WHITE PAPER

The Journey Towards the Patient-Centered Medical Home

The Kansas City Experience

March 13, 2014

Advancing Healthcare
Improving Health

BACKGROUND

This white paper was prepared to disseminate the learnings from the REACH Healthcare Foundation Medical Home Initiative to the broader health community as primary care practice is redesigned to adopt the patient-centered medical home (PCMH) model of care. It examines the journey of nine safety net primary care clinics in Kansas City as they strive to integrate components of patient-centered care into their daily work.

The Medical Home Initiative was funded by the **REACH Healthcare Foundation** in Kansas City. For further information, contact Brenda Sharpe, President & CEO of the REACH Healthcare Foundation at (913) 423-4196 or via email at Brenda@reachhealth.org.

PARTICIPANTS INCLUDE:

Missouri Clinics

1) Cabot Westside Health Center
2) Kansas City CARE Clinic (formerly KC Free Health Care Clinic)
3) Samuel U. Rodgers Health Center
4) Sojourner Clinic

Kansas Clinics

1) Children's Mercy West
2) Duchesne Clinic
3) Health Partnership Clinic of Johnson County
4) Silver City Health Center
5) Turner House Children's Clinic

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INTRODUCTION

Background

The REACH Foundation's interest in patient-centered medical care and the medical home movement stemmed directly from the foundation's mission: *To inform and educate the public and facilitate access to quality healthcare for poor and underserved people.* After making significant program and core operating grant investments in the Kansas City region's primary care safety net clinics in the foundation's first three years of grantmaking, 2005-2008, REACH staff noted the considerable variation among its grantee clinics in terms of organizational capacity, staffing, availability of services, utilization of health information technology, and commitment to quality improvement and patient-centered care. Recognizing that nonprofit clinics seldom have the financial resources to engage high-quality practice transformation consultants, and with a desire to advance consistency across the safety net health care delivery system, REACH invited its grantee clinics to participate in the PCMH initiative. Rather than provide individual grants to individual clinics to engage a consultant, REACH staff contracted with an expert technical assistance provider to work with the participating clinics individually and in group settings.

During the planning stages of the Medical Home Initiative, the REACH Foundation executives identified a number of key drivers, resources, and emerging models that motivated them to explore options supporting a more optimal, coordinated health care framework. The leaders at the REACH Foundation became aware of the PCMH movement while following the work of The Commonwealth Fund's Safety Net Medical Home Initiative (see below), which launched its planning year in 2008, followed by four years of technical assistance to 65 primary care safety net sites in five states. PCMH initiatives were novel then, but the concept gained momentum through the applied work of early adopters in that timeframe. The key drivers of the REACH Medical Home Initiative are also excellent resources for others interested in learning more about the topic. They include:

- **Safety Net Medical Home Initiative:** From 2008 to 2013, Qualis Health and the MacColl Center for Health Care Innovation at the Group Health Research Institute directed a 5-year initiative to help 65 primary care safety net sites in five states (Oregon, Idaho, Colorado, Massachusetts, and Pennsylvania) become high-performing patient-centered medical homes (PCMHs) and achieve benchmark levels of quality, efficiency, and patient experience. The goal of the Safety Net Medical Home Initiative was to develop and demonstrate a replicable and sustainable implementation model for medical home transformation. The initiative called for partnerships between safety net providers and community stakeholders to work together towards a new model of primary care delivery that is recognized and rewarded for its holistic approach to patient care. Keenly aware that policy activation is critical in this transformation, the partners in this initiative were active participants in Medicaid and other policy reform efforts in their respective regions. The initiative was sponsored by The Commonwealth Fund in New York, long recognized as a thought leader in healthcare research, policy and practice. The REACH Foundation first became aware of this initiative when the two primary care associations in their catchment area (Kansas Association for the Medically Underserved [KAMU] and the Missouri Primary Care Association) expressed interest in participating and solicited letters of reference in support of their applications. http://www.safetynetmedicalhome.org

- **"Closing the Divide: How Medical Homes Promote Equity in Health Care—Results from the Commonwealth Fund 2006 Health Care Quality Survey".**[1] Key points from this research in health care quality include: 1) most disparities in health care disappear when patients have a medical home; 2) safety net clinics—clinics that serve the most vulnerable members of society—are less likely than private doctors' offices to have indicators of a medical home.

- **The Joint Principles of the Patient Centered Medical Home:** In 2007, the leading primary care medical associations (the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Physicians, and the American Osteopathic Association) released the *Joint Principles of the Patient-Centered Medical Home.* [2] This collaborative defined the PCMH as an approach to providing comprehensive primary care for children, youth, and adults in a healthcare setting that facilitates partnerships between individual patients, their providers, and, when appropriate, the patient's family. According to the *Joint Principles*, a PCMH has the following characteristics:

  - Patients have a continuous relationship with a personal physician in a physician-directed practice.
  - The practice has a whole-person orientation.
  - Care is integrated and coordinated.
  - Quality and safety are hallmarks.
  - Enhanced access to care is available through systems and new communication options.

The *Joint Principles* also address the importance of a payment system that provides appropriate incentives and reimbursement for care provided in PCMH practices.

- **National Committee for Quality Assurance (NCQA) Patient Centered Medical Home Recognition Program:** NCQA's Patient-Centered Medical Home (PCMH) is an innovative program for improving primary care. In a set of standards that describe clear and specific practice operations criteria, the program gives practices information about organizing care around patients, working in teams and coordinating and tracking care over time. The NCQA Patient-Centered Medical Home standards strengthen the practice operations by emphasizing the importance of the partnerships between individual patients and their personal care providers and, when appropriate, the patient's family. Operational characteristics are defined to ensure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner. Clinical care is facilitated by information technology, condition-specific registries, and health information exchange. NCQA launched its first set of PCMH standards in 2008, revisions in 2011, and is currently considering a new set of revisions to be released in 2014. www.ncqa.org

- **National Academy for State Health Policy (NASHP):** Since the release of the Joint Principles of the PCMH in 2007, and with support from The Commonwealth Fund, NASHP has been tracking and supporting state efforts to advance medical homes for Medicaid and CHIP participants. As of April 2013, 43 states have adopted policies and programs to advance medical homes. Medical home activity must meet the following criteria for inclusion on NASHP's map: 1) program implementation (or major expansion or improvement) in 2006 or later; 2) Medicaid or CHIP agency participation (not necessarily leadership); 3) explicitly intended to advance medical homes for Medicaid or CHIP participants;

and 4) evidence of commitment, such as workgroups, legislation, executive orders, or dedicated staff. www.nashp.org

Community clinics are well-poised to meet the nationally adopted standard of care for high-performing patient-centered medical homes.

The Medical Home Initiative in Kansas City centered around a diverse group of safety net clinics in the metropolitan area; these health care entities cover the spectrum of business operating models, from free clinics to academic-affiliated health centers, to one health center with federally qualified health center (FQHC) designation. This paper documents the journey of Kansas City area safety net clinics and details their significant action steps towards patient-centered care. Early published literature about the adoption of the PCMH model cast a doubt that the safety net health care providers could be successful.[3] The Kansas City Medical Home Initiative experience demonstrates the opposite—that community clinics are well-poised to meet the nationally adopted standard of care for high-performing patient-centered medical homes.

Focus on the Safety Net

The REACH Foundation includes in its core values a commitment to strengthening the Kansas City health care safety net as essential providers of care to the uninsured and underinsured populations in the region.

