



HEALTH HOME INNOVATION FUND: Highlights from Year 1

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Introduction

National health reform has brought renewed attention to supporting innovation in the health care delivery system. When fully implemented in January 2014, the Patient Protection and Affordable Care Act (ACA) will establish a range of reforms aimed at improving health outcomes, patient experience and controlling the costs of care. ACA provisions expand support for Patient Centered Medical Homes (PCMH), also known as “health homes” for the millions of additional persons eligible for health care coverage in 2014. These practice models call for the following components to succeed:

- Integrated care teams of health professionals
- Practice culture changes (including care coordination efforts, information sharing)
- Better implementation of health information technology (e.g., QI reports tracking treatment outcomes)¹

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 incentivize and sustain health home implementation. The purpose of the HHIF is to provide flexible funding and technical assistance resources to spread the implementation of health homes for low-income populations throughout California. In partnership with The California Endowment, the Center for Care Innovations (CCI)² funded eight collaborative projects for 2 years to progress toward fully integrated health homes with the following core components, as defined by the Affordable Care Act (ACA):

- Care coordination and health promotion
- Comprehensive transitional care from inpatient to other settings
- Support for patients and their families
- Referral to community and social support services
- Use of health information technology to link services
- Comprehensive case management

¹ Bates, T., Blash, L., Chapman, S., Dower, C., & O’Neil, E. 2011. California’s Health Care Workforce- Are We ready for the ACA? UCSF Center for the Health Professions Research Brief. December, p 3.

² CCI was previously known as the Community Clinics Initiative

At the core of the HHIF initiative is the vision and expectation of long-term systems change to improve the health care delivery system for safety net populations. CCI acknowledges that the grant funding and timeline is not sufficient to fully achieve this long-term goal, but does provide the support necessary to spark innovation and make progress toward transforming the system of care.

Evaluation Approach

The HHIF evaluation uses a mixed method approach to examine key questions concerning the implementation and effectiveness of the projects funded through the initiative, and to assess their progress toward achieving sustainable transformation within their respective health care systems. The evaluation is also assessing the effectiveness of collaboratives in progressing toward and achieving three critical healthcare objectives of the Institute for Healthcare Improvement's (IHI) Triple Aim:

- 1) Improving the health of the population
- 2) Enhancing the patient experience of care (including quality, access, and reliability)
- 3) Reducing the per capita cost of total health care

The following brief provides a snapshot of the implementation progress and experiences of the eight collaborative projects in the first year of the HHIF grant.

HHIF Collaborative Project Areas

The Health Home Innovation Fund supports eight geographically diverse collaboratives to facilitate health home transformation. Because all health care is local, the strategies and activities to transform systems of care vary by collaborative, as do the lead organizations, existing infrastructure and capacity, target populations and number of participating clinics.

Table 1: Structure of HHIF Collaboratives

Health Plan Lead	Clinic Consortium Lead	“Hybrid”* Lead
<ul style="list-style-type: none"> • Inland Empire Health Plan (IEHP) • Health Plan of San Joaquin (HPSJ) 	<ul style="list-style-type: none"> • Coalition of Orange County Community Clinics (COCCC) • North Coast Clinic Network (NCCN) • San Diego Community Clinics Health Network (SDCCHN) • San Francisco Community Clinic Consortium (SFCCC) 	<ul style="list-style-type: none"> • Health Improvement Partnership of Santa Cruz and Central CA Alliance for Health (HIP/CAAH) • Redwood Community Health Coalition and Partnership Health Plan (RCHC/PHP)

**Entity involving health plan and consortium, or public/private member coalition*

Project Areas

Achieving core PCMH components and NCQA PCMH certification	Enhancing panel management and care coordination	Implementing or enhancing clinical information systems and informatics
<ul style="list-style-type: none"> • Empanelment • Team-based care • Enhanced access • Quality improvement • Patient-centeredness • Care coordination • Utilization of external consultants‡ practice coaches, and trainings for providers 	<ul style="list-style-type: none"> • Key component of the PCMH model³ • Health navigation and care management for complex, chronic populations 	<ul style="list-style-type: none"> • Electronic health record systems • Disease registries • Improved cross provider and system data sharing (health information exchange) • Improved service delivery coordination and efficiencies, outcomes, and costs

3 California’s 1115 Waiver, including the Low Income Health Program and Seniors and Persons with Disabilities transition to managed care.

