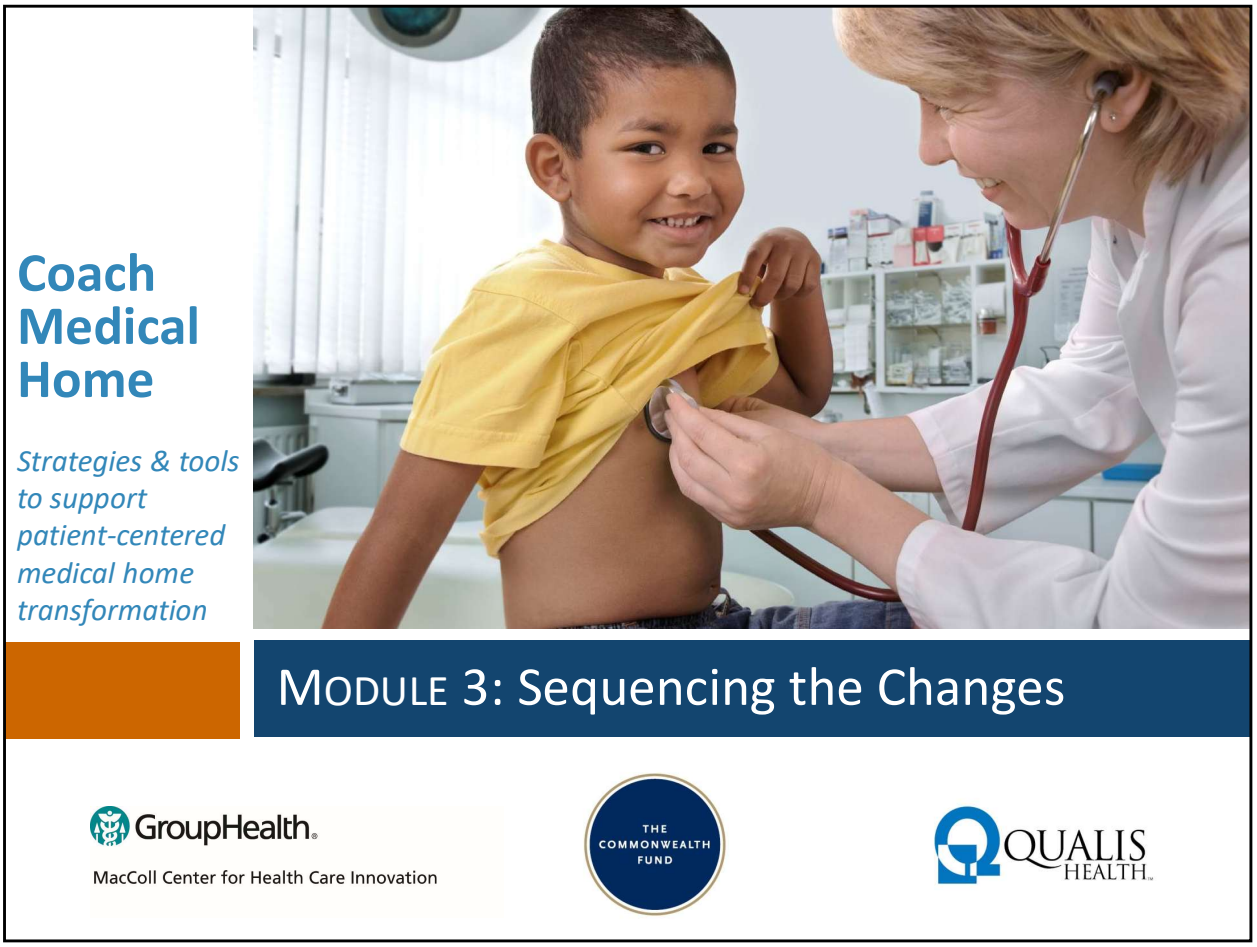


This is the third module of Coach Medical Home—a six-module curriculum designed for practice facilitators who are coaching primary care practices around patient-centered medical home (PCMH) transformation. Based on the Safety Net Medical Home Initiative Framework for Practice Transformation, these modules provide knowledge and tools coaches can use to support practices as they improve quality of care, become medical homes, and achieve PCMH recognition.

Each module has two components: a PDF handbook like this one and a companion PowerPoint® presentation also available on the Coach Medical Home website. The PowerPoint® slides can be saved, modified, and used in your presentations with practice leaders and others. The detailed notes in the handbook will help you learn more and link you to other useful resources. You may also find it helpful to use these notes to guide your talking points during presentations.

Supported by The Commonwealth Fund, a national, private foundation based in New York City that supports independent research on health care issues and makes grants to improve health care practice and policy. The views presented here are those of the authors and not necessarily those of The Commonwealth Fund, its directors, officers, or staff.

Suggested citation: Coach Medical Home: A Practice Facilitator's Guide to Medical Home Transformation. (Prepared by Group Health's MacColl Center for Health Care Innovation and Qualis Health, supported by The Commonwealth Fund), January 2013.

Learning objectives for this module

2

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.

Coach Medical Home: Module 3

Transformation to a patient-centered medical home (PCMH) is a major undertaking for a practice. **In order to make the change manageable, it is important to break it into steps**. This module helps the practice facilitator understand the changes required to become a medical home and provides techniques and tools to help guide practices in making change.

Throughout this module, you will find coaching tips and links to useful tools to help you accomplish the action step(s) listed on that page. Look for the following icons on certain pages:



The light bulb icon points out key tips and insights that will help you in your role as a coach.



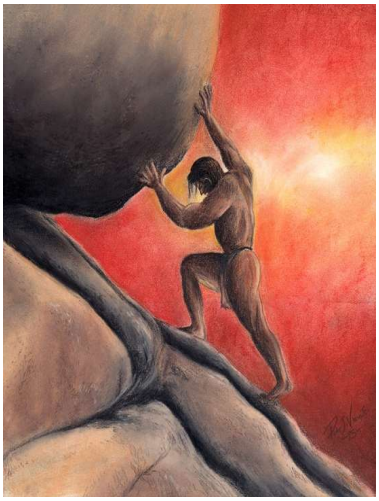
The toolbox icon points out tools you can access via the link provided.

What are we trying to achieve?