The safety net system provides essential healthcare services to vulnerable populations: low-income populations, minorities, young children and the elderly, and those who live in medically underserved areas. For the purposes of this initiative, safety net providers are those who:

- Organize and deliver a significant level of health care and other related services to the uninsured, Medicaid, and other low-income populations.
- Either by legal mandate or explicitly adopted mission to maintain an "open door," offer access to services for patients regardless of their ability to pay.
- Provide comprehensive primary care services.

Key characteristics of the safety net population include:

- They have fewer access points to the healthcare system.
- They are more likely to delay primary or preventive care, leading to increased hospitalization, longer hospital stays, and worse health outcomes.[4] A longer wait time for primary care services is also associated with higher mortality.[5]
- They come into the health care setting sicker, and with higher acuity levels, than patients seen in private practice.

Over the last two decades, there has been much emphasis on recognizing and reducing disparities in health care. The federal government implemented the National Health Disparities Collaboratives in the 1990s, with a goal of delivering a chronic care management model that would enable safety net providers to implement processes and improvement strategies to eliminate these disparities. The enhanced access focus on the patient-centered medical home model has shown that racial and ethnic differences in access and receiving preventive care disappear with equal access to a medical home, and that these disparities are reduced for families who can identify their primary care provider.[6]

There are many barriers faced by safety net providers as they strive to deliver care to an underserved population. Access to specialty care presents an enormous

challenge for most clinics/health centers/private practices that see Medicaid and uninsured patients. Public hospitals and health systems are often the safety net's best option for specialty care, but there is never enough supply to meet the demand.

The reimbursement models of today's health care system are inadequate to support the PCMH model, which has at its core a robust care management team which, when working effectively, will reduce ambulatory-sensitive emergency department visits and hospitalizations/re-hospitalizations as well. Health care settings must apply significant human resources to the tasks of financial and eligibility screening as required by all payor sources, each of which has its own eligibility criteria. In many cases, a sliding fee scale can be offered to the patient, resulting in an individual share of cost, which must be managed and updated annually. In addition, patients fall in and out of eligibility for a variety of reasons, requiring intensive follow-up by health center staff to mitigate the churn rates associated with enrollment/ disenrollment from Medicaid and state CHIP programs in order to maintain a fluid revenue stream. The PCMH Joint Principles clearly mark out the structure and rationale for the need for reimbursement reform, which calls for a payment model that appropriately recognizes the added value provided to patients who have a patient-centered medical home.[7]

The PCMH model—with its well-coordinated services, evidence-based care, and enhanced access to a clinical team—aligns with the Institute for Healthcare Improvement's Triple Aim and holds promise for improving clinical quality, improving patients' experiences, and reducing healthcare costs system-wide.[8] As such, all Americans would benefit from access to a patient-centered medical home. But a medical home is especially important for those who struggle with language barriers, multiple chronic conditions, barriers to access, and other issues that make improved communication and coordination particularly critical elements of effective care.

There are a number of other PCMH initiatives underway in the states of Kansas and Missouri. Some of the participants in the REACH Medical Home Initiative are also members of PCMH collaboratives and gain support of additional coaches for their transformation work and applications to the National Committee for Quality Assurance (NCQA) for formal PCMH recognition. Each initiative has its own design, criteria for participation, curriculum, and a variety of training modalities. These initiatives are detailed in Appendix 3.

PROJECT DESIGN

The project design was a collaborative effort between the Qualis Health consulting team and the REACH Healthcare Foundation. The REACH Foundation solicited input from the safety net clinics most likely to participate in order to assess their understanding of the PCMH Model, their self-assessment of readiness to begin the transformation effort, and their priorities for operational improvements. The core content areas for practice transformation followed the Joint Principles of the Patient-Centered Medical Home as well as the NCQA PCMH standards and intent, incorporating best practices in key content areas into the training curriculum. The project was designed to enable and support the clinics in their redesign and transformation work as a priority of the REACH Foundation. Through the course of the Initiative, the REACH Foundation encouraged all of the participating clinics to pursue transformation work with an eye towards formal application for NCQA PCMH recognition. Since 2007, the REACH Foundation has invested more than $1.5

million dollars in the Medical Home Initiative. For the four years of the initiative presented in this document, the foundation invested more than $1.1 million in support of eight clinics. [Note: the number of participating clinics fluctuated due to individual clinic readiness and circumstances from year to year.]

Understanding the PCMH Model of Care

The PCMH Model of Care is at the center of the healthcare reform movement in the United States. This model of care delivery places the responsibility of comprehensive, coordinated care in the hands of the primary care provider. Patient safety and quality of care are hallmarks of the model, and require the direct attention of a care team and care coordinator to understand the patient's healthcare needs, engage the patient in healthcare decision-making and self-management, and guide and follow the patient between healthcare venues.

Inherent in the care coordination effort is a shared commitment to and responsibility for population health management. Primary care practices must implement evidence-based guidelines and quality improvement strategies to ensure that subpopulations at risk are identified, standards of care are implemented, and patients are engaged and informed. Consistent follow-up and outreach strategies are deployed to ensure that patients receive the care that they need to optimize their health status.

Readiness Assessments

At the outset of the Medical Home Initiative, the participating clinics were required to complete a scored self-assessment using a tool based on the six domains of the NCQA PCMH Standards. The initial assessment established a baseline for each practice site, as well as provided aggregate data by which to compare the technical assistance needs across sites and develop a curriculum that would be responsive to the needs of the group and sequenced in the appropriate order. These semi-annual self-assessments were repeated by all participants through Year 3.

2011 NCQA PCMH Standards	
PCMH 1: Enhance Access and Continuity	A. Access During Office Hours B. Access After Hours C. Electronic Access D. Continuity E. Medical Home Responsibilities F. Culturally and Linguistically Appropriate Services (CLAS) G. Practice Organization
PCMH 2: Identify and Manage Patient Populations	A. Patient Information B. Clinical Data C. Comprehensive Health Assessment D. Using Data for Population Management
PCMH 3: Plan and Manage Care	A. Implement Evidence-Based Guidelines B. Identify High-Risk Patients C. Manage Care D. Manage Medications E. Electronic Prescribing
PCMH 4: Provide Self-Care and Community Support	A. Self-Care Process B. Referrals to Community Resources
PCMH 5: Track and Coordinate Care	A. Test Tracking and Follow-up B. Referral Tracking and Follow-up C. Coordinate with Facilities/Care Transitions

2011 NCQA PCMH Standards	
PCMH 6: Measure and Improve Performance	A. Measures of Performance B. Patient/Family Feedback C. Implements Continuous Quality Improvement D. Demonstrates Continuous Quality Improvement E. Performance Reporting F. Report Data Externally

Baseline data showed the expected variation, both in areas of strength and in total scores. These baseline numerical scores were not a true reflection of the clinics' current operational state, due in part to: 1) the lack of full understanding of the intent of the NCQA standards, 2) the self-report data collection method in which the tools may have been over-scored or under-scored by the clinics' PCMH teams, or 3) a limited data collection effort conducted by the PCMH lead or executive officer responding to the survey questions in solo. Subsequent assessments (every six months for 3 years) were validated by interview with each respective PCMH team in order to more accurately mark progress.

The baseline self-assessment was used as a conversation starter as the technical assistance work was initiated with each participating clinic. The Qualis Health consulting team spent 3-4 hours on-site with each clinic, in direct observation of patient flow, interview of key staff, and utilization of the practice management system and medical records (either paper or electronic). Each clinic was evaluated based on their current state and reviewed against the NCQA PCMH framework in order to obtain a gap analysis.

Individual gap analysis reports were written for each clinic, and a customized technical assistance plan was collaboratively built with the clinic's PCMH team that was responsive to their current operational state, self-declared problem areas, existing performance improvement initiatives, and organizational goals.

