific patient care tasks are assigned to the team members with the most appropriate training to perform them well.**

HHIF clinics used a variety of methods to communicate these practice changes to patients, including informational brochures on PCMH and the importance of having a care team, team specific identification cards, picture boards, and color-specific registration areas and exam rooms demarcating specific teams. In many clinics, patients are displaying commitment to their "team" by scheduling follow up appointments with their assigned provider or care team, even if they have to wait longer for this appointment.

Lessons Learned:

- **TEAM FUNCTIONING AND COHESION.** For effective team development and functioning, it is important to understand the skill sets and characteristics required, as well as matching the personality traits and temperament to the team assignment. Care teams need to be interdisciplinary, non-hierarchical, and consistent. To aid communication and team cohesion, clinics have incorporated daily huddles to prepare for the schedule of patients. Teams also need ground rules for communication, roles, attendance, training new team members, etc.

- **IMPACT ON PROVIDER SATISFACTION.** Team-based care relieves PCPs of some of their responsibilities and many report improved job satisfaction with this orientation to care. Medical assistants working at the top of their professional license, with standing orders

in place, can order routine tests and perform routine clinical tasks, taking pressure off of the medical provider. HHIF clinics report that care teams are positively related to provider satisfaction, which in turn influences patient experience. According to provider surveys across multiple clinics, the more cohesive and consistent the care teams, the lower the levels of stress and burnout.

- **CARE TEAM SUCCESS FACTORS.** HHIF clinics identified multiple factors that enhance the success of care teams, which include: leadership support, a clear division of labor and roles for team members, frequent opportunities for communication and feedback, clear clinical and administrative processes to support teamwork, and implementation of PDSA cycles to understand success and failures in team functioning for ongoing quality improvement purposes. Finally, one of the most important factors is to include the patient as a member of the care team, and their perspective in development of treatment goals and care plans.

3. Panel Management

Panel management is the use of panel data to promote proactive population-based care and performance improvement processes.[8] Effective panel management relies on a patient registry to identify care gaps, and a panel manager with protected time to review, update, and oversee the registry. After the panel manager has identified patients with care gaps, outreach is conducted to identify patients overdue for care, and in-reach is conducted with patients who come into the clinic based on standing orders to expedite care and close all gaps.[9]

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Clinic staff across several HHIF collaboratives received training and technical assistance, as well as follow-up mentoring, in panel management. These clinics use data from registries and EHRs to identify patients in need of care and ongoing management. Methods used to conduct panel management outreach included mailings and phone banking with scripts.

A significant outcome of implementing the PCMH model commonly reported across the clinics is the elevated and expanded role of the MA. Clinics noticed a positive culture shift as MAs take greater responsibility for managing their panel of patients. Changes and additions to job responsibilities, such as panel management and patient outreach, has led to enhanced job satisfaction and feelings of empowerment. Many MAs report they feel they are an important member of the care team with a distinct role and opportunities for job growth, which has a positive affect on job turnover for the clinic.

Lessons Learned:

- **READINESS.** Clinics need the foundational elements of the PCMH model (e.g., empanelment, care teams) and supportive leadership prior to engaging in panel management training and implementation. Panel management requires a significant change in practice style and thinking. When implemented, it does improve patient experience and care quality, but also adds oversight activities to PCP workload during early stages of implementation.

- **LEVERAGING NON-CLINICAL TEAM MEMBERS.** It is important to have all providers agree on clinical guidelines and standing orders so that panel management can take place by non-clinical staff. Team-based care and panel management are interrelated, and having established care teams facilitates the process. It is important to have a lead or "star" MA to build the internal capacity at the clinic for panel management as well as for sustainability.

- **TIME CONSTRAINTS.** Effective panel management relies on protected support staff time to identify patients with the greatest needs, gather summary information for the physician/care team and communicate (primarily by phone) with patients and family members. In some clinics, the MAs and RNs do not have the protected time to conduct thorough outreach and follow up activities. This is particularly true when working with patients with complex psychosocial issues.