3

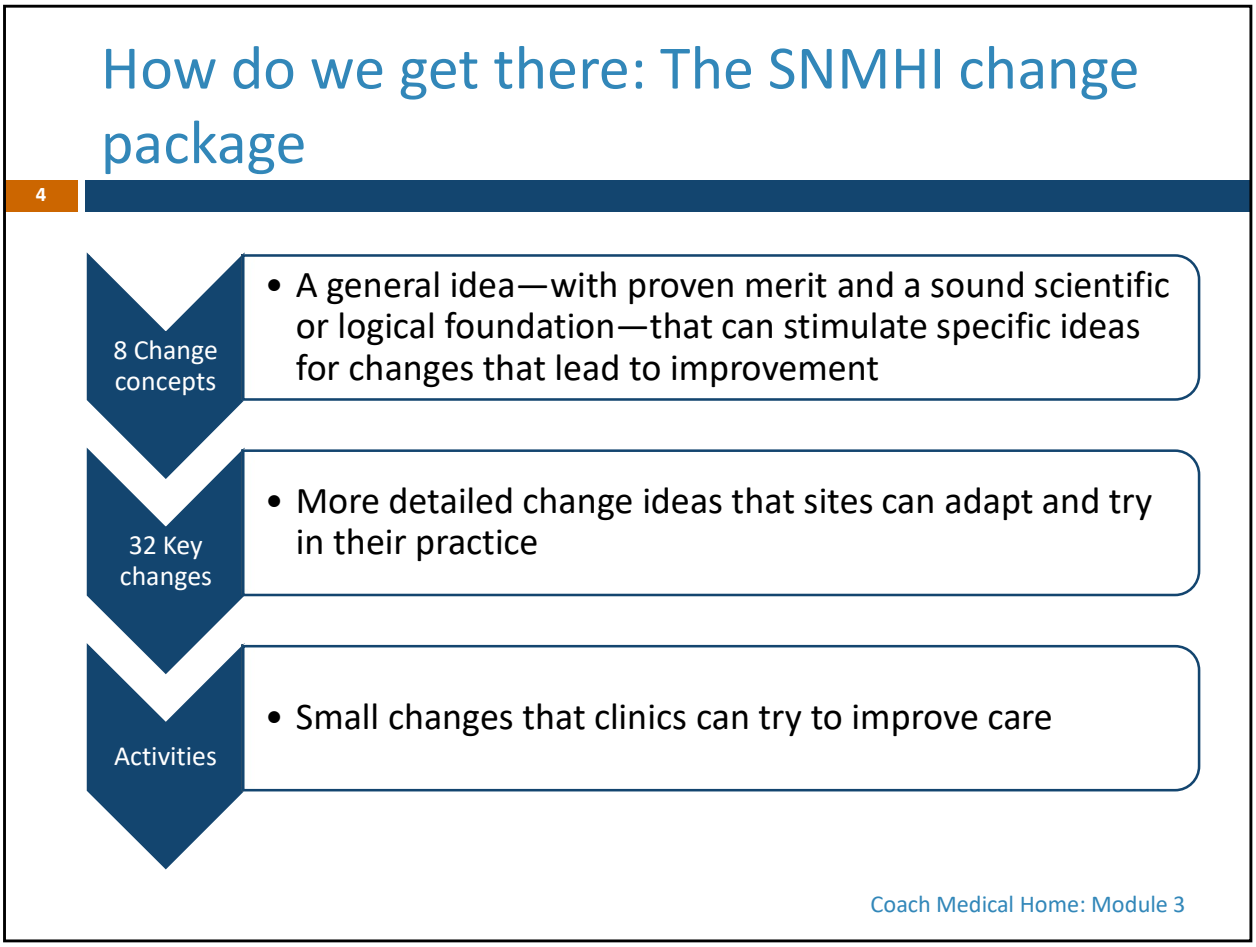
Benchmark performance in quality and efficiency

- ↑ 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



Coach Medical Home: Module 3

As Module 1: Getting Started explains in more detail, PCMH transformation sets out to make changes that dramatically enhance the value and experience of health care. For most practices, the desired changes in quality and efficiency are much more dramatic then any improvement efforts they have tried in the past. This journey may take a few years and considerable effort. Initiatives to support and coach practices should not underestimate the magnitude of the challenge that practices face.

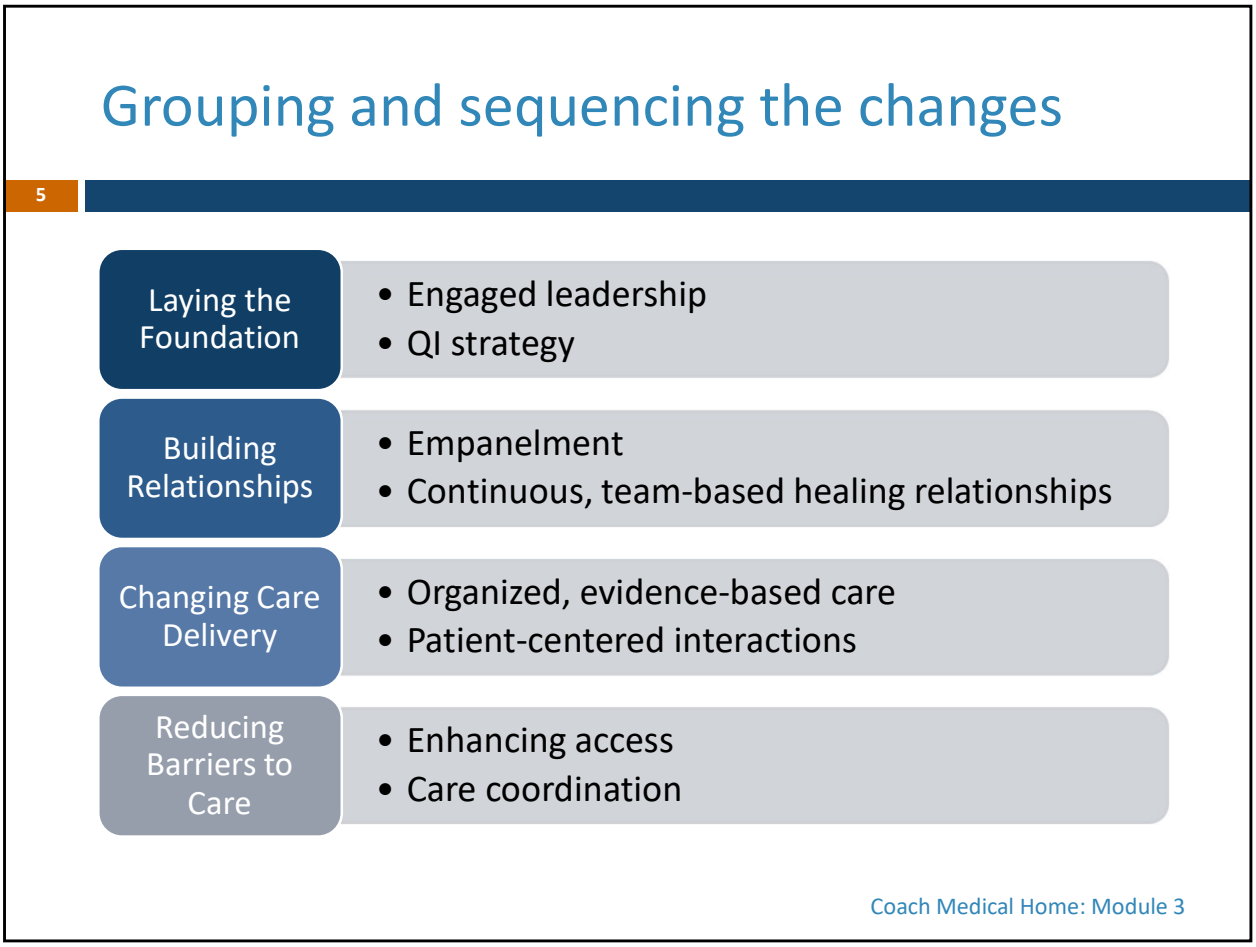


The eight change concepts that define the PCMH are broad ideas. Under each change concept are key changes—more specific ideas about change that sites can adapt and try in their practice. For sites that want even more specific ideas, activities are examples of small changes that clinics have made to improve care within a change concept.

The change concepts and key changes were created by national experts and tested in the Safety Net Medical Home Initiative (SNMHI) PCMH demonstration. **The change package is now used in PCMH efforts around the United States, including state initiatives and the Advance Primary Care Practice demonstration.**

The change concepts and key changes are general concepts. We expect that they will be implemented differently in different places.

Reference: Wagner EH et al. 2012. The changes involved in patient-centered medical home transformation. Prim Care 39(2):241-59.



Practices will be overwhelmed if they try to implement the entire change package at once. Additionally, many of the recommended changes cannot be made unless other changes are already in place. For example, providing continuity of care depends upon the explicit linking of each patient with a primary provider.

To focus work and reduce confusion, the change package lays out the following order:

1. **Foundational Changes:** Practice transformation requires visible leadership support and an effective quality improvement approach to change culture and practice systems. Without this foundation, practices find it difficult to move forward on the other changes.

2. **Building Relationships with Patients:** A strong provider-patient relationship, especially when the provider is part of a well-organized team, improves patient outcomes and experience. Other system changes like continuous, team-based care build on and reinforce the relationship.