Synthesis of the gap analysis data (see Appendix 2) allowed the Qualis Health team to design a group technical assistance curriculum that would meet the clinics "where they are" at baseline, responding to the most acute needs first and folding in other components in a logical sequence. These data revealed that access strategies, aspects of care management and care coordination, and QI program development and implementation would require a significant amount of attention throughout the project.

Technical Assistance Roll-Out

The table below illustrates the key focal areas during the respective years of technical assistance through the REACH Medical Home Initiative.

TECHNICAL ASSISTANCE	Year 1	Year 2	Year 3	Year 4
Anchoring the Medical Home Standards		✓	✓	✓
Empanelment / Access		✓	✓	
Scheduling Models / Access	✓	✓		
Team-Based Care & Care Management	✓	✓	✓	✓
Process Improvement / Quality Improvement	✓	✓	PERC	✓ plus PERC
HIT & Meaningful Use		✓	✓	
Nurse Leadership Focus		✓	✓	

TECHNICAL ASSISTANCE	Year 1	Year 2	Year 3	Year 4
Medical Assistant Skills Enhancement			✓	
Leadership Challenges in the PCMH			✓	✓
Integration of Behavioral Health			✓	✓
NCQA PCMH Application Support		✓	✓	✓
Staff Engagement / Board Engagement		Upon request	Upon request	Upon request
On-Site Consultation	Monthly	Monthly	Bi-Monthly	Quarterly

Year 1: During this inaugural year, the Qualis Heath technical assistance consulting team introduced group workshops in PCMH content areas and conducted a workshop on Lean process improvement. This was complemented by individual clinic-level technical assistance. Recognizing that each of the participating safety net clinics had been the recipient of multiple levels of consulting assessment and advice, the Qualis Health team focused on operational details, synthesizing many consultative recommendations into a comprehensive list aligned with the PCMH model. The technical assistance program introduced the NCQA PCMH standards in this year, but did not specifically tailor the training to these standards, desiring a more global approach to improved practice operations, leadership engagement and quality improvement protocols.

Year 2: Workshops during this year involved a deeper dive into PCMH core content areas, again supplemented by monthly individual clinic-level technical assistance. A special staff training was developed and delivered to most of the clinic staffs, and in some cases to their boards of directors, about the PCMH model, its importance in the national landscape of health care reform, and the roles and responsibilities of respective staff members. Additional group workshops were conducted for nurse managers in preparation for expanded roles in team-based care and to introduce these key staff members to population health management concepts and use of condition-specific registries. Each clinic PCMH team selected three clinically important conditions to follow and began to populate registries to enable outreach, monitoring and follow-up.

Year 3: Further group workshops with expanded team interactions were conducted on core content areas. Individual, on-site, clinic-level technical assistance was modified to a bi-monthly schedule, supplemented by interim telephonic support. In lieu of a workshop on quality improvement, the PERC (PCMH Effectiveness Reporting Collaborative, described in a later section in this report) was launched. Clinics were coached to integrate the PERC metrics into their existing quality improvement programs.

At the close of Year 2, it was noted that the clinics were struggling with the formation of patient care teams, largely due to varying levels of trust in the skills of the clinical support staff. The evaluative literature on the effectiveness of the PCMH model suggests that clinical care improves and costs decrease when team members other than the primary care provider help to meet patient need; similarly, process of care improves when the collective clinical expertise of the team improves.[9]

In response to this need, the Qualis Health team offered additional group trainings for medical assistants in preparation for expanded roles in team-based care. The 3-day Medical Assistant Training is summarized in the table that follows.

REACH Medical Home Initiative MA Skills Building Sessions		
DAY 1	**DAY 2**	**DAY 3**
Introduction to Training Program/PCMH Concepts	Assisting Patients with Limited Mobility	Team-Based Care
Vital Signs	Preventive Care Guidelines	Team Dynamics & Conflict Resolution
Infection Control	Coaching Patients for Self-Management	Customer Service/Phone Etiquette
EKGs	Lab Testing	Triage and Telephone Advice: The MA Role
Immunizations	Medication Safety	Innovative Care Models

Year 4: During the fourth year of technical assistance, a group training on the Integration of Behavioral Health was introduced because of the new NCQA standards which centered on this topic. Three leadership/provider forums were conducted in order to facilitate an inter-clinic dialogue about successes and barriers in integrating the PCMH model overall, establishing team-based care, and implementing a full scope quality improvement program. Quarterly individual clinic-level technical assistance was provided to the participating clinics in their choice of one of the three core areas mentioned above. The PERC Data Reporting Collaborative continued throughout this year.

Discussion: During Year 1, the Qualis Health team discovered that the participating clinics had been exposed to multiple types of consultants (through Rockhurst University, KU Health Partners, and others), and the ensuing reports and recommendations often contained conflicting information. These reports were reviewed in detail, and the respective recommendations were reviewed with each PCMH project team for relevancy and current status.

With this background in mind, the Qualis Health team focused on the alignment of the consultants' recommendations into the PCMH model, giving shape, stability and direction to each individual clinic. Recommendations that were no longer relevant were dropped, and those which had potential to contribute to the organization's successful transformation were folded into the clinics' individual technical assistance plans. These recommendations were folded into the group trainings as well, where appropriate.

The Qualis Health consultants designed the training curriculum carefully, recognizing that the sequencing of changes would be important in that making some changes before others would speed up the transformation process and provide a better platform for sustainability and future improvements**. Empanelment** and **Team-Based Care** were incorporated first, and the program elements built one on the other throughout the project period. Each program contained a focused discussion on leadership requirements and also performance improvement process and/or metrics. The clinic teams were observed to struggle significantly with the concept of empanelment—the act of assigning patients to providers. Some of the challenges presented included practice management systems incapable of supporting the required data fields and reporting criteria, and provider and/or administrator reluctance to move towards an empanelled practice model.

Other practice transformation teams found team-based care difficult to embrace. Early pilot projects have demonstrated that team-based care is most successful

when tasks are matched to skills, credentials and interests; appropriate training occurs; roles are clearly defined; team roles are transparent to patients; team members work at the top of their licensure/legal scope of practice; and cross-training occurs.[10] The primary reason for resistance lay in the providers' lack of trust in the clinical skills of support staff (nurses, medical assistants and others), a scenario commonly encountered as clinics open the dialogue about team formation. This caused a reluctance to allow the clinical support staff to take action based on standard work without the direct order of a provider. Lean staffing models also presented a challenge to this. When a practice has fewer than one medical assistant per provider, there simply are not enough "hands on deck" to manage the patient flow in an efficient manner. Taking these issues into account, and recognizing that the process of care improves when the collective clinical expertise of the team improves, the Qualis Health consulting team designed a series of Medical Assistant Skills Building trainings, which were conducted in Year 3.

Care Management practices, including goal-setting and offering self-management support, were also difficult for some sites to implement. Experts recommend that at least a minimal level of self-management support be provided at every visit, and that self-management support be an ongoing process best performed in the context of multiple clinical interactions.[11] Challenges to this in the Kansas City cohort included the difficulty in hiring nurses to support an effective care management program that would include patient education, chronic disease management, goal setting, and coaching towards improved health status. Some sites were successful in securing the support of the health education department of a local health plan to provide training to staff on condition-specific management (such as for diabetes or asthma). Other issues compounding this component of the PCMH included inadequate HIT systems to support condition-specific registries, lack of personnel to support data entry to populate the registry, and difficulty retrieving panel registry data to enable outreach to patients in need of identified services.