4 Grantees have contracted with state and national experts, including Health Team Works, Qualis, UCSF Center for Excellence in Primary Care, Stanford Patient Self-Management model, and Coleman and Associates.

Accomplishments and Progress

1 Planning and Preparation

During the first year of HHIF grant funding, the majority of collaboratives primarily worked on strategic planning and building capacity for change at the clinic level and across partner organizations. All projects created new or expanded existing partnerships and collaborations, which they will continue to develop over the course of the project. Many also completed clinic assessments on PCMH transformation and NCQA certification readiness.

Collaboratives focused time and resources conceptualizing, building capacity for and implementing components of their health home projects. Key activities in this phase included:

Obtaining Buy-In and Defining the Intervention. An initial step for most collaboratives was to work with partners to define the intervention and develop a work plan to move the system of care toward a patient-centered health home. Collaborative partners worked to establish a common definition of a health home and patient-centered care. Grantees that contracted with external consultants participated in organizational readiness assessments to determine their “baseline” and established project goals for clinic partners interested in achieving PCMH recognition. Other related activities involved developing scopes of practice and job descriptions for key staff including case managers/navigators, defining the role of coaches and developing coaching capacity within many of the projects.

Engaging Partners. An important effort during the planning phase was developing, strengthening and managing relationships among partners to define roles, create infrastructure, increase capacity and develop operational protocols. This involved activities such as:

- Gathering consensus among collaborative partners regarding the vision, goals, and activities to be undertaken as part of the project
- Establishing charters and MOUs outlining the duties and expectations of collaborative members, including resource allocation and reporting requirements
- Conducting process and workflow mapping to identify gaps across the system of care and developing strategies for communication/intervention
- Developing protocols to facilitate cross-provider and cross-system conversations and data sharing.

Participating in Trainings. To better understand the issues of practice redesign and health home transformation, partners participated in numerous trainings on PCMH model components. Training areas included: panel management, team based care, health coaching, and complex care management tailored to the medical and behavioral health issues of patients. These educational sessions helped to generate buy-in among providers and staff, build capacity at the clinic level for practice transformation and prepare clinics for NCQA certification.

Selecting Metrics and Developing Data Collection Protocols. Projects are implementing clinical and operational quality metrics at the network and clinic level. These metrics specifically address and track IHI's Triple Aim outcomes: 1) improving the health of the population, 2) enhancing the patient experience, and 3) reducing the per capita cost of total health care. Grantees developed protocols for collecting and analyzing data to identify patients for the intervention, and track patient satisfaction and health outcomes.

2 Implementation Progress

Over the first year, most grantees secured buy-in from clinic partners and successfully moved from planning to implementation, making significant progress meeting work plan goals for transformation, including:

1) Implementing Core Components of the PCMH model and progressing toward NCQA PCMH certification. After conducting PCMH readiness assessments, and investing in practice coaching and training, grantees made significant operational and clinical changes within their partnering clinics including:

- Patient empanelment
- Establishing care teams
- Expanding access, streamlining appointment scheduling
- Using data for patient outreach (preventative care and disease management)
- Implementing morning team “huddles” to improve communication
- Conducting Plan-Do-Study-Act (PDSA) cycles to improve referral follow up and care coordination
- Using Quality Improvement metrics to inform practice
- Developing communication materials to educate patients on PCMH

2) Promoting Data Sharing. Improving the quality of care through improved data informatics and sharing was a primary goal of the collaboratives. Collaboratives with established partnerships and prior investments in practice transformation and IT infrastructure enhancements were able to build capacity and protocols to facilitate data sharing across participating clinics, hospitals, consortia and health plans.

3) Advancing Case Management and Cross System Care Coordination. Two of the collaboratives moved well beyond the planning phase during year one and implemented new models of case management and coordination across their HHIF partners. In one of these collaboratives, clinics completed organizational assessments, created 3 new positions and hired staff, identified target populations, and began engaging patients in case management services. In the other collaborative, patients were connected to insurance coverage and social services, and relationships between health centers and county social service departments were advanced to streamline application processes for various programs. Several grantees facilitated convenings or “meet and greets” between hospital and clinic partners to discuss care transitions of high-risk, high-cost patients and develop strategies for proactive communication when patients visit or leave the hospital.