3. **Changing Care Delivery:** Transformation goals will not be reached unless the way in which care is delivered is more patient centered, planned, and proactive. Measuring improvements in clinical performance is essential to sustaining motivation and energy and overcoming change fatigue.

4. **Reducing Barriers to Care:** Improving access and coordination requires engaging with both staff in the clinical practice as well as partners outside, like hospitals and specialists. Practices are more able to create helpful partnerships with others when their own partnerships are organized.

Planning sequencing

6

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

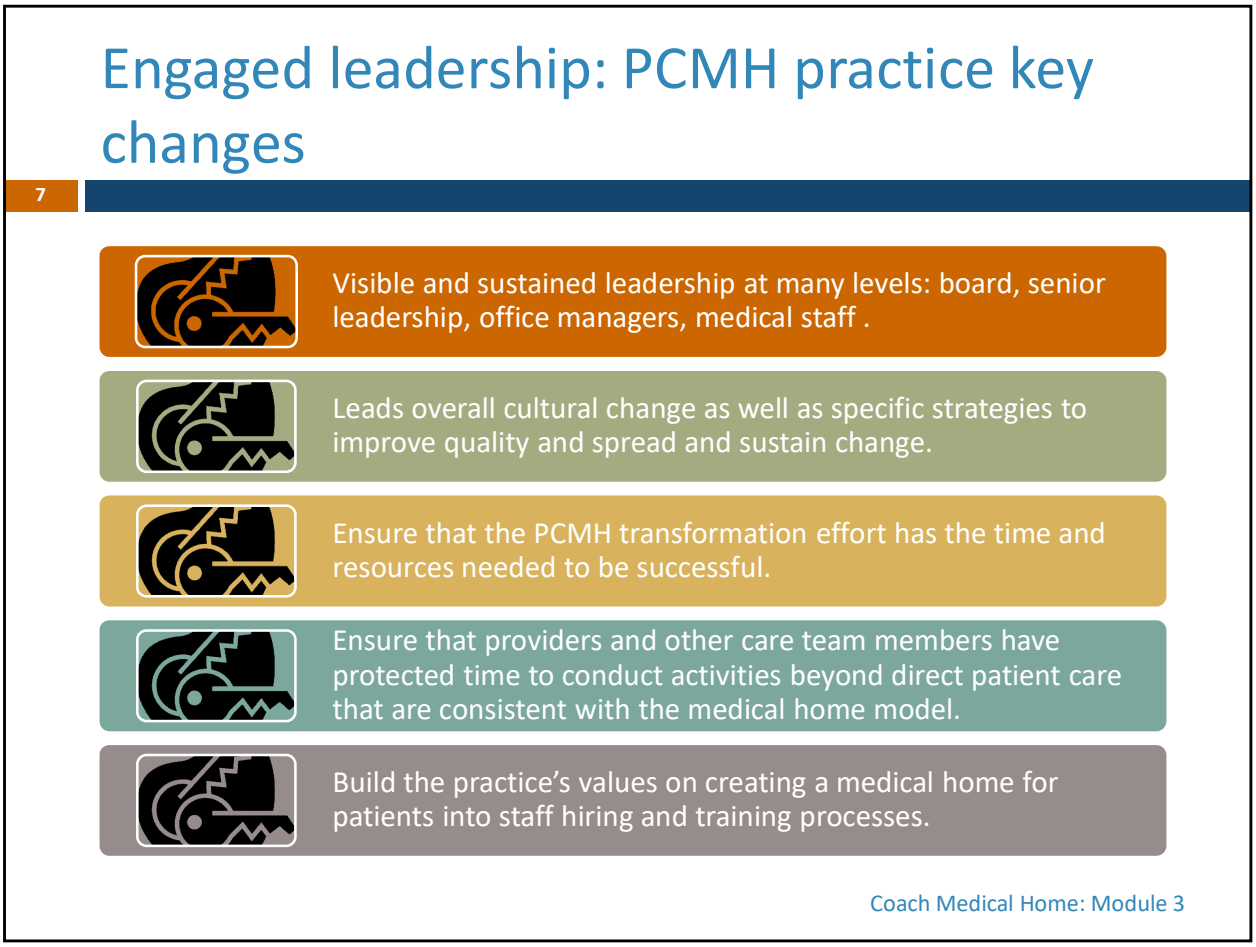
- PCMH-A, Implementation guides, and more



Coach Medical Home: Module 3

Understand and share the sequence of the eight change concepts. Work with teams to create a vision for where they want to go, and help them identify where to start. Not all teams will work through the changes in just this sequence. You will need to understand what processes and infrastructure the teams already have in place –for example, they may already have a good team structure up and running. Also consider what other state-level or national-level PCMH initiative demands might need to be met by sites, like NCQA PCMH™ Recognition or a care management program.

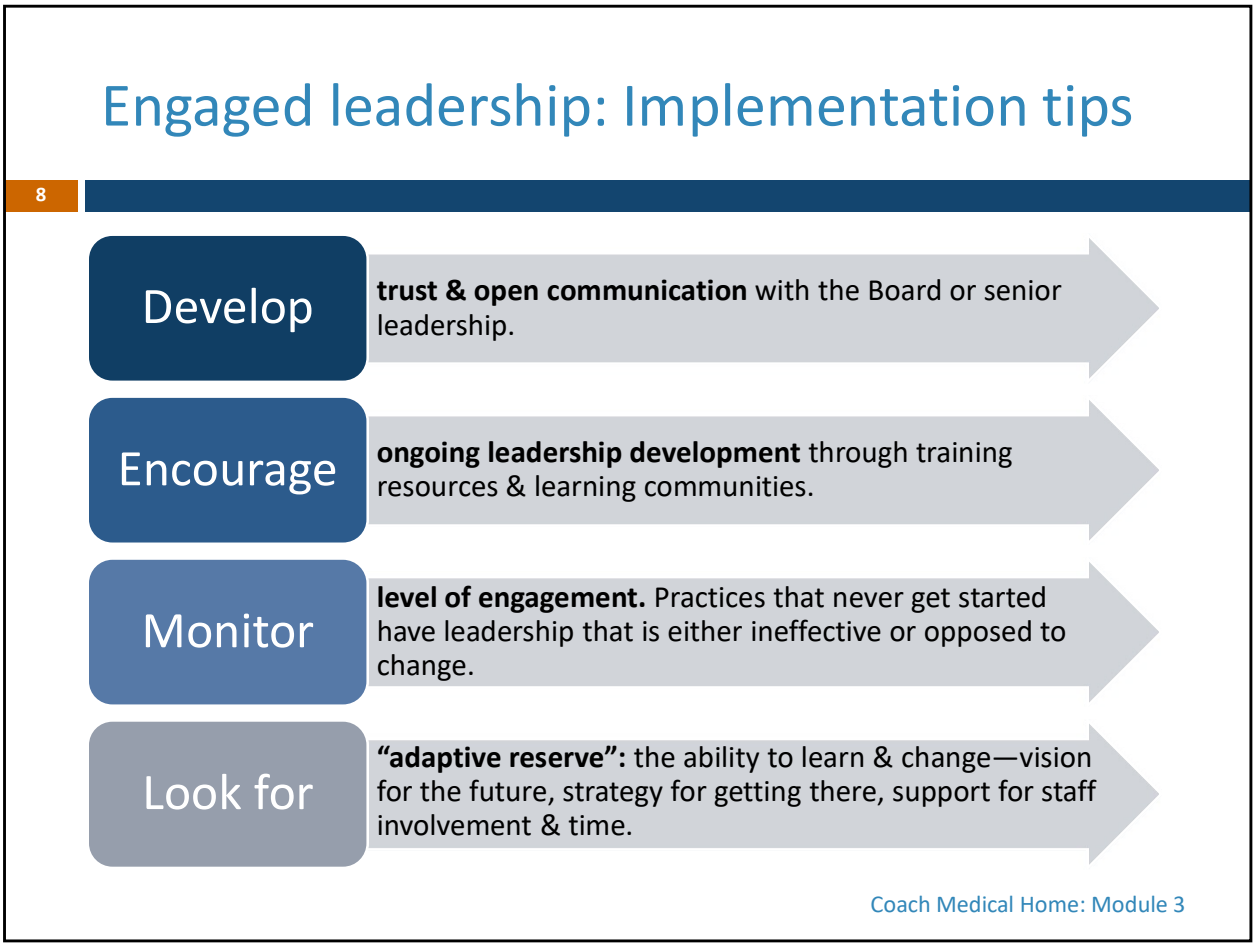
The rest of this module provides additional detail about how the changes are interdependent and build on one another, and to provide a starting point for a conversation with sites about their improvement work.