Technical assistance was built around the NCQA PCMH standards, with primary emphasis placed on industry standards and best practices in health center operations. As the evidence base for PCMH transformation evolved, a variety of resources and tools were added to the technical assistance program in the Kansas City project. These included the Change Concepts for Practice Transformation, an evidence-based practice transformation framework developed by Qualis Health and the MacColl Center for Health Care Innovation at the Group Health Research Institute for the Safety Net Medical Home Initiative.[12]

The NCQA PCMH standards were introduced in their entirety in Years 2 and 3 as clinics demonstrated readiness to prepare their applications for PCMH recognition. Of particular note, there is strong overlap between the domains and intent of the NCQA PCMH standards and the Change Concepts for Practice Transformation.[13]

Engagement with Community Partners

It has long been recognized that providing patient-centered care and effective care coordination is not a solo effort. It takes the focus and attention of a network of community partners to build bridges within the care delivery system to adequately and appropriately modify the existing healthcare system into the desired PCMH model. The PCMH emphasizes functional linkages with community organizations and with other healthcare entities such as hospitals, specialists, other service providers, urgent care, etc. Sustained partnership involves developing relationships

that are patient-centered and grounded in local knowledge of the family and community.[14]

The participating clinics developed new relationships—and strengthened existing relationships—with key partners in community health in order to establish systems of care that would support patients as they navigate between health care settings. These partnerships included emergency departments, hospitals, pharmacies, imaging centers, laboratories, specialty care, social services and health education entities.

In addition to the collaboration at the clinic level, the REACH Foundation facilitated other partnerships in support of the PCMH transformation work. These are noted below.

Chronic Care Management Support

Recognizing that the clinic teams needed training on how to support patients with chronic disease, the health education division at Family Health Plan in Kansas City, MO, was called upon to provide condition-specific training to each health center. The educators went to the respective clinics to provide training on motivational interviewing and standards of care for asthma, diabetes and hypertension, at the clinics' request. Family Health Plan also began to provide data on their members with these conditions so the clinics could initiate outreach to engage the patients and bring them into the clinic for needed services.

Culturally and Linguistically Appropriate Services

The REACH Foundation introduced a **Cultural Competency Initiative** in 2009 to increase understanding and practice of cultural competency in health and human service organizations, with a long-term goal of reducing health disparities. The initiative focuses on policies, practices and internal structures that influence cultural competence within organizations. A major component of the initiative is individualized technical assistance to help program managers, organization executives and trustees address internal policies and practices that affect culturally competent services and health outcomes. Several of the participating clinics have received grants from the REACH Foundation to obtain support in this critical area of patient-centered care.

Many of the safety net practices in the Kansas City metropolitan area serve patients whose primary language is not English and require the services of medical interpreters. In an attempt to avoid the less-than-ideal situation whereby a patient's friend or family member serves as interpreter, the REACH Foundation provided scholarships to a **Medical Interpretation Course** sponsored by Jewish Vocational Services in Kansas City, MO. Many health centers made this 40-hour intensive training a requirement for their medical interpreters and medical assistants in order to deliver patient-centered care. Over the course of the initiative, 30 clinical support staff were trained through this program.

Through the REACH Medical Home Initiative, 30 clinical support staff received training in medical interpretation to better serve patients whose primary language is not English.

PROJECT RESULTS

Assessments

The participating clinics conducted periodic assessments using a scored survey instrument based on the NCQA PCMH standards. These assessments measured their progress towards the NCQA PCMH application, and also followed their progress with specific operational elements. The results are noted below.

Operational Element	Baseline	Year 1	Year 2	Year 3
	N = 8	N = 8	N = 9	N = 6
Empanelment / continuity of care goals	0 of 8	1 of 8	4 of 9	4 of 6
Improved scheduling model	---	5 of 8	7 of 9	5 of 6
Use of new patient orientation visit	1 of 8	5 of 8	7 of 9	5 of 6
Available after-hours care	3 of 8	6 of 8	6 of 9	4 of 6
Use of multidisciplinary care teams	1 of 8	7 of 8	7 of 9	6 of 6
Registry use for population management	3 of 8	8 of 8	9 of 9	4 of 6
Use of evidence-based guidelines	3 of 8	9 of 8	8 of 9	6 of 6
EHR system	2 of 8	4 of 8	6 of 9	4 of 6
Full scope QI program in place	4 of 8	8 of 9	8 of 9	6 of 6

Comments: At Baseline and Year 1, there were eight clinics participating. In Year 2 a ninth clinic was added to the collaborative. Three clinics opted not to participate beyond Year 2, leaving an N of six for Year 3.

At the time of publication, two clinics did not have an electronic health record (EHR) system in place. Both of these clinics experienced technology system planning delays within their parent corporations; however, one clinic was especially adept at using their practice management system and chronic disease registry application to enable empanelment, continuity of care, and clinical outcomes improvements. In Year 2, all nine clinics were using registries for population management for at least one clinically important condition. Two clinics were unable to sustain their use of the registry system due to staff shortages, so they reverted to manual chart reviews for data reporting purposes.

The “horse race” diagram that follows shows the clinics’ movement towards NCQA PCMH recognition, with each color denoting a six-month interval assessment. In most cases the progression was linear; however, backsliding was noted by some of the practices. This interesting regression was related to the fact that the PCMH teams gained a stronger understanding of the NCQA PCMH Standards with time, which caused them to downgrade their scores on assessments subsequent to the baseline assessment.

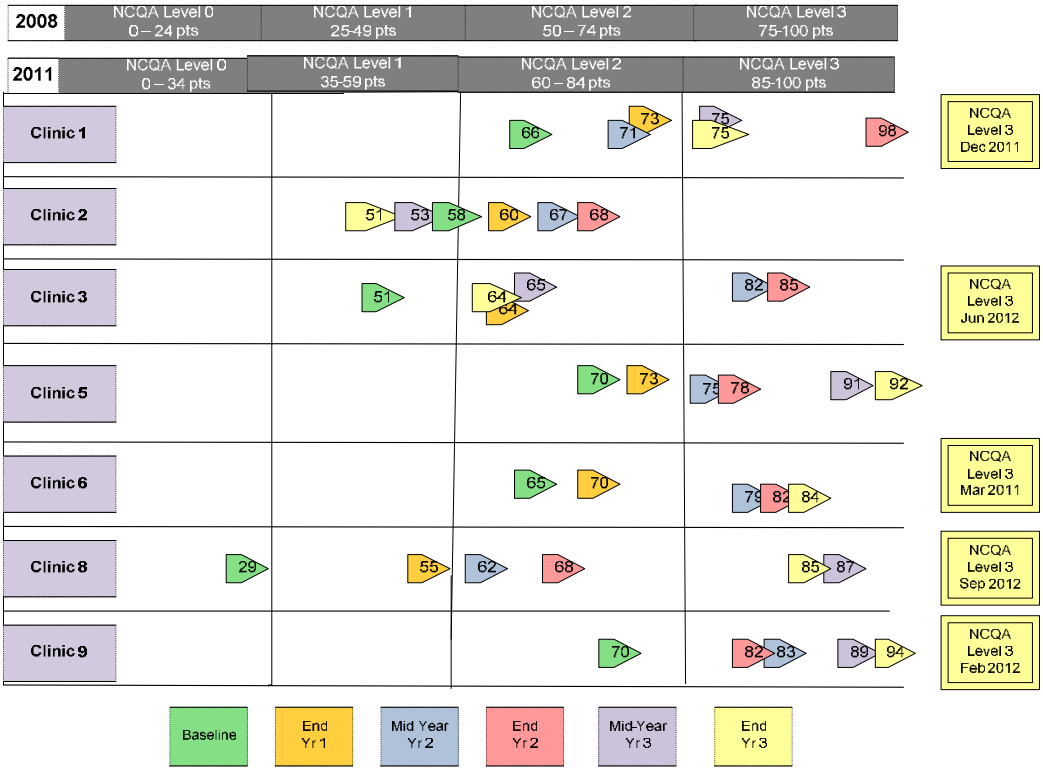
Regarding the NCQA PCMH Recognition trends, the following exceptions are noted:

- Clinic 9 joined the initiative in Year 2; therefore, their baseline was taken at the beginning of Year 2 and there is no score noted at the end of Year 1.
- Clinic 4 discontinued participation at the end of Year 2 and had no plans to proceed with NCQA PCMH recognition. Therefore, they are not represented in this table or in data included in the PERC section.