4. Use of Data & Technology for Quality Improvement

Successful implementation of the PCMH model assumes a certain level of clinical information system infrastructure and capacity for population management and quality improvement (QI). Population management requires the use of electronic health records (EHRs) and disease registries for clinical support and monitoring,[10] while QI strategies rely on routine data collection and performance measurement to identify areas for improvement and change.[11]

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From the start of the HHIF, clinics identified and began tracking clinical and operational quality metrics related to the Triple Aim. Many also began implementing routine practice improvement strategies, such as PDSA cycles. Depending on clinical information system (CIS) capacity and access, clinics used various types and combinations of data to inform decision-making and practice transformation, including EHRs, registries, and health plan encounter data. Many clinics also enhanced health information exchange capabilities across their networks to target patients and share data across health plans, clinics, and hospitals.

While many of the HHIF collaboratives initiated regular meetings across partner organizations to review and validate data for QI and inform practice redesign across participating clinics, several collaboratives (comprised by approximately one third of the participating clinics) did not have functioning EHRs or registries over the course of HHIF implementation. These clinics developed work around solutions to conduct QI activities, but these were not routine or consistent.

Lessons Learned

- **CREATING A QUALITY IMPROVEMENT CULTURE.** A blend of clinical and IT expertise is needed to create a quality improvement culture within an organization. Providers that are engaged in using data, understanding the metrics being tracked, and evaluating improvements have very high levels of buy-in and support for a culture of quality improvement because they can see the impact of their work. However, data driven clinical decision-making and QI requires an expansion of roles for both clinicians and IT staff. Many clinicians are not used to data entry and analysis as part of the clinical workflow and IT staff are not accustomed to serving in the role of medical support. QI focused data analysis is a challenge for many clinics that lack dedicated staff time and sufficient IT expertise that blends clinical and technical knowledge.

- **DATA VALIDATION.** The data validation process is critical for ensuring the quality and validity of data extracted from clinics. HHIF grant requirements included quarterly QI data submissions, which provided the collaboratives an opportunity to share data across their systems and examine the validity of the data under review. Many sites discovered discrepancies and took steps to ameliorate them so that data could be used by practices to make improvements. In addition to the validation process, it is important that data feedback is shared in a timely fashion so practices can see the impact of their QI efforts over time and make operational and clinical adjustments as needed.

- **ELECTRONIC HEALTH RECORDS.** A functional EHR is a critical (although not a necessary) component for empanelment and panel management for designated populations. Clinics without EHR still empaneled patients and used PDSA cycles to conduct outreach and panel management activities. Having EHR is not a silver bullet and many clinics that have this technology still have challenges tracking outcomes over time and creating meaningful reports. Dedicated staff time, IT expertise, and commitment to ongoing quality improvement are as important to practice transformation and outcome tracking as EHR capacity.

5. Patient-Centeredness

Patient-centered care is at the heart of most PCMH definitions. Ideally, in the PCMH model, patients are informed and engaged participants in their care.[12] Patient-centered interactions increase patients' involvement in decision-making, care, and self-management.[13] Self-management education and support increases patients' problem-solving skills and confidence in managing their health problems.[14] Patient-centeredness also elevates a focus on the patient experience, a key component of the Triple Aim.

> **Patient-centered interactions increase patients' involvement in decision-making, care and self-management.**

HHIF collaboratives addressed the goal of patient centered care using various strategies ranging from implementing the evidence-based Stanford Patient Self-Management model to establishing patient advisory groups to consult on QI, practice transformation, and customer service improvements. Implementing team based care also was a key strategy for meeting the needs of individual patients. Many clinics used surveys and focus groups with patients to learn about their experiences of clinic transformation, care teams, and overall quality of care. Others considered or implemented web-based portals to increase patient access to health information, involvement in preventative services and self-management activities.