Visible and sustained leadership support is essential to make transformational change happen in a busy federally qualified health center (FQHC). Leadership support ensures that the vision and resources for transformation are in place. This must happen at many levels: board, senior leadership, office managers, medical staff.

As a coach, this means thinking about how to support different kinds of leaders simultaneously, and emphasizing the many roles that they play. To start, acquaint yourself with tools and resources for fostering leadership in an FQHC.

The SNMHI Engaged Leadership Implementation Guide provides tangible examples of how engaged leaders act—and what to do when they're not on board. https://comagine.org/resource/2572



Most PCMH initiatives **start with engaging the Board and senior leadership**. Coaches may make this early connection, or it could be done by or in partnership with the leader of the organization that the coach works for. Involve all members of the senior management in your initial meeting, including the chief financial officer and Board chair. Be clear and explicit up front about costs and benefits of participation to help get the initiative off to the right start.

Promote leadership development. Practices without engaged leadership or with high turnover will need extra support. Leadership development is not a one-time activity. The coach or a primary care association may wish to organize an ongoing learning initiative to run in parallel with PCMH transformation. For example, some states organize monthly or quarterly meetings to develop leadership skills and cross-clinic communication, and to keep leaders up-to-date on state and federal policy changes.

If you suspect a team is not making progress because the leadership is not engaged, do not wait and hope the issue will resolve. Talk to leadership within your organization and ask for help reaching out to practice leaders and connecting them with resources or mentoring from a high-functioning practice.

NACHC Leadership Development Institutes

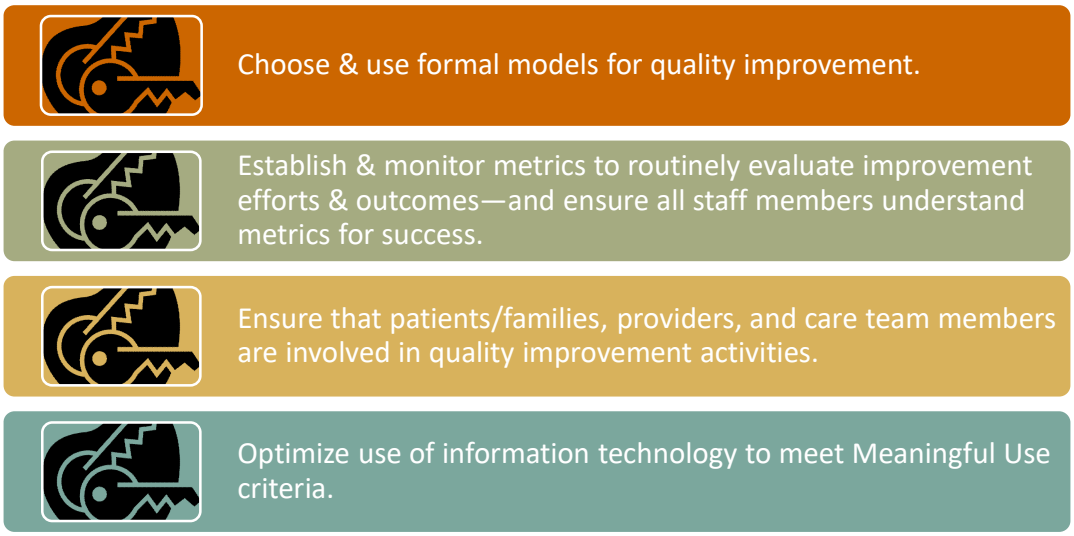
Missouri PCA's PPT about introducing PCMH to the Board and Senior Leadership

SFQCS Curriculum Plan

The Practice of Adaptive Leadership

Quality improvement (QI) strategy: PCMH practice key changes

9



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

Coach Medical Home: Module 3

All practices that are successful at making change use a system to guide their quality improvement (QI) efforts. Through the Institute for Healthcare Improvement (IHI) Breakthrough Series Collaboratives, staff at many FQHCs learned and used the Model for Improvement (PDSA cycles) to test small ideas for change in practice, learn from that experience, adjust and try again. However, PCMH evaluation to date shows that other QI strategies (e.g., Lean) work just was well, if not better. **What matters is that the practice has a regular, shared, and ongoing process for improvement.**

Quality Improvement Strategy Implementation Guide
https://comagine.org/resource/2576

QI strategy: Implementation tips

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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.

Coach Medical Home: Module 3

As a coach, you must be able to guide the teams in selecting and using a QI model.

- Some of the sites you are working with will not remember the Model for Improvement, or will use another methodology like Lean.
- If this area is new to you, or you are looking for more formal training, please see IHI's online Open School QI courses 101 through 106.
- Helping teams organize and facilitate well-run meetings. Meetings are the place where the QI work begins or ends.

Never underestimate the importance of helping teams put in place a measurement strategy that helps them see progress.

- Work with the team to identify metrics they care about, collect measures regularly, and report on them. See Coach Medical Home Module 4 for more information.
- For teams that are struggling with 'where to start,' coaches can help by reminding them of the gaps they found in their baseline PCMH-A scores. If your sites are pursuing NCQA PCMH recognition, use the change concepts/PCMH-A/NCQA crosswalk to find high leverage changes.

NCQA/CHANGE CONCEPT/PCMH-A crosswalk

PCMH-A examples tool

Red-yellow-green tool

Dartmouth Clinical Microsystems "Outpatient Primary Care" Greenbook.

Video on team meetings in a clinical environment

Empanelment: PCMH practice key changes

11



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.