- Clinic 7, because of its operational model as a medical student and volunteer-led clinic operating one day per week with limited services, was not eligible for NCQA PCMH recognition. Therefore, they are not represented in this table nor are these data included in the PERC section.

The diagram contains scoring increments from both the 2008 and 2011 NCQA PCMH recognition programs. The clinic names have been blinded.

Figure 1 – Scoring Increments



NCQA PCMH Recognition

Five of the REACH Medical Home Initiative clinics made significant progress in the four years of the project that enabled them to successfully submit applications to NCQA. Their achievements are noted in the table above.

Samuel U. Rodgers Health Center submitted their corporate application to initiate their multi-site NCQA PCMH application in June 2013. Duchesne Clinic intends to make application following implementation of an electronic record system. Over the four-year project term, six of the eight eligible clinics have submitted and/or attained NCQA recognition.

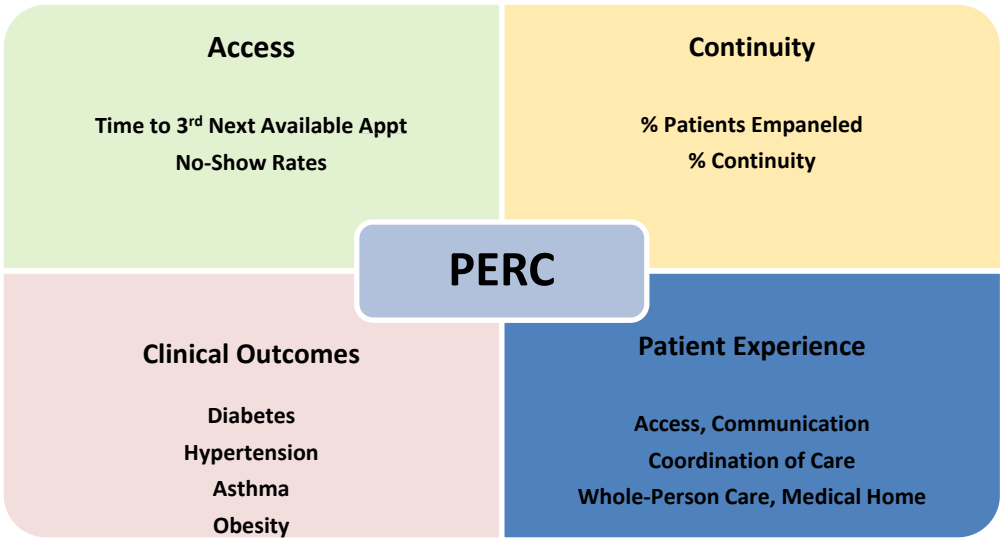
Practices that have a strong operating structure in place are better prepared for, and score higher on, the formal NCQA PCMH application survey. Practices with mature infrastructure components of policies and procedures, job descriptions, health information technology, and an intact quality improvement program are well positioned to meet the criteria. Even in these ideal situations, however, a fair amount of practice transformation and re-design is required to ensure effective team

functioning, HIT functionality (including reporting), and use of data for performance measurement and improvement.

The PCMH Effectiveness Reporting Collaborative (PERC)

In Year 3, the Qualis Health consultants convened two planning sessions for the data reporting activity, known as the PERC (PCMH Effectiveness Reporting Collaborative). Across the United States, PCMH pilots are reporting outcomes specific to patient-centered care. Researchers are recommending metrics in several domains, including access, continuity of care, clinical outcomes, patient satisfaction with care, ED utilization, and hospital admission/readmission. The leadership from the participating clinics reviewed various reporting options and came to consensus around the metrics in the following table. With the exception of Patient Experience, which is reported quarterly, each domain is reported monthly at the clinic level, with the monthly trends reported quarterly to the PERC. PERC data is reported for the six clinics continuing in the REACH Medical Home Initiative in Years 3 and 4.

Figure 2 – PCMH Effectiveness Reporting Collaborative

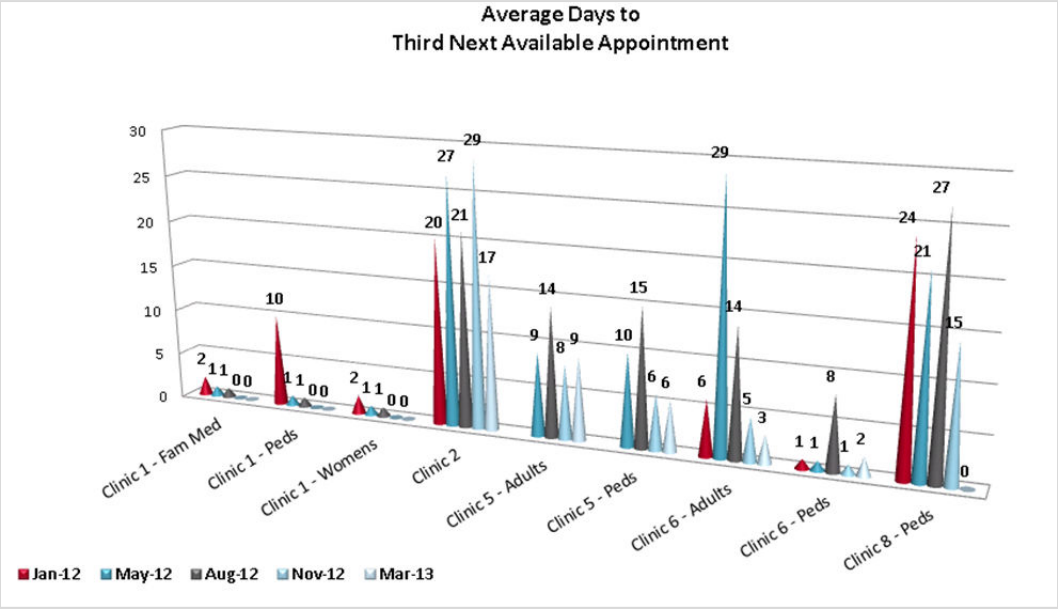


The clinic participants chose Time to 3rd Next Available Appointment and No Show Rates as metrics demonstrating **access** to care.

The Time to Third Next Available Appointment has become the barometer for access to care. The **third next available appointment** is measured in days from today, with a goal of zero days which would indicate ideal access to care. The next available appointment is not measured because it could have resulted from a cancellation today, and thus would not provide a true indication of appointment availability.

Open access appointment scheduling has been proposed as a way to better meet patient needs and has been shown to improve appointment wait time and reduce no-show rates.[15] The participating clinics' progress with this measure is depicted below.

Figure 3 – Time to Third Next Available Appointment



The no-show rate is a general indicator of access and may lead the clinic to improve access by evaluating the reasons for failure to keep appointments. The average no-show rate in community health centers nationally is 30%, in private practice settings of all types 15%.[16] Given the large amount of waste associated with no-shows, clinics should continually strive to reduce no-show events. Data from early PCMH demonstration projects shows that empanelment and implementation of team-based care have a positive impact on the no-show rate, and all of the participating clinics are working to sustain these activities.