Recognizing that patient-centeredness involves more than a primary care focus within a confined physical clinic setting, one collaborative worked to integrate a wellness and prevention focus in the PCMH approach promoting access to community gardens on-site at clinics, hosting nutrition classes, hosting mobile cancer screening events to reach rural areas, and incorporating patient-centered principles into the architectural design of new clinic sites (e.g., indoor-outdoor waiting rooms, multi-use spaces for exercise, and cooking classes at the clinic).

Lessons Learned

- **SHIFTING THE PARADIGM.** The infrastructure, time, resources, and culture change needed to transform practices to a patient-centered focus are significant. Seeing fewer patients for longer periods is not a realistic solution to improving patient centered care given the current reimbursement structure. Teams that "share the care" provide the best strategy for meeting the needs of individual patients. Providers need to be flexible, patient and adaptable. Treatment and support must reflect the intensity needed by the patient at any given time, which may change from moment to moment.

- **PATIENT ENGAGEMENT.** Patient outreach and engagement in care is an area that poses significant challenges for clinics since having a customer service orientation is new for many. While partial implementation of PCMH components can lead to improvements in patient satisfaction and experience, customer service remains the number one training area needed and requested by many clinics. Regardless of the role (e.g., PCP, MA, nurse, front desk clerk), team members and clinic staff need to be customer (patient) oriented, have high health literacy, and the capacity to translate medical information to patients, and successfully engage and activate patients.

- **PROVIDER SATISFACTION INFLUENCES PATIENT EXPERIENCE.** Many clinics remain reluctant to measure provider and staff satisfaction because they fear it will negatively affect morale or lead to complaints about productivity targets. However, it is important to consider and measure staff satisfaction since this influences both patient experience and quality outcomes. Clinics that solicited feedback from providers and staff through satisfaction surveys and focus groups learned there was strong support for the PCMH model and team-based care. As clinics advance in their PCMH goals, job satisfaction increased which has a positive impact on the patient experience.

- **PATIENT TO PERSON-CENTERED CARE.** As clinics listen to the voice of their patients, the ultimate goal is to shift from a "patient" to "person" centered care model. In this model, professionals and patients exchange information, share decision-making power, act as co-investigators in diagnosing problems and developing solutions, and the provider team serves as "expert consultants" on the individual's journey to overall health and wellness.

Summary

Despite implementation challenges, the HHIF projects made significant progress in implementing the core components of the PCMH model, including patient empanelment, establishing care teams, using data and QI metrics to inform practice, and patient-centered care. Several factors appear related to this implementation success, including:

- Providing strong and sustained support for the PCMH care model by clinic leadership

- Building genuine momentum and support for practice transformation among providers as they gain experience and confidence with a new service delivery paradigm

- Increasing provider buy-in regarding data collection, sharing and QI activities

- Embracing the use of outcome data to assess the impact of clinical work by the care team

- Growing a culture of "these are our patients" among care teams who are responsible and accountable for patient experiences and outcomes

- Committing to sharing lessons and best practices across the provider network and consortium of clinics

- Improving provider and patient satisfaction with PCMH implementation

The experiences and lessons of the HHIF collaboratives provide important insights into the opportunities and challenges that will emerge with the broad scale system redesign called for in the ACA.

Endnotes

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4. Bodenheimer T, Ghorob A & Wong J. Panel Management Training Curriculum. UCSF Center for Excellence in Primary Care. Nd. Brownlee B. Panel Management presentation. HHIF Fall Convening. Oakland, CA. October 30, 2012.

5.   Safety Net Medical Home Initiative- Implementation Guide- Empanelment Part 1: Establishing Patient-Provider Relationships. March 2010.

6. Safety Net Medical Home Initiative- Implementation Guide- Empanelment Part 2: Assigning and Managing Panels in a PCMH. June 2011.

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11. Wagner EH, Coleman K, Reid RJ, Phillips K & Sugarman JR. Guiding Transformation: How Medical Practices can become Patient-Centered Medical Homes. The Commonwealth Fund, New York. Feb 2012.

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