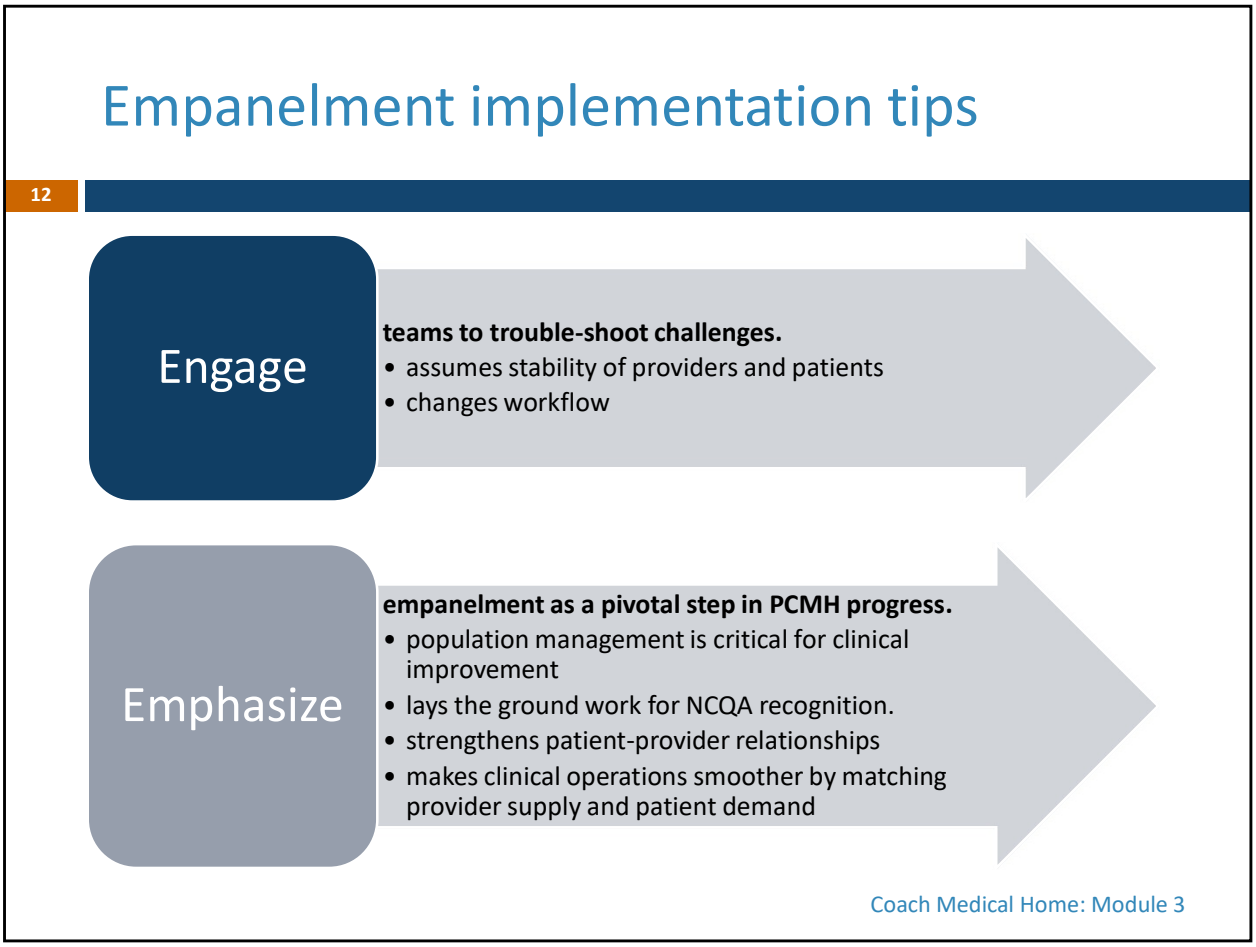
Note: For practices pursuing NCQA recognition, **using data for population management** is a must-pass element.

Coach Medical Home: Module 3

An essential feature of every definition of a medical home is its emphasis on explicit patient-provider relationships. The first step is to link patients to care teams, creating panels of patients that each team manages. Teams that do not start with empanelment—or who don't already have a system of paneling patients—often have to go back and do this work to make improvements in other areas like continuity, care management, and organized evidence-based care. Getting a handle on a panel of patients is the foundation for population management and access to care.



The Empanelment Implementation Guide



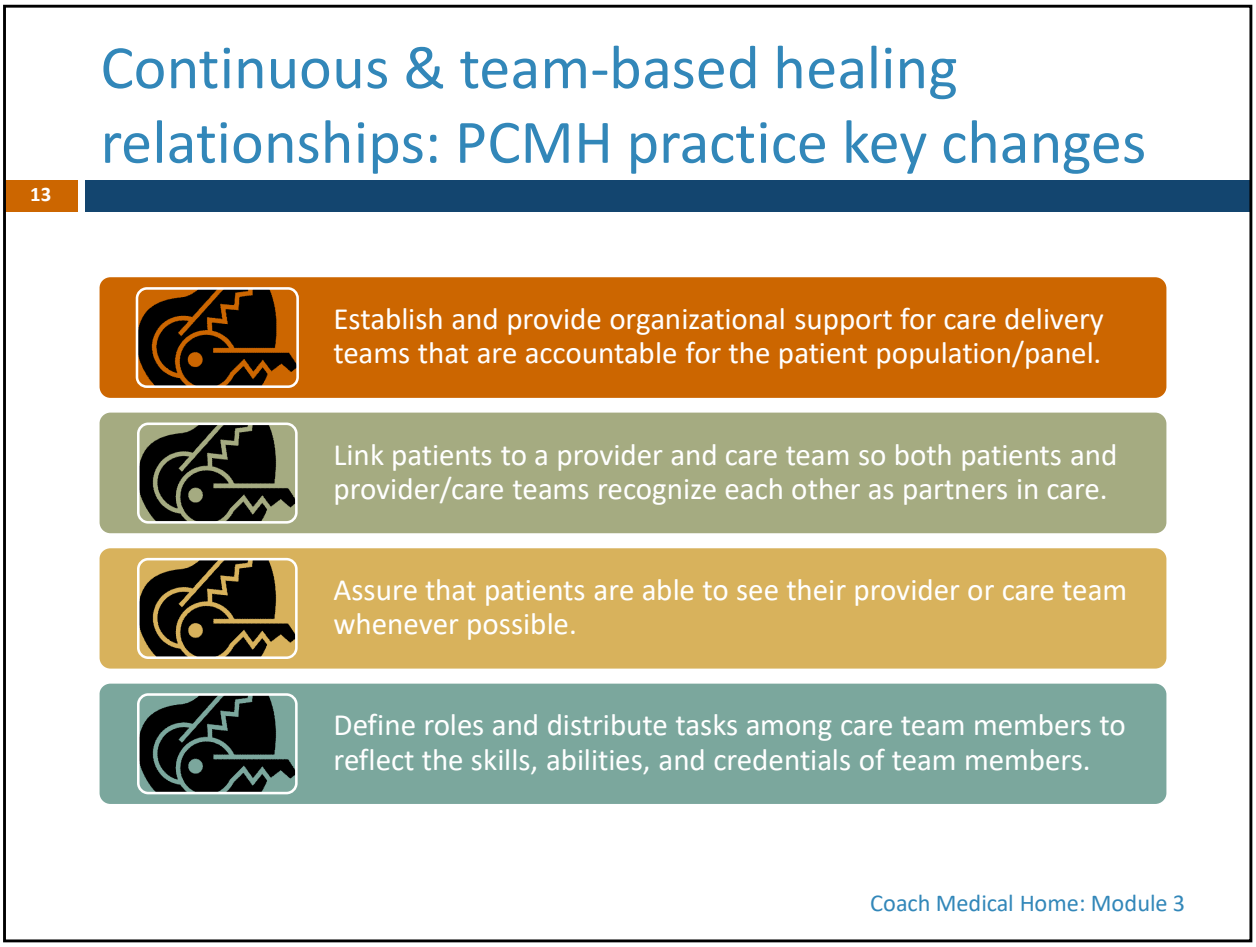
Developing leadership and quality improvement capacity are ongoing efforts throughout the medical home journey. But it's when teams take their first crack at empanelling patients that they finally feel like they are making progress on the transformation process.

Help teams see the importance of this early work by explaining and giving examples of how it lays the groundwork for PCMH progress and NCQA recognition:

- Using panel data to track sub-populations of patients is a key part of NCQA PCMH Recognition.
- Is "patient centered" by asking patients who they want to work with and enabling them to have and see their own PCP.
- Helps clinical operations by matching the supply of providers with patient demand. This work will be important for improving access later.
- Enables teams to start thinking creatively about addressing all the needs of their panel of patients – work that comes up in team based care and organized evidence based care later.

Acknowledge that empanelment brings a major cultural shift and data challenges:

- Talk with teams early about how they see themselves—as a medical home that provides great care to a population of patients, or as an acute care facility whose job is to be open to see and treat as many as possible. These conversations can be helpful in generating buy-in and aligning the vision of senior leaders and frontline staff around PCMH transformation.
- Most safety net practices have the data that allows them to use common sense approaches such as the "four-cut" method to link patients with providers.