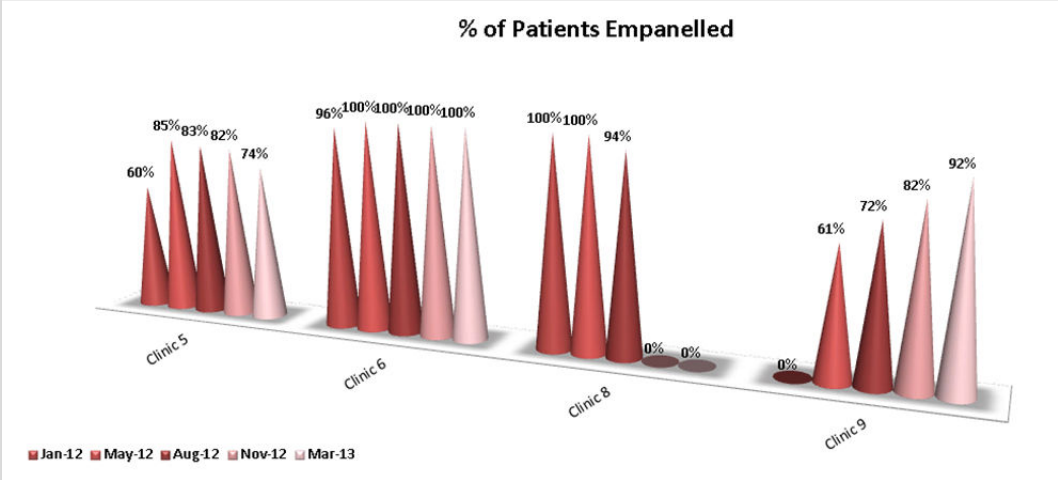
While all of the clinics tracked their no-show rates over the PERC reporting periods, there were determined to be too many influencing variables to draw conclusions from the data. For example, clinics cited issues with provider vacancies (either from turnover or vacation time) and patients on extended holiday to their home countries at predictable times of year. Because these issues could not be mitigated to maintain some level of control over the no-show rate, the data are not presented here.

Continuity measures included empanelment and continuity of care. These data are presented in the tables that follow.

Continuity of care, which is achieved by establishing the patient-provider relationship through the empanelment mechanism and providing a structure of care delivery which supports visits with the same provider, has been linked to higher quality patient-provider communication, identification of medical problems, and patient satisfaction.[17] Increased provider satisfaction has been documented as well.[18] The literature also finds that continuity of care reduces hospital and emergency department admissions[19] and contributes to a lower cost of health care overall.[20] In addition, a sustained partnership between patient and provider is most important to improving health.[21] Almost all patients value having a primary care provider as a source of first contact and coordinator of referrals.[22] By the end of Year 3, all of the clinics able to report empanelment data had attained greater than 80%

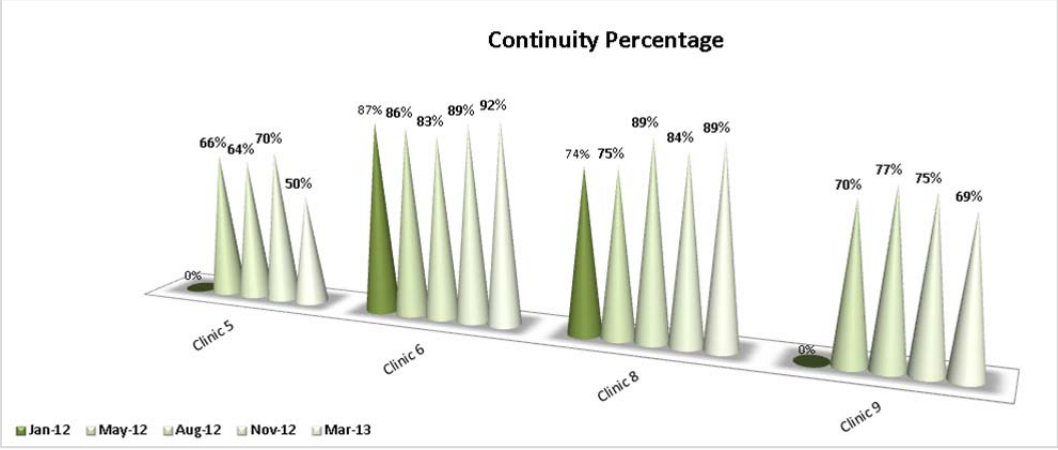
empanelment. Two clinics were unable to conduct and/or complete empanelment due to technology deficits; therefore, the graphs for Patients Empanelled and Continuity Percentage contain data from four clinics. Clinic 8 was unable to report its empanelment data for the two most recent reporting periods due to system reconfiguration and limited reporting capability.

Figure 4 – Percent of Patients Empanelled



Once the empanelment data were derived, each clinic could then determine how frequently their patients were seen by the assigned primary care providers. The PERC data includes Continuity as a trended measurement to encourage the participants to set internal goals for continuity of care. By the end of Year 3, the empaneled practices were all over 70% continuity and most were climbing. Some backsliding is noted in Clinic 5 and Clinic 9, most likely due to interim provider shortages.

Figure 5 – Continuity Percentage



Clinical Process and Outcomes Measures were unique to each participating clinic. Each was asked to identify a clinically important condition and adopt metrics using nationally recognized guidelines. Data were captured in each practice monthly and reported to the PERC quarterly. Trended data could then be displayed. The goal of this measurement effort was to get the clinics to adopt standards of care; to increase

the percentage of their patients receiving optimal care for chronic conditions; and to improve the health status of a designated sub-population of patients. The PCMH team at each clinic set the performance goals for their respective organizations.

Improvements gained by the end of Year 4 are demonstrated in the tables that follow. Clinic results at or above goal during the March 2013 reporting period are denoted in bold. Some clinics were not able to report data on various metrics during PERC reporting periods; these instances are denoted by "n/r" to indicate no data were reported.

Diabetes metrics adopted for the PERC were derived from the American Diabetic Association and the National Quality Forum. Process measures for diabetes care are easily met by offering the service to patients. This can be tracked through the electronic record system as lab orders placed. Clinical outcomes (lab test results) are also captured through the EHR or manual chart audit. Improvements in clinical outcomes are more difficult to attain because patient behavior may influence the test results, or may preclude obtaining the test.

Several clinics are measuring blood glucose control through the HbA1c level, with the threshold set at 7%. However, Clinic 2 has established a threshold at 9% because this metric was defined by a grant that they receive which requires regular reporting. This type of discrepancy is not uncommon in the safety net arena, where funders and program administrators issue data definitions and reporting criteria that may or may not be based on evidence-based guidelines for care.

Clinic 2 has chosen the metric of offering the eye exam at least once in the last 24 months. While the industry standard for diabetes care includes obtaining a retinal eye exam every year, ophthalmology specialty care for Clinic 2's patients is arranged by the availability of grant funding only. Therefore, scores are higher for this metric when funding is available, and wanes when the funding has been used up for the specified grant period.

