



CCI

CENTER FOR CARE
INNOVATIONS

Health Home Innovation Fund

Final Program Report

Based on evaluation data from
Desert Vista Consulting



Entering the Era of Health Homes

For most American consumers, the Affordable Care Act centered on providing affordable health coverage to millions of uninsured. But for healthcare professionals, particularly those that serve Medicaid recipients, the sweeping reform also pushed changes in the way primary care is delivered and how different health services are – or should be - connected. The idea was that patients shouldn't just go to the doctor, or the counselor, or the specialist—they should have a single, local institution or provider that was responsible for their overall health and coordinated all their care in a way that ensured continuity, promoted prevention and reduced unnecessary expense. We call this coordinating structure a “health home.”¹

The ACA has expanded coverage, much of it through Medicaid, to low-income Americans and to patients with chronic, complex and high-cost conditions—both groups that may particularly benefit from the health home model of care. For healthcare organizations that have traditionally served those without insurance, this upheaval requires adaptation, transformation, and a stronger push to explore and adopt innovative health home models.

The Health Home Innovation Fund

In 2011, the Center for Care Innovations (CCI) partnered with The California Endowment to launch the Health Home Innovation Fund (HHIF). This grant program supported partnerships among safety net organizations to build patient-centered, integrated systems of care, and explore payment reform options to incentivize all participants to keep patients healthy and costs down. With two-year grants of \$500,000, HHIF encouraged diverse safety net organizations to work together to build workable health homes for California's underserved, particularly low-income families and people of color. In addition, \$200,000 grants were awarded to two collaboratives that focused on developing case studies for health homes at rural areas and in school-based health centers.

The grant program used two main approaches. First, it funded multi-stakeholder regional collaboratives to implement health home coordination. Bringing together a range of organizations, including regional clinic consortia, local health plans, community health centers, hospitals, and other community-based organizations, these collaboratives set out to assemble the building blocks of communication and operational transformation that are foundational to the health home model.

Second, HHIF provided resources, training and technical assistance for individual clinics pursuing quality improvement efforts and health home recognition; and for

¹ Some use the term “patient-centered medical home” (PCMH) or even expand the concept to consider community health as a “health neighborhood.”

larger health systems seeking to improve care transitions and cross-system case management for their highest-utilizing or most complex patients.

Safety net organizations are diverse, built to meet the needs of unique places and populations. They came to the tasks of health reform with very different starting points, perspectives and resources. HHIF sought to unite them, regionally, towards a vision of creating a fully integrated, sustainable health home system for underserved populations.

Grantee Collaboratives and Approaches

“As a result of the HHIF collaborative, clinics are much more likely to reach out directly to the health plan or community-based organizations for resources. This work, and primary care transformation, demands outreach with partners, and the work of this collaborative fueled clinic self-confidence in conducting outreach and networking to improve patient care and services.” –Clinic consortia representative

HHIF brought together organizations from all levels of the safety net, many of which had never collaborated before. The strategies and activities to transform systems of care varied by collaborative, as did the lead agencies, existing infrastructure and capacity, target populations, constellation of partners and number of participating primary care clinics. Though the grants themselves funded a wide variety of different projects and technical assistance, this collaboration proved fruitful and fundamental to building health homes and left a legacy of human and organizational connections that will support future efforts.

A total of 57 clinics participated across the eight fully funded collaboratives. HHIF clinic partners ranged from very small clinics that see fewer than 150 patients annually, to large, multi-site clinic systems with over 100,000 patients seen each year. In addition to the 57 clinic partners, the HHIF collaboratives included eight health plans, nine hospitals, multiple academic institutions, community-based organizations and county departments of public health.

Council of Community Clinics San Diego Community Clinics Health Network (CHCN)

- *Partners:* Four clinics, two hospitals and the Medi-Cal managed care plan
- *Mission:* Implement patient empanelment, team-based care, and enhanced referral tracking and follow up
- *Target:* The four clinics targeted their entire patient populations, but provided special care management help to patients with diabetes.
- *Unique Project Component:* The Council conducted a local evaluation that tracked the progress of health home implementation efforts. They also

collected data on the patient experience and staff and provider satisfaction at the clinics.

Health Improvement Partnership of Santa Cruz (HIP)

- *Partners:* Three clinics, two hospitals and the Medi-Cal managed care plan
- *Mission:* Implement a Health Navigation pilot to provide care coordination for complex patients discharged from hospitals and transitioning back to their primary care health homes.
- *Target:* Low-income, newly insured or uninsured adult patients.
- *Unique Project Component:* HIP used an interagency, community-wide team model, which brought together clinics, hospitals, behavioral health staff and the County to learn from one another and develop strategies to leverage collective resources to serve shared patients with complex needs.

Health Plan of San Joaquin (HPSJ)

- *Partners:* Two clinics, a county behavioral health service agency and one hospital
- *Mission:* The collaborative engaged in coaching, care team implementation, data-driven care coordination, and peer-led efforts to teach patients better self-management
- *Target:* 700 patients with co-occurring diabetes and depression
- *Unique Project Component:* Dedicated resources to training and clinic implementation of the Stanford Patient Chronic Disease Self-Management Program

Inland Empire Health Plan (IEHP)

- *Partners:* Riverside County Department of Public Health and ten family care centers.
- *Mission:* Build capacity for team-based care through Plan-Do-Study-Act cycles.
- *Target:* Clinics focused on operational changes that impacted all patients and IEHP provided clinic-level dashboards on IEHP member outcomes.
- *Unique Project Component:* IEHP purchased a population health management tool for all ten county clinics to help track patient outcomes and support quality improvement efforts.

North Coast Clinic Network (NCCH)

- *Partners:* four clinic systems, two hospitals, and county Social Service and Public Health departments
- *Mission:* Increase patient access to health insurance and enhance care coordination to include community resources. The collaborative worked to

develop a health home concept that engages providers, patients and community resources in an array of prevention and wellness activities.

- *Target:* Low-income, uninsured and publicly insured patients served by the clinics
- *Unique Project Component:* NCCH focused on community-based interventions, prevention and wellness, collaboration with county departments, and patient involvement in practice transformation activities.

Redwood Community Health Coalition (RCHC) and Partnership Health Plan of CA (PHP)

- *Mission:* Support the implementation of transformation activities to become health homes recognized by the National Committee on Quality Assurance (NCQA) in all RCHC member clinics. The collaborative also implemented an intensive case management pilot in three clinics and assessed the model's return on investment.
- *Target:* Medi-Cal managed care patients with complex, chronic diseases and high resource utilization.
- *Unique Project Component:* A key asset of the RCHC/PHP collaborative was strong leadership support from both organizations, coupled with the data access and analytic capacity of the health plan. This analytic capacity allowed them to assess the outcomes and return on investment of the Intensive Case Management pilots.

San Francisco Community Clinic Consortium (SFCCC)

- *Partners:* UCSF Center For Excellence in Primary Care (CEPC), the San Francisco Health Plan, six consortium clinics and six San Francisco Department of Health clinics
- *Mission:* Implement CEPC training on the "10 Building Blocks of High Performing Practices," provide clinic coaching, and pilot complex care management programs supported by San Francisco Health Plan incentive payments.
- *Target:* Clinics focused on operational changes that impacted all patients.
- *Unique Project Component:* The collaborative leveraged and standardized CEPC curriculum to share with clinics throughout the SF region.

Two Case Study Collaboratives

In addition to the eight grants above, the HHIF program also supported two smaller initiatives aimed at exploring health home implementation in two unique settings: rural areas and school-based health centers.

California School Health Centers Association (CSHCA)

The goal of this project was to conduct an exploratory analysis of the role that school-based health centers (SBHCs) could play in the implementing health home systems in California. SBHCs are well positioned to become health homes for children and adolescents based on their proximity and access to young people, interdisciplinary team approach to care, and access to community resources to address the medical, behavioral health and social needs of children and families.

As part of this effort, CSHCA partnered with Qualis Health to publish the paper, [“Patient-Centered Medical Home: How Are California School-Based Health Centers Relating to This New Model of Care?”](#). This paper reviewed best practices for SBHCs to move closer to the health home model, outlined the strengths SBHCs have in meeting the requirements for health home recognition, and provided recommendations on how SBHCs can improve current practices to meet health home standards.

Health Alliance of Northern California (HANC)

The focus of HANC’s program grant was to build the foundation to implement patient centered health homes by developing regional leadership partners and advancing advocacy efforts to implement a Medi-Cal managed care model in northern California. In this project, HANC worked closely with the Shasta County Health Assessment and Redesign Collaborative to promote a quality system of care for rural counties in northern California.

Through its significant and persistent regional advocacy efforts during this project, HANC helped achieve implementation of the County Organized Health System (COHS) seven northern California counties in September 2013. These counties will operate the COHS managed-care model in collaboration with Partnership HealthPlan of California. This shift in the payment model for Medi-Cal beneficiaries will allow these counties to better develop and advance quality improvements focused on improving patient care.

Grantee Strategies and Outcomes

In addition to establishing cross-sector partnerships, grantees found common strategies to build key components of the health home model. These included:

- Transforming practices at the clinic level
- Intensive case management and care transitions navigation for complex patients
- Leveraging IT systems to track outcomes and share data

The HHIF collaboratives provided unique platforms to tackle these three critical building blocks of the health home model, as articulated in the ACA.

Practice Transformation

Progress on practice transformation at the clinic level was greatly accelerated by the HHIF cross-sector partnerships, which provided greater access to needed resources, expertise, training and data. Key measures of primary care transformation were used to determine the success of the HHIF in building health homes at a clinic level. Across the 57 clinics involved in the HHIF, significant progress was made on all of them. In particular, as of November 2013, 40% of the clinics had applied for NCQA recognition as patient-centered medical homes, and of these, 48% received at least a Level 1 rating. An additional three clinics applied for and received health home recognition from another accreditation source, such as The Joint Commission or AAAC.

Progress by Clinics on Core Health Home Components

| Component | Clinic Activities | % of Clinics Pre-HHIF | % of Clinics Post-HHIF |
|--|---|-----------------------|------------------------|
| Empanelment | Empanelled at least a sub-set of patient population | 50% | 91% |
| | Empanelled all patients | | 58% |
| Team-Based Care | Use care teams | 42% | 84% |
| | Use huddles routinely | 35% | 79% |
| Panel Management | Use panel management | 23% | 58% |
| Use of Data/Technology for Quality Improvement (QI) | Develop and use QI plans | 56% | 81% |
| | Conduct PDSA cycles as part of QI work | 49% | 79% |
| Patient-Centeredness | Involved patients in PCHH transformation activities | | 25% very involved |

In particular, the percentage of clinics using team-based care doubled from 42% to 84% by the end of the grant period. Across the HHIF clinic sites, physicians increasingly recognized that inter-professional teams embedded in primary care are more effective in addressing the needs of patients – especially those with complex needs - and yield greater patient satisfaction. Team based care is a fundamental and

necessary shift in paradigm underlying care delivery transformation. Team composition varied across clinics; however, most clinic teams were comprised of a primary care provider, RN, medical assistant, and front desk staff. Some clinics used “teamlets,” where primary care providers work consistently with the same medical assistant each shift. Staff members were used to the top of their licensure and clinics expanded the role of medical assistants. Other providers worked with behavioral health providers, health educators, dietician nutritionist, and benefit enrollment specialists—non-traditional partnerships that expanded the scope of primary care to better serve complex patients.

Complex Care Management

Over the course of the HHIF program, there were significant increases in the number of clinics offering care management programs that particularly benefit complex patients. These include services to help patients navigate the often-confusing realms of the medical world, support and education for self-management by patients, and facilitating access to behavioral health services.

Progress on Care Management Service Implementation

| Activity | % of Clinics Pre-HHIF | % of Clinics Post-HHIF |
|--|------------------------------|-------------------------------|
| Provided care management | 32% | 58% |
| Provided patient navigation services | 19% | 63% |
| Provided self-management support | 56% | 79% |
| Provided integrated behavioral health services | 40% | 63% |

Further, all members of the collaboratives increased their knowledge of care management strategies and the needs of complex patients, which can inform other statewide efforts for Medi-Cal expansion and improving complex care. In particular, many partners enhanced their understanding of the needs of the low-income, newly insured population entering the healthcare system.

Collaboration improved between health plans, clinics, hospitals, and consortia in the design, implementation and evaluation of complex case management and hospital transition programs. Because of this, HHIF demonstrated, with early results, trends toward positive return on investment of the health home model in potential cost

“We leveraged our partnership with hospitals, clinics and behavioral health resources to enhance and ensure care coordination across the systems. Bringing these partners to the table on a regular basis was beneficial not only to the evolution of our HHIF care transitions program, but to the safety net system as a whole.” –HIP

savings, reduced ED and hospital utilization, and improved patient outcomes.

By working together to identify a shared target population, collaboratives developed a sense of collective accountability among the partners. Clinics used data from registries and electronic health records to identify patients in need of care and ongoing management. Responsibility for that care increasingly became the responsibility not of a single organization, but other key care partners in the collaborative.

Health IT and Data Sharing

“We send clinical data to the Network on a quarterly basis and they create dashboards that show our data over time for our individual health centers. We have goal lines and national and state benchmarks so that we can see how we are performing in relation to the rest of the state and the country. These dashboards are displayed and discussed at our quarterly QI meetings.” –Health Center Representative of NCCN

Clinics with limited information technology infrastructure experienced significant barriers in adopting health home practices. Without a working clinical information system, electronic health records, or a patient registry, health centers run into numerous challenges with managing patients, coordinating care transition from hospital to primary care, and tracking population health outcomes.

Over the course of the program, the percentage of clinics with a functional clinical information system or electronic health records increased from 54 to 70 percent.

HHIF grantees also increased the frequency with which there was routine and proactive data sharing among the collaborative partners. Health plans in the collaboratives began to create customized, user-friendly reports for their clinic partners, including performance data on HEDIS measures, hospital utilization, and patient costs, as well as monthly provider report cards.

Clinic consortia developed dashboards to share best practices with clinic members through peer network meetings. Some county departments used data partnerships with clinics to promote quality improvement efforts or expedite enrollment of patients in social services. Where strong relationships were in place, hospitals provided partners with information on patients admitted to emergency departments, and in two HHIF collaboratives facilitated “warm handoffs” hospital discharge to the patient’s primary care clinic.

Finally, an important cultural shift was needed in how safety net organizations used data for decision-making and quality improvement efforts. Many clinics, at least initially, lacked in-house capacity to analyze, interpret, and use the data from their health IT systems. Health plans and clinic consortia took on the role of collecting and integrating data from participating clinics to provide clinic leaders and staff with useful

reports on performance metrics and patient outcomes. While demand for integrated data across systems and partners outpaces analytic and technical capabilities, over the course of the grant period the collaboratives' lead agencies made significant progress in building this data capacity in clinics.

Lessons Learned

HHIF was an especially early and large effort to make the often-discussed concept of health homes a daily reality for thousands of safety net patients. As the final phases of the Affordable Care Act settle into place, the collective experiences, successes and challenges of the grantees provide a rich source of lessons learned that can inform future programs and policy.

Below we discuss five key areas where the experiences of the HHIF grantees offer valuable lessons for the rest of the field as more organizations implement health home models.

Scope, Scale and Spread

First, system-wide changes take time and effort. Clinics needed significant infrastructure, resources, and culture change to adopt patient-centered practices. Developing and stabilizing a health home program—and demonstrating outcomes—in just a two-year period proved a real challenge.

For safety net health systems to move away from volume-based to providing value-based care, there needs to be a culture shift from reactive treatment to proactive prevention—prevention that focuses on more than just reducing ED visits and hospital readmissions. This culture shift requires adequate staff resources dedicated to transformation from start to finish. As with any disruptive innovation, either technological or process-based, adopting a health home model is heavily dependent on deliberate change management. As such, all the attendant success factors for managing change are required for health home implementation and sustainability: leadership attention, staff buy-in, alignment of incentives and resource allocation. Physician champions are also instrumental in driving the innovation, testing and implementation of new processes.

A Team Approach

Provider buy-in to team-based care is essential for increasing access and providing supportive services that are essential to the health home model. Effective care teams need to be interdisciplinary, non-hierarchical and consistent. Care teams also need leadership support, clear division of labor, and frequent feedback.

Beyond the primary care team, the HHIF collaboratives illustrated important roles for the teamwork within the larger safety net community. Clinic consortia, for example, are

in a unique position to convene stakeholders in a care community, align goals, provide training and spread best practices. Health plans have a key role in aligning incentives for health home activities, providing utilization data and helping to analyze the total cost of care for an individual. Hospitals, too, play an important part by ensuring that patients are connected back to their primary care health home after discharge or ED visit for follow up care. At all points on the care continuum, partners and patient-centered teams need to work together, connected by technology systems and care agreements, to transform the health care system one patient at a time.

Patient Centeredness

Team members and clinic staffs need to be sensitive to the needs and desires of patients, have high health literacy, and be able to translate medical jargon into clear language. Partial rollout of other health home components can lead to increases in patient satisfaction, but actual focus on creating a positive patient experience is the most important element in these improvements. Customer service and patient communication skills remain the number one area of training requested by clinics. While some clinics and health centers have taken steps to incorporate the patient voice into the care delivery and transformation process, patient involvement in these efforts is still in the nascent stages. Establishing patient and family councils, providing multiple channels for care team contact (e.g., using a patient portal), and establishing visit agendas are techniques piloted by HHIF grantees. Achieving true patient-centeredness through deep end-user empathy continues to be an area needing improvement in health home transformation.

Care for Complex Patients

Individuals with complex, chronic conditions require tailored and intensive interventions to better manage their health and improve their quality of life. Often dubbed “high risk, high cost”, these patients also offer high opportunity to intervene with services that, in the long run, will reduce the total cost of care. Staff members working with these patients need experience with addressing both the medical and psychosocial needs of this population, and data from across providers is critical to matching the right services to the right patient. Complex care management programs need to define tiered care based on acuity level, as well as clear disenrollment criteria.

Developing the business case for health home implementation and complex care management programs often lies with payers. Payers can incentivize these programs by devising reimbursement structures that allow for clinics to share in the savings and cover the cost of the health home activities and intensive care management. Yet payers also assume risk that they will eventually reap the benefits of lowered total cost of care with high risk, high cost patients. This tension remains a challenge in supporting health home implementations.

Health IT and Data Analytics

Robust IT infrastructure is critical to nearly every element of the health home model. So is a thorough understanding of the data these IT systems offer. Providers that are engaged in using data, understanding the metrics being tracked, and evaluating improvements are much more likely to support a culture of quality improvement because they can see the impact of their work. Safety net providers need to move toward models of health information exchange that “push” data to organizations that need it, rather than relying on a process of “pulling” data from an information system. The latter approach requires staff and providers to log into a remote system to look for shared patients at certain intervals; a tedious process at best and often unreliable to facilitate care coordination and ensure appropriate transitions in care. Pushing uses a notification system that alerts providers of their patients’ status at other organizations.

Implementing health IT systems and data exchange within a single organization or across systems almost always takes longer and costs more than expected. Data analytic capacity and data validation processes are critical for ensuring that the health home model and the business case for it are advanced in a sustainable way.

Conclusions

Overall, the collaboratives funded through the Health Home Innovation Fund showed ample evidence of progress in advancing health home transformations at both the clinic and cross-system level. Grantees made less progress in developing alternative payment strategies, addressing patient experience and expanding the concept of prevention. Still the work conducted over the two-year grant period also built important infrastructure to support the further expansion of health home practices in the participating communities. Grantees varied in their activities and approaches, but all benefited greatly from working as a collaborative involving multiple system partners.

HHIF facilitated linkages across safety net partners to align efforts on health home recognition, using data to inform clinical practice, building a strong QI infrastructure, and preparation for the ACA and Medi-Cal expansion. This policy context accelerated support for the health home model at the clinics. This reform environment is also essential for sustaining the practice transformation accomplishments of the HHIF grantees now and in the future for all safety net providers.