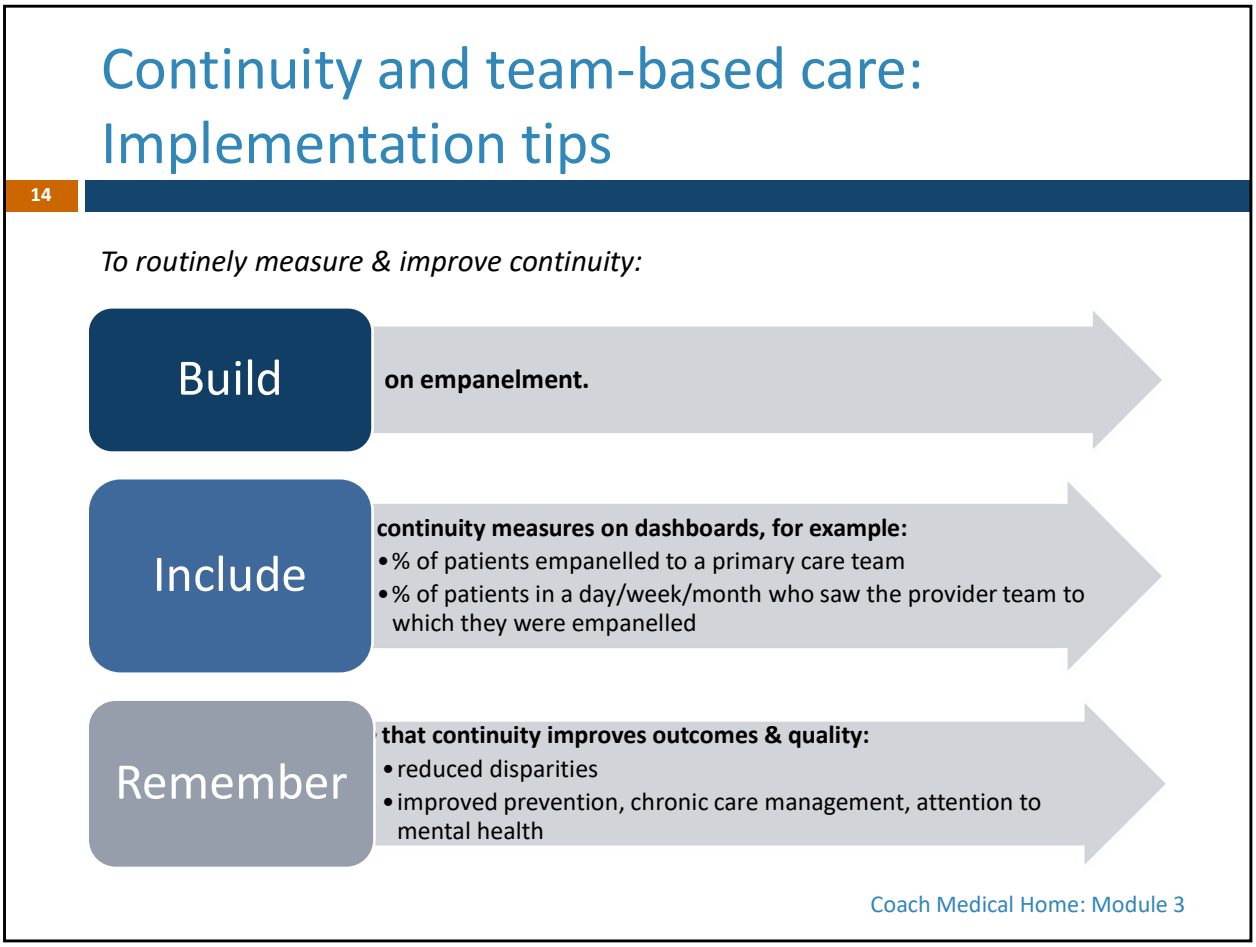


Continuity of care is associated with better clinical outcomes, better patient experience, and reduced costs. It also enhances the career satisfaction of primary care providers and staff who often are attracted to primary care because of its long-term relationships with patients. But there is not enough time in the day for a single provider to meet all the acute chronic and preventive care needs of a panel of patients—it takes a team.

Effective teams support better care. As practices develop effective patient care teams, they need to consider:

- What roles must each core primary care team be able to perform?
- Are providers comfortable in assigning clinical roles to staff, and are staff eager to take on new responsibilities?
- Do practice teams communicate and support each other adequately?
- Do existing staff have the time and skills needed to perform those key roles?
- Are existing staff performing tasks and roles that are unnecessary or less important?

Continuous, Team-based Healing Relationship Implementation Guide
https://comagine.org/resource/2594



Coaches who work with safety-net practices to become medical homes say **that tracking continuity** is one of the most meaningful measures for clinical teams.

To encourage routine measurement and improvement of continuity, **emphasize continuity's powerful relationship to achieving practice transformation and suggest measures to use**. Empanelment doesn't guarantee continuity, but it makes it much easier to attain.

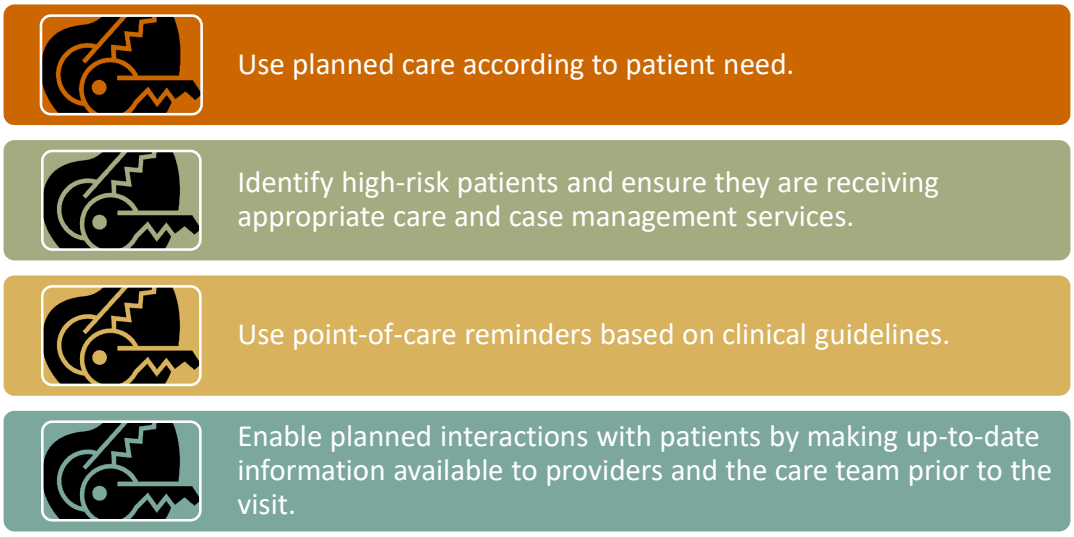
Team-based care is one of the most important and difficult changes to make in practice. It is the only real way to ensure patients get all the preventative and chronic care they need. Coaches can do a lot to support team-based care in practices, but it has to be something that clinical teams want to do.

Create will and confidence for team-based care by:

- Connecting clinical practices without teams to a practice that does use teams well. Encourage a phone meeting at least—a site visit is even better.
- Finding and sharing as many different models of team-based care as you can. Talk to other coaches to see what arrangements they have seen work in practice and share those ideas with your clinical practices.
- Equipping yourself with knowledge about the regulatory environment in your state. Many practices may not be aware that RNs or MAs in various states have a lot of leeway to take on new roles and responsibilities.
- Watching practice teams in action and in meetings in order to tailor feedback.

