Safety-Net Clinics Try Out the Patient-Centered Medical Home Concept: Lessons from Kansas City

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The president and CEO of a Midwest health foundation relates what she and colleagues have learned thus far from its initiative.

Five years ago, the REACH Healthcare Foundation hosted a day-long forum in Kansas City, Missouri, for local safety-net health care providers on a concept that was then relatively new to us and to many other health grantmakers—the patient-centered medical home. Melinda Abrams, vice president, Patient-Centered Coordinated Care at the Commonwealth Fund, traveled to Kansas City to talk about medical home start-up programs and Commonwealth's experience in advancing the medical home model of primary care.

Approximately seventy individuals, from hospital and clinic directors to physicians and other allied health professionals, participated in our 2007 forum. Most were unfamiliar with the concept of a medical home; many were skeptical that a model being tested in private practices could work in a safety-net environment. Their concerns included limited staffing, outdated records systems and inadequate technical support, and lack of reimbursement for services beyond direct care. Few people who attended the forum that day had a clear sense of how this work would help their practice and improve patient health outcomes.

Today, we have a different story to tell about our region's safety-net clinics. The patient-centered medical home movement is alive and thriving in the Kansas City region. Our foundation cannot take credit for this health care movement, but I'd like to think we played a small part in introducing the concept of medical home into the vernacular of our local market.

A few months after the foundation's medical home forum, we launched an initiative to introduce safety-net clinics to the patient-centered practices advanced by the National Committee for Quality Assurance (NCQA), Our initiative started with four clinics and now involves eight that span the Kansas and Missouri bi-state metropolitan area. There is tremendous variety in our initiative participants: they include nurse-led clinics, free clinics, pediatric care clinics, federally qualified health centers (FQHCs), and other configurations. Working with a consulting team from Qualis Health, we have taken an approach that centers

on providing assessment, tailored technical assistance, and coaching to help clinics adopt NCQA standards associated with patient-centered care.

Instead of setting up a competitive grant process, we reached out to clinics that the foundation was already funding and that had shown interest in the tenets of patient-centered care. The foundation didn't offer grant support; instead, it offered ongoing, onsite technical assistance and the chance to be part of a learning collaborative to help clinics reconfigure their operations.

Early interest in the initiative by clinics was mixed at best. Some participated because they thought it would help their business model evolve and become more sustainable in a time of uncertainty over what health reform might bring; others likely decided to join in order to satisfy a funder.

Some of our key community health leaders (longstanding clinic directors and community health providers) were more direct: They said that safety-net clinics could not and would not become medical homes. Furthermore, why undertake the work if there are no financial rewards for changing their practices?

As is often the case, the reality lay somewhere in the middle. We now know that safety-net clinic providers, whether they are FQHCs, FQHC look-alikes, or free clinics, can implement medical home standards. Over the past eight months, three of the eight clinics in our initiative have achieved Level III NCQA recognition, the top tier of recognition for patient-centered care, and another has achieved recognition at Level I. Patient waiting lists at these clinics have been reduced with improved scheduling and better office flow; patient communication has improved; patients are matched consistently with health care teams; and health outcomes are being measured and tracked.

We have learned some lessons about the challenges. For example, clinics that rely heavily on volunteer medical providers have an especially difficult time with empanelment, the assignment of patients to particular providers to better manage treatment protocols and monitor patient outcomes. Simply put, it's difficult to track progress toward treatment goals if the patient cannot expect to see the same person when he or she accesses care. Also, adopting electronic medical records systems takes time, money, and expertise—resources that can be in short supply in safety-net settings.

Our early skeptics were correct that money matters and tends to drive practice management changes more quickly than any other factor. Medicaid and other payment reforms that provide incentives for care coordination and other medical home practices that aren't typically reimbursed remain elusive in Kansas and Missouri, where we work. However, even though policy leaders in our two states stand firmly opposed to federal health reform, there is interest among some government leaders and insurers in incorporating components of the medical home model as part of their bigger interests in reforming Medicaid and controlling spiraling health care costs. While the clinics in our initiative aren't receiving differentiated Medicaid or other payor reimbursements for their practice changes, they will be ahead of their private-practice peers if and when those payment reforms are adopted.

In assessing this foundation venture, our board of directors and staff see a positive return on investment. Following the NCQA standards and engaging an effective technical assistance

team has allowed us to track outcomes and see results. Furthermore, as clinics have pursued their medical home goals, we have seen an increasing openness to rethinking practice models that were in many cases decades old.

This experience has also influenced the REACH Foundation's grant-making strategies—for example, we particularly see the value of funding leadership development, business operations, program design, and general operating support for safety-net health clinics. In addition, the foundation's work in the patient-centered medical home model has increased our comfort level with engaging in state health policy discussions about support for the safety-net system, the benefits of integrating oral health care and mental health services with primary care, and Medicaid reform.

The patient-centered medical home model is not the sole solution to our fragmented system of health care. But it does offer a compelling framework by which safety-net clinics can approach quality improvements, manage their scarce resources, and strengthen their impact on the health of vulnerable populations. That's what health philanthropy is all about.

Editor's notes:
See a February 13 GrantWatch Blog post by Tom David: "What in the World Is a Health Home?"
See "Tool Used to Assess How Well Community Health Centers Function as Medical Homes May Be Flawed," by Robin M.A. Clarke of the University of California, Los Angeles, and colleagues, Health Affairs, *March 2012.*
Watch for the September 2012 issue of Health Affairs: *a thematic issue on payment reform.*