DIABETES CARE	CLINIC	CLINIC GOAL	Dec 2011	Mar 2012	May 2012	Aug 2012	Nov 2012	Mar 2013
HbA1c test in past 12 mos.	1	90%	95%	99%	97%	98%	100%	**92%**
	2	100%	100%	100%	98%	100%	100%	**100%**
HbA1c < 9%	2	85%	62%	58%	63%	62%	53%	63%
HbA1c < 7%	5	40%	n/r	29%	34%	32%	29%	**42%**
	6	60%	n/r	57%	52%	68%	64%	**63%**
BP < 140/90	1	95%	68%	87%	78%	89%	89%	72%
	2	90%	89%	91%	95%	94%	89%	**95%**
	5	65%	n/r	67%	56%	56%	55%	56%
	6	60%	n/r	21%	21%	87%	75%	n/r
LDL test in past 12 mos.	1	90%	89%	92%	89%	89%	89%	73%
	2	90%	100%	91%	100%	91%	100%	**100%**
LDL < 130	2	85%	89%	68%	79%	77%	79%	79%
Eye exam offered in past 24 mos.	2	85%	73%	58%	46%	81%	63%	47%
Foot check in past 12 mos.	1	90%	63%	71%	82%	91%	89%	56%

Bold indicates at or above goal
"n/r" indicates that no data was reported during this timeframe

Two of the participating clinics are pediatric centers and are following **asthma** care metrics. The presence of an updated Asthma Action Plan in the patient's clinical record is an important indicator of patient engagement and activation. The scored Asthma Control Test (ACT) is recommended by the American Lung Association for all asthma patients 12 years and older. This 5-question assessment tool provides physicians and patients a simple yet highly predictive tool they can use to help assess asthma control. The questions included in the test are based on measures of asthma control established by the National Institutes of Health. Clinic 8 showed progress with this until moving their asthma registry into their electronic record system, which included a larger cohort of asthma patients. Data mapping problems persisted as of this writing, so the clinic was not able to assess progress. Clinic 9 has shown steady progress with this measure.

Clinic 9 is part of a large health system in the Kansas City metro area, and has access to Emergency Department and Urgent Care Center (EDUCC) data. This allows them to track asthmatic patients through these external care environments and apply educational intervention to those who use the ED and Urgent Care rather than coming to the clinic as their medical home. This data collection and improvement effort is consistent with national efforts to evaluate and reduce emergency department utilization.

ASTHMA CARE	CLINIC	CLINIC GOAL	Dec 2011	Jan 2012	May 2012	Aug 2012	Nov 2012	Mar 2013
% Action Plan in record	8	100%	95%	98%	100%	71%	n/r	n/r
	9	>75%	n/r	67%	74%	78%	80%	**78%**
% ACT Score >= 5 years	9	>50%	n/r	n/r	27%	35%	41%	42%
% EDUCC last 30 days	9	< 5.0	n/r	n/r	0.89	0.65	0.96	**.064**
% EDUCC last 90 days	9	< 5.0	n/r	n/r	4.36	1.32	3.43	**3.7**

Bold indicates at or above goal
"n/r" indicates that no data was reported during this timeframe

"In the early stages of the initiative, when health information technology was underdeveloped in terms of reporting capability, sites learned that "if you can't measure it, you can't improve it".

Discussion: At the outset of the REACH Medical Home Initiative, very little performance data were collected by any of the participating clinics. While data were available to some practice sites, there was a limited amount of organization around data definition, collection and reporting. To address this, technical assistance focused heavily on quality improvement rationale, structure and methodologies over the project term. At the close of four years, all participating practice sites had a quality improvement program in place, had developed an improvement program with metrics of interest to their patients and communities, and were reporting internally and to the PERC on a regular basis.

The evolution towards an open data-sharing collaborative was not an easy road. Initially, most sites had difficulty retrieving the data, but with coaching support, clinics designed a reliable reporting methodology unique to their respective practice settings. Two clinics without a chronic disease registry used manual chart audits to collect data. This methodology provided a snapshot of the practice's performance, but the data were not as reliable since the practice selected a different sample of patients with each audit.

Building a sustainable discipline for data collection, analysis and reporting has helped to ingrain a culture of quality in each organization. Clinic administrators initially held their data closely, but over time came to understand the value in sharing

data and their stories about successes, progress, and barriers. The data are a proven conversation starter that often leads to peer-to-peer collaboration and problem-solving. The data collection and comparative reporting over a metropolitan-wide catchment area demonstrates a shared commitment to raising the bar in healthcare delivery, both within the clinic and across the system of care.

The PERC data and trends represent an important component of REACH's daily work and continue to influence their grant-making processes and decisions. These data, now available to the REACH Foundation in comparative format, demonstrate individual and regional progress towards patient-centered care in terms that the Foundation can understand. Through quarterly reporting cycles, the Foundation is able to review progress and barriers, and use the data as an objective and measurable platform to inform Foundation investments.

Patient Experience Data: A Critical Element of PCMH Assessment

As is common among safety net clinics, metrics for patient experience were fairly difficult to select as collaborative reporting measures. There are several reasons for this. Each clinic used a different patient satisfaction survey instrument, some of which were validated survey tools and others not. In addition, the clinics were each conducting the surveys using a different methodology: in-person interviews with patients following the clinic visit and mail-in surveys; monthly, quarterly and annual sampling added another variation. Clinics that were a part of a large health system were limited in their ability to make changes to the survey or delivery approach. Modifying an existing tool can result in forfeiting trend data on specific questions, which organizations are often reluctant to do. The clinics also reported that their funding sources required reporting on specific questions on the patient satisfaction survey. The group agreed to begin reporting on at least one shared question in each of the following domains: Access, Communication, Coordination of Care, Whole Person Care, and Medical Home.

Technical assistance guided the clinics towards measuring patient *experience* versus patient *satisfaction*. This required revision of survey questions to measure the patient's actual experience of care; e.g., "How satisfied were you with the wait in the waiting room today" to "Please tell us how long you waited in the waiting room today – 0-15 min, 15-30 min, 30-45 min, 45-60 min, 60+ min."

The PCMH teams from the participating clinics all considered using the CAHPS survey for primary care (see http://www.cahps.ahrq.gov/ for more information), but found the lengthy survey instrument unwieldy and anticipated difficulty in administering it to their patients. However, questions in the chosen domains on the CAHPS survey tool were highlighted and each clinic opted to either adopt the question verbatim or adapt it for inclusion on their survey tool.

Survey results remained somewhat static across the board for all clinics in all domains. Patients in safety net practices tend to be generous in their assessment of patient satisfaction/patient experience overall, resulting in generally high scores for each survey administration. Dips in scores may be noted during any time of process change because patients are unfamiliar with the new process.

The following table demonstrates the Patient Experience questions that were chosen for reporting and trending through the PERC. Notable results are presented in bullet points below the referenced question.