In addition, grantees reported the following early accomplishments in year one:

- Increased provider knowledge of and “buy-in” for the PCMH care model
- Increased provider and staff satisfaction with team approach to care
- Increased organizational clarity on changes needed to achieve NCQA certification
- Improved communication across the system to enhance care transitions for high-cost patients
- Increased empowerment of providers and staff in using data for clinical practice improvement

Early Lessons

Building a stable foundation for health home transformation and clarifying roles and expectations across partner organizations in a collaborative requires significant time and focused attention. Following are some of the key factors that challenged and facilitated implementation progress in the first year and reflect early lessons learned.

Flexible funding is critical for sparking innovation. Flexible grant funds provide safety net institutions with the kind of funding that is rarely available to support pilot programs, conduct experiments in service delivery and leverage other transformation initiatives. HHIF funding encouraged grantees to convene stakeholders in strategic planning, identify gaps in the systems of care, enhance provider skills through training, test innovative concepts, and gather evidence to demonstrate the effectiveness of the program.

Implementing and stabilizing the intervention takes time. Innovation requires time and resources for thoughtful planning to conceptualize creative solutions to complex problems. For many of the HHIF projects, moving from planning to actual program implementation took longer than anticipated. Factors affecting the implementation timeline include establishing clear roles and expectations across the collaborative partners, defining the scope of the project in terms of target population and achieving consensus about intervention components. In addition, clarifying the role of the various care coordination functions (e.g., case managers, social workers, discharge planners, health navigators, and nurse educators) that exist in clinics, hospitals and health plans within local systems of care required significant attention in many communities.

Hiring external consultants can serve as a catalyst for change. Leaders within the participating collaboratives generally agree that contracting external consultants to facilitate PCMH transformation was important to “jump start” project implementation, by providing content expertise in the PCMH model and creating external accountability to work plan goals. External consultation and coaching produced significant improvements to proposed interventions, work plan objectives and outcome measures. However, bringing on consultants also required an unanticipated time investment, which interrupted the implementation of several projects due to administrative demands associated with developing new contracts, scopes of work, scheduling clinic site visits, provider interviews and completing organizational assessments.

Implementing practice transformation in the “real world” requires flexibility and adaptability. Health system transformation activities at the local level often take place in a chaotic, political, fragmented and competitive environment. In the HHIF initiative, several collaboratives faced unanticipated challenges, including: turnover in key leadership, or loss of program champions (e.g., Chief Medical Officer),

county public health system restructuring and management changes, disallowance of intended financing strategy, inability to recruit and retain key program positions and multiple clinics withdrawing from the collaborative after participating for nearly a year in planning and program design. Despite these significant setbacks, each collaborative has re-grouped, secured commitment from their partners, revised their work plan activities and timeline and continues to move forward in their process of health home transformation. For the safety net provider system, overcoming unforeseen challenges is the “norm” rather than the exception.

Successful implementation requires engaged leadership and commitment across partners and staff. Changes in key leadership positions and staff turnover are familiar challenges for most organizations embarking on change initiatives or implementing new programs. Collaboratives reported turnover in clinic medical directors, medical assistants and front desk staff positions when first introducing the PCMH model and expectations for change. At the collaborative level, the challenge was to align a unified vision for transformation across participating partners that often have different levels of motivation and buy-in for the change process. Having a strong program champion — clinic or medical director or health plan leader — was critical in the HHIF collaboratives to bring the right composition of partners to the table and motivate them to maintain momentum when the change process became overwhelming.

Concurrent transformation activities can lead to change fatigue. As one grantee said, “In an environment of massive changes in health care, it is a significant challenge to understand what to focus on first.” The ACA and California’s Bridge to Reform⁵ have accelerated the push for quality improvement and practice transformation in local health care systems. Localities participating in HHIF are also receiving funding from other sources to invest in system and practice transformation. Health plans and clinic systems are working to implement practice improvements while addressing the needs of many newly insured patients who are sicker and have more complex psychosocial needs than existing patients. In addition, many clinics involved in HHIF are also concurrently implementing EMRs, which requires significant resources and focus, and disrupts the timeline and capacity for implementing other practice improvements associated with PCMH implementation. The magnitude and pace of change associated with these numerous concurrent efforts can create added burden on staff and what has been referred to as “change fatigue.”⁶

Transferring training knowledge to practice is a long-term commitment. Trainings and webinars introduce concepts, but do not necessarily convert to organizational or practice changes. Buy-in from front line clinic staff and the methods

5 California’s 1115 Waiver, including the Low Income Health Program and Seniors and Persons with Disabilities transition to managed care.