Organized, evidence-based care: PCMH practice key changes

15



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

Coach Medical Home: Module 3

The goal of this change concept is to make evidence-based care routine. This is accomplished through both planned interactions initiated by the practice, and through point-of-care reminders which help ensure that every interaction is informed by the clinical needs and wishes of the patient. This means that the availability of up-to-date patient information is key, as well as the care team's ability to review patient data before the visit and communicate via team huddles or other formats to work efficiently as a unit and maximize the value of each interaction.

Organized Evidence Based Care Implementation Guide
https://comagine.org/resource/2603

Organized, evidence-based care: Implementation tips

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System changes that improve clinical performance	Care management is a major part of organized, evidence-based care

• 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.
	• 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.

Coach Medical Home: Module 3

Care management is an area of great interest because it has the potential to reduce utilization and costs for insurance companies and large employers. Some PCMH initiatives sponsored by health plans even offer funding to support a care manager, so be sure to understand if this is available in your community. Note that for practices pursuing NCQA recognition, this is a must pass element.



Coaches can help:

- Introduce the care management role—many practices will not be familiar with it.
- Encourage teams to try out small changes in these areas—like trying to do outreach to bring in patients with chronic illnesses—and then revisit them to go deeper. For example, they might explore how a nurse care manager could help a team manage the complex chronically ill.
- Provide examples of early, easy changes for teams to make to their clinical care.
- Help trouble-shoot electronic health records to enable the team to have up-to-date information about each patient at the point of care.
- Link practices thinking about care management with job descriptions, stories, and tools from other sites that have done something similar.

Patient-centered interactions: PCMH practice key changes

17



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

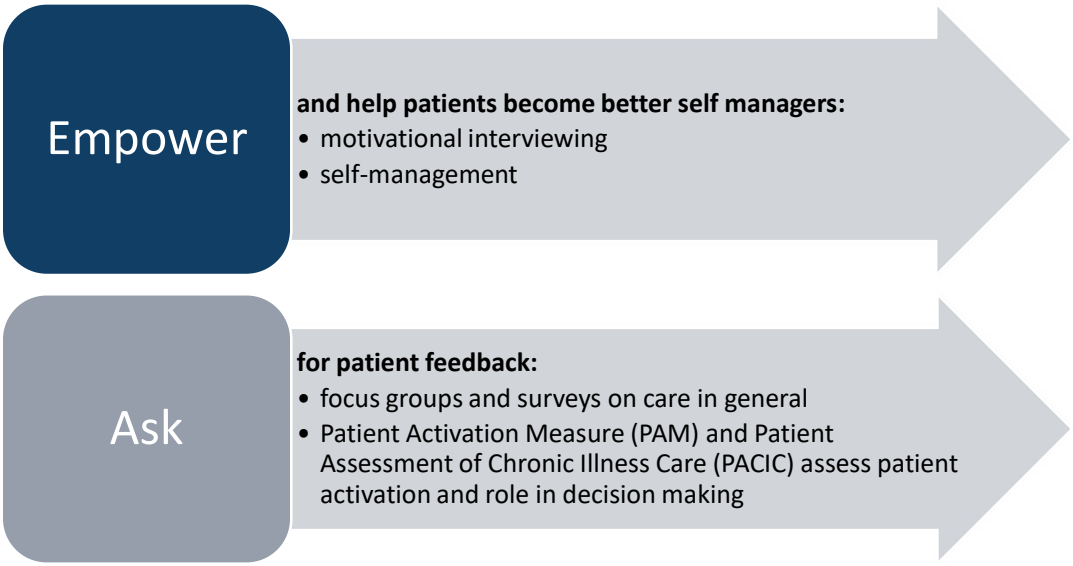
Coach Medical Home: Module 3

The previously presented change concepts set up the structures and teams to make good patient-provider relationships possible. The patient-centered interactions change concept provides tools on how to change the interaction for the better.

Patient-Centered Interactions Implementation Guide
https://comagine.org/resource/2603

Patient-centered interactions: Implementation tips

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

Coach Medical Home: Module 3

Coaches can advise on self-management support and motivational interviewing:

- Providers may not be trained in collaborative, empowering self-management support. Help identify team members with this knowledge and training opportunities.
- Motivational interviewing elicits what is important to patients. Identify motivational Interviewing and other related self-management counseling approaches available to your providers. This is a great skill to develop as a coach as well! Just like teams use motivational interviewing with patients, coaches use motivational interviewing to help teams change their behavior.

Also emphasize the importance of patient feedback:

- There are a tremendous number of surveys available for practices to use in getting feedback from patients and families about their experience – from long formal research-based tools, to short, one-question surveys. Though formal surveys can be helpful, they can also be time consuming and the data generated may not be sufficiently specific for teams to use in improving care.
- Consider encouraging teams to start with hosting an informal focus group to get patients' opinions, or station someone in the waiting room or after visits to ask patients what could be improved. **Getting teams to try something easy and find success is more important than using the 'right' tool or survey.**

Motivational interviewing for clinicians

Self-management toolkit for clinicians

Self-management cycle

Enhanced access: PCMH practice key changes

19



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.

Coach Medical Home: Module 3

Enhanced access refers to expanding patients' and family members' options for interacting with their health care team, including opportunities for in-person visits, after-hours care, phone calls, emails, and other services. Enhanced access requires flexible appointment systems that can accommodate customized visit lengths, same-day visits, scheduled follow up, and multiple provider visits. The Enhanced Access Change Concept expects that a patient's health care coverage is viewed as a shared responsibility to be addressed by the patient and an assigned member of the care team.



Enhanced Access implementation Guide
https://comagine.org/resource/2613

Enhanced access: Implementation tips

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

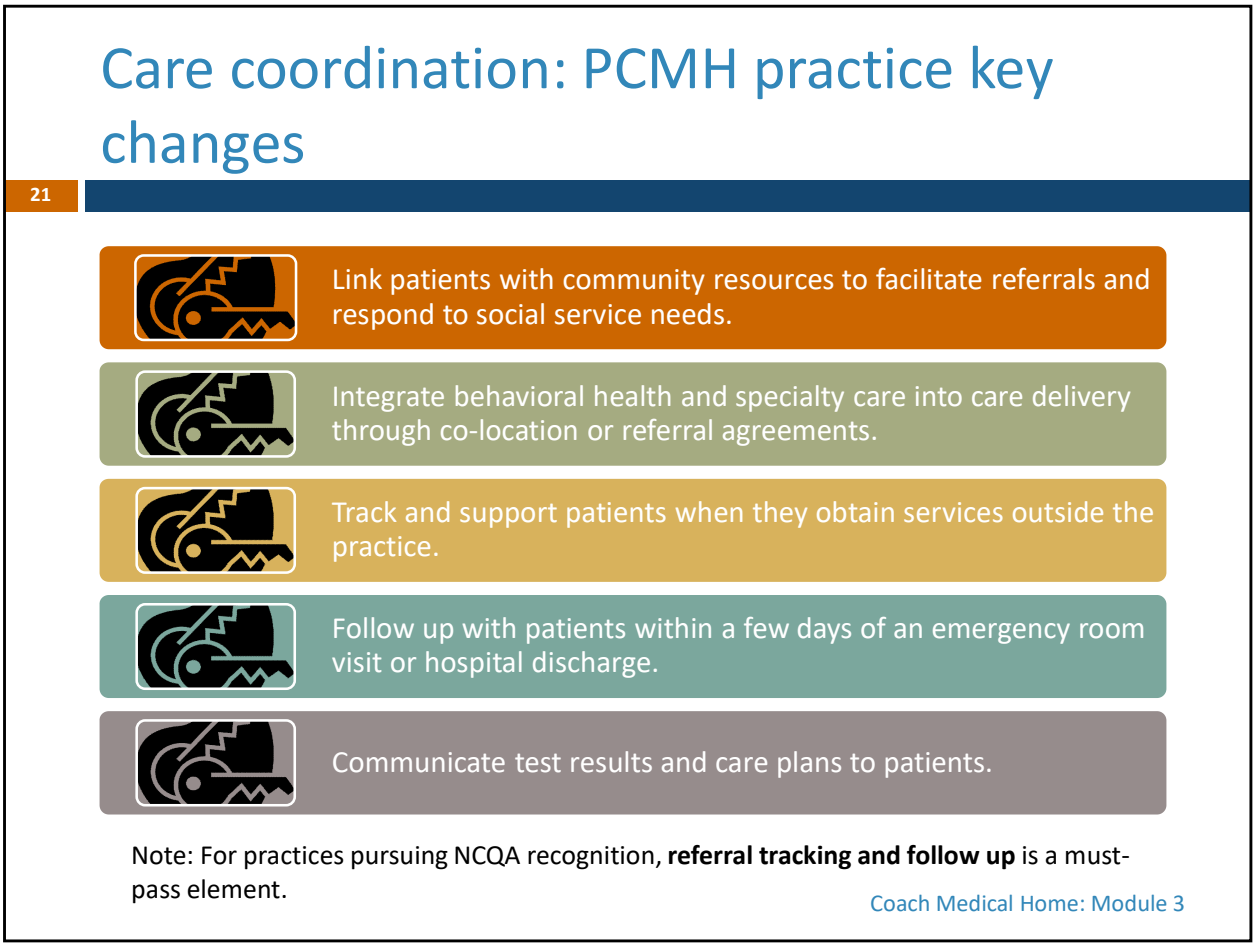
Improving access means different things to different people	Solicit team and patient input on what matters most
• In-person visits during regular business hours (for example, same day access)? • Phone or email communication? • After hours care?	• For patients, likely to mean ensuring a way to get care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