Clinic	Question
Access to Care Questions about access to care attempt to understand barriers to access, such as wait times for an appointment or wait times while in the clinic. *Note:* Most clinics showed improvement in the area of access to care. Clinic 8 has shown significant improvement in wait times, both in the waiting room and in the exam room, shifting to a less than 15 minute wait for most patients today.	
Clinic 1	Convenience of our office hours. ▪ Stable at 98%.
Clinic 2	I can usually get an appointment within two to three weeks. ▪ Slight reduction 85% to 81%.
Clinic 5	Ability to get an appointment. ▪ Steady improvement noted from 81% to 85%.
	Convenient hours of operation. ▪ Steady improvement noted from 85% to 94%.
Clinic 6	Ability to get in to be seen. ▪ Slight increase from 4.64 to 4.74 on Likert scale 1-5.
Clinic 8	Were you able to get an appointment as soon as you wanted? ▪ Improvement noted from 90% to 97%.
	How long did you wait in the waiting room? ▪ Less than 15 minutes – improvement from 49% to 80%. ▪ More than 15 minutes – significant improvement from 41% to 13%.
	How long did you wait in the exam room to see the doctor? ▪ Less than 15 minutes- Improvement from 42% to 57%. ▪ More than 15 minutes- Improvement from 36% to 27%.
Clinic 9	Were you able to get an appointment as soon as you wanted? ▪ Due to corporate reporting format, no trending data is available.
	If your child's appointment did not start on time, did someone give you a reason for the delay? ▪ Due to corporate reporting format, no trending data is available.
Communication with Provider Fostering a positive patient-provider relationship is pivotal in influencing clinical outcomes. Questions in this domain attempt to understand the relationship between patient and provider and any communication barriers which may impede patient engagement. *Note*: Most of the participating clinics charted improvement in the communication domain. Most notable is the achievement of Clinic 8, advancing 5% to 16% on all questions.	
Clinic 1	Instructions the provider gave you about follow-up care. ▪ Stable at 98%.
Clinic 2	The person who provided my medical care gave me understandable instructions. ▪ Improvement noted from 88% to 93%.
Clinic 5	The provider listened to you. ▪ Slight decrease from 96% to 93%.
	The provider answered your questions. ▪ Slight improvement from 93% to 95%.
	The provider gives good advice and treatment. ▪ Slight improvement from 91% to 92%.
Clinic 6	The provider explains what you want to know. ▪ Stable at 4.82 to 4.83 on a Likert scale of 1-5.
	The provider gives good advice and treatment. ▪ Improved from 4.78 to 4.83 on a Likert scale of 1-5.
Clinic 8	The doctor listened to what I had to say. ▪ Steady improvement from 78% to 96%.
	I trusted the doctor. ▪ Significant improvement from 78% to 87%.

Clinic	Question
	The doctor respected what I had to say. ▪ Significant improvement from 79% to 97%.
	I understood what the doctor told me. ▪ Significant improvement from 79% to 84%.
	Did anyone explain any medications that were prescribed to you? ▪ Steady improvement from 51% to 60%.
Clinic 9	Did anyone teach you how to give your child his or her new medicines? ▪ Due to corporate reporting format, no trending data is available.
	Did someone explain [aspects of your child's health] [the purpose of any prescribed medicines] in a way that you could understand? ▪ Questions of this nature are stable at 89-89%.
	Did you have any problem talking with the care provider because of a language problem? ▪ Due to corporate reporting format, no trending data is available.
Coordination of Care Well-coordinated care is an important part of the patient's experience. Each of the participating clinics invoked their own priorities in crafting questions on care coordination that were meaningful to their clinics. *Note*: Most clinics are trending upwards; however, the most significant improvement is seen in Clinic 8 around aspects of care coordination.	
Clinic 1	Do we communicate with you about your referrals? ▪ New question May 2013, 62%; no trend data available.
Clinic 2	Was the staff helpful in assisting you to get medicine? ▪ Decreased from 90% to 67%.
	Did the provider discuss medicines with you during your visit? ▪ Decreased from 100% to 73%.
Clinic 8	Did you get any reminders about your child's care from the office between visits? ▪ Improvement noted from 63% to 77%.
	Did anyone follow up to give you test results? ▪ Low but stable scores at 23% to 24%.
	Did your provider seem up-to-date about the care your child received from the specialist? ▪ Significant improvement noted from 31% to 53%.
Clinic 9	If your child needed another visit with another provider, did the staff do everything they could to make the necessary arrangements? ▪ Due to corporate reporting format, no trending data is available.
	Did the provider seem to know the important information about hour child's medical history? ▪ Due to corporate reporting format, no trending data is available.
	Did the provider give you enough information about what you needed to do to follow-up on your child's care? ▪ Slight improvement from 98% to 100%.
Whole Person Care Whole Person Care is difficult to capture in question format, but is considered a strong indicator of patient-centered interactions which are central to the medical home environment. *Note:* Most clinics chose questions that centered around respect and inclusivity; one clinic opted for indicators of parental guidance around childhood development.	
Clinic 1	Provider's efforts to include you in decisions about your treatment. ▪ Stable at 98%.
Clinic 2	The person who provided my medical care treated me with respect. ▪ Decreased from 96% to 88%.
	The person who provided my medical care took enough time with me. ▪ Decreased from 94% to 92%.

Clinic	Question
Clinic 8	Did anyone talk with you about your child's growing and learning abilities? ▪ Improvement noted from 63% to 73%.
	Did anyone talk with you about the kinds of behaviors that are normal for your child at this age? ▪ Improvement noted from 61% to 67%.
Clinic 9	Did the provider treat your child with respect and dignity? ▪ Stable at 100%.
	Did the provider show respect for what you had to say? ▪ Stable at 100%.
Medical Home Questions in this domain attempt to determine the patient's recognition of a site of care as their medical home. *Note:* Most clinics reported only slight variation in scores (increase or decrease of 1%-3%) over the two years of measurement. However, Clinic 8 reported a significant improvement from 80% to 91% for the patients' recognition of the clinic as their medical home.	
Clinic 1	Do you feel we are your Medical Home? ▪ New question May 2013, 86%; no trend data available.
Clinic 2	Is this center your main source of care? ▪ Slight decrease but stable from 98% to 97%.
	This clinic is my regular source of medical care. ▪ Slight decrease but stable from 98% to 97%.
Clinic 5	Is this Center your main source of care? ▪ Increased from 91% to 94%.
Clinic 6	I consider this to be my regular source of care. ▪ Decreased from 100% to 97%.
Clinic 8	Is this clinic your main clinic? ▪ Improvement noted from 80% to 91%.
Clinic 9	Would you recommend this clinic to your family and friends? ▪ Improvement from 85% to 98%.

LESSONS LEARNED

Over the four-year project term, the practice sites participated in many group workshops and received over 1500 hours of individual on-site and telephonic coaching. Each of the clinics was in a different operational state from the others, and all had established improvement priorities. As the Qualis Health consulting team worked with each respective clinic to move them forward towards PCMH adoption, many lessons were learned from them through their triumphs and their struggles.

Leadership Perspectives

Understanding that strong leadership is the key to successful practice transformation, the following PCMH team leaders were interviewed to reflect on the challenges faced by their respective organizations as the PCMH model was implemented.

Michelle Haley, MD
Pediatrician, Children's Mercy West, and
Associate Medical Director, Children's Mercy Pediatric Care Network

The most significant challenge facing Children's Mercy West was the fact that it was part of a large corporate entity. As part of a large health care system, with multiple layers of committees, it was hard to initiate and implement change. Another structural component of note is the alignment of clinic personnel; the nurses, providers and front desk were each part of a siloed group with different reporting chains and lines of authority. While responsibilities could be assigned, accountability was difficult to achieve.

"Leadership across the board is critical to success"

Dr. Haley reports that strong nursing leadership was available to her as physician champion and PCMH team lead. This facilitated adoption made implementation of PCMH components much easier. Corporate leadership was also on board as demonstrated by the Memorandum of Understanding with the REACH Foundation for participation in the Initiative. The trainings, coaching and NCQA PCMH standards provided a structure and a timeline, and leadership across the board allowed them to make progress at a good pace.

Providers find it easy to implement evidence-based guidelines, says Dr. Haley, which are a part of the PCMH model. The efficiencies in team-based care allow the provider to focus on the patient in a different way— "How can I change the way that I engage with the patient?" These soft skills, along with patient engagement and communication techniques, such as motivational interviewing, can help give providers a different perspective. The result is a new ability in leading patients towards positive behavior change. Childhood obesity has long been a focus of the Children's Mercy West clinical team, but with varying results in the past. Dr. Haley reports that she is now seeing children coming in for return visits with notable weight loss, a result that is pleasing to her as well