6 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;7:254–60.

used to enable front line staff to adopt the transformation require multiple strategies, training formats, patience, and time. It is important to maintain a strong connection between leadership of the project and the teams implementing the work and to ensure that the TA opportunities are reaching the front line workers. Clinic leaders are faced with the challenge of balancing staff time for training while knowing that time away from patient care results in delays for patients and lost revenue for clinics. During times of fiscal constraints, it is challenging for organizations to commit dedicated resources for transformation at the clinic operational level – especially when training attendance does not readily lead to immediate and visible change.

Existing data capacity and infrastructure limits progress in implementing PCMH components, and Triple Aim measures.

Successful implementation of the PCMH model requires information technology (IT) infrastructure and EHR capacity for panel management, quality improvement monitoring and outcome reporting. Collaboratives that included clinics without sufficient data capacity were at a disadvantage in implementing core PCMH components (e.g., empanelment and population management), selecting measures and collecting outcome data and sharing data with other providers and agencies. Additional challenges included data lags in claims and utilization data across providers, which affected routine quality improvement monitoring. Accessing “real time” data on ER visits and hospital admissions to support care management is another barrier experienced by programs targeting reductions in high-cost, high utilization patients.

It is important to keep the patient at the center of the PCMH. Collaborative partners continue to explore ways to define, document and measure patient experience in a robust and meaningful way. Grantees have experienced challenges developing strategies for measuring this area of the Triple Aim beyond using the standard elements included in the CAPHS survey. Patient outreach and engagement in care is also an area where clinics continue to struggle. Once clinics are more comfortable with changes in clinic operations, they are faced with the challenge of how to truly partner with the patient in their care and empower them to take responsibility for self-management goals. Having a “customer service” orientation in health care is new for many FQHCs and offers both challenges and enormous promise for clinics that want to compete in the new health care marketplace and be responsive to the needs of the communities they serve.

Testing and Implementing Alternative Payment Reforms. Developing systems to reform payment is challenging in the rapidly shifting environment of national and state health reform. For the majority of the collaboratives, payment reform strategies are in the very early stages of development. A critical first step in developing new payment methodologies requires tracking and documenting the financial implications and costs of transformation (e.g., initial costs required and incurred by clinics and health plans, time invested in partnership) and the cost effectiveness of the intervention to determine the return on investment. Some collaboratives still cannot access critical cost data related to services, which will

be essential to build the business case for the intervention (e.g., 30-day hospital readmission rates).

All collaboratives are dealing with fragmented reimbursement systems and need to secure additional grant resources to expand and sustain training and practice transformation for clinics. While most stakeholders involved in the HHIF are interested in developing new strategies, they are awaiting sufficient data on clinical outcomes for patients and clear evidence of cost savings before they can commit to a new financing or reimbursement structure. Initial financing reform efforts focus on maximizing “pay for performance” and quality improvement incentives at the clinic level.

Conclusion

The practice transformation process is complex and takes time. Facilitating sustainable practice redesign and establishing well-coordinated partnerships within local health care systems while achieving measurable progress in Triple Aim outcomes is challenging within the accelerated time horizon of health reform. Over the next year, grantees will continue making incremental steps toward health home transformation by:

- Building data sharing capacity across collaborative partners to improve care coordination and management
- Expanding access to needed services, including benefits counseling, specialty care, and social services
- Communicating and coordinating care transitions between hospitals and primary care to connect patients to their health homes
- Tracking and documenting improvements in population health, patient experience and costs of care to establish the business case for PCMH sustainability
- Determining sustainability and expansion strategies to scale program activities to entire patient population within clinic, clinic networks, health plans and communities

Engaging in these activities over the next year is essential for grantees to develop a sense of collective accountability and sustainable change within their collaboratives and to realize the promise of the patient-centered health home.



For more information on the Center for Care Innovations
and the Health Home Innovation Fund, visit



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