Coach Medical Home: Module 3



A coach can really help in focusing the team's efforts implementing this change concept.

- Work with your teams to be clear on what element of access they most want to improve.
- Encourage the practice to also ask patients. Ongoing patient involvement can make the difference between interventions that are well received and those that aren't.
- Redesigning scheduling impacts staff and patients almost immediately.



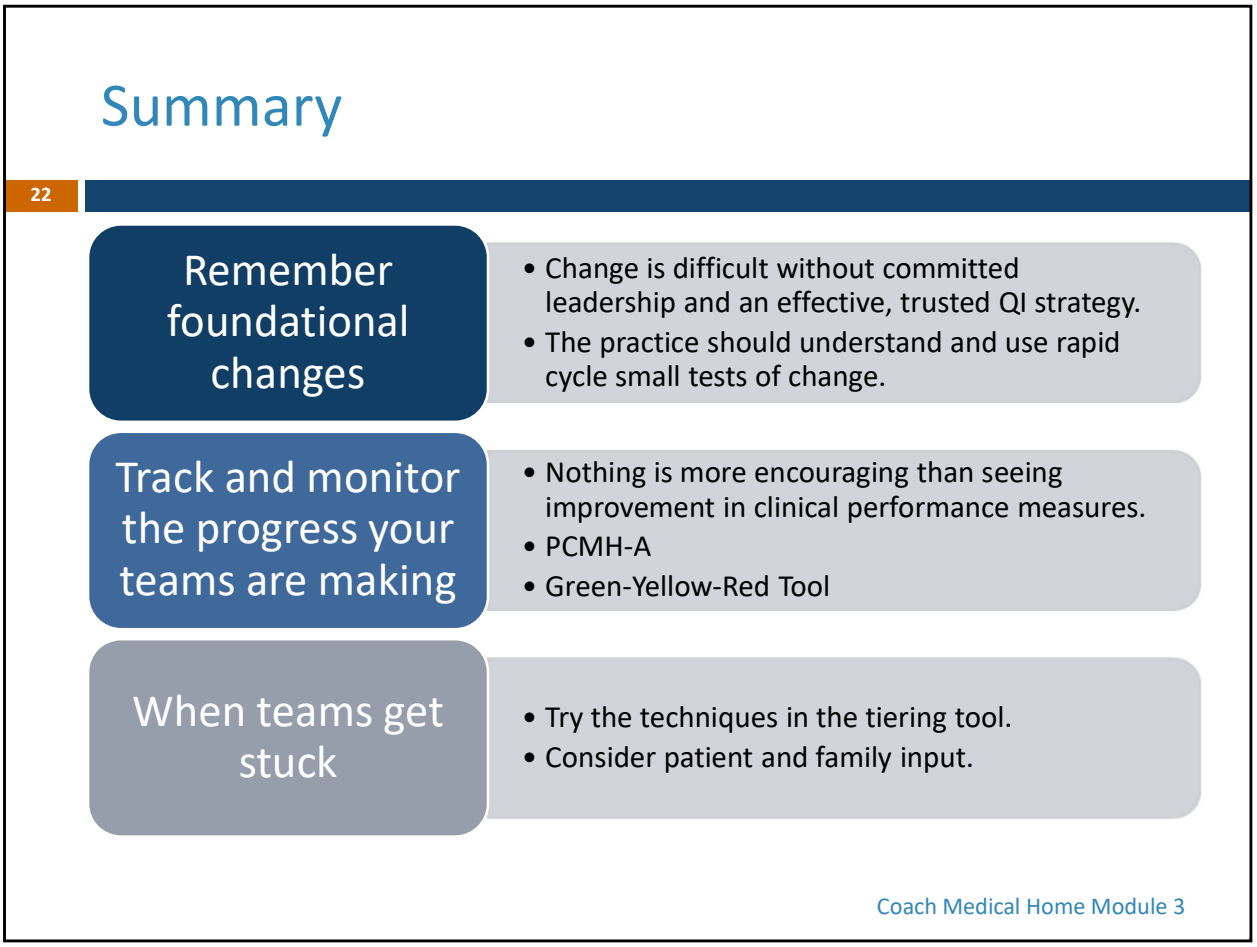
The goal of this change concept is to make the primary care practice the hub of all relevant activity. Care must be coordinated not only within the practice, but with community settings, labs, specialists and hospitals. **The responsibility of the PCMH is not just to be informed by community providers and resources, but to reach out and connect with them**. There are a variety of ways to ensure coordination of care, from co-location with the practice, to protocols and standardized referrals. This work is especially challenging in safety net settings.

Help teams to think judiciously about which relationships they want to improve:

- Which specialists or hospitals do they work with most often, or who cause them the greatest headaches.
- Patient input helps focus the team's attention on relationships that matter most.
- Coaches may be able to facilitate introductions between primary care and specialists, hospitals, or plans that can provide the primary care team with data about admissions, discharge plans, and other important clinical information.
- Clinical teams located in tight-knit, rural communities may be less challenged by care coordination issues than those located in large urban areas because folks are less likely to know each another.

Care Coordination Implementation Guide https://comagine.org/resource/2621

This is a relatively new area, and the tools and expertise are still developing. In addition to the SNMHI Care Coordination Implementation Guide, identify colleagues working on similar initiatives and seek to understand what's working for them.



In summary, this module has provided an overview of the following:

- As indicated in Module 1: Getting Started, practices that are unstable (e.g., high staff turnover, sloppy financial systems, partially implemented EMR) will have greater difficulty changing care systems. They may benefit from specific assistance (e.g., an IT or practice-management consultant) to remedy these core issues. Improving leadership and QI strategy should be an early priority for transformation efforts. The engaged leadership and quality improvement strategy implementation guides provide relevant information and tools.
- A major reason that practices involved in transformation efforts fail to make progress is that they never start or stop testing changes. Practice facilitators should use tools like the Key Activities Checklist to monitor the nature and extent of practice change actually taking place.
- Nothing motivates practices more than seeing progress. But when teams do get stuck, you can use the tiering tool. Also, remember to focus on the long-term goal of improving patient outcomes and work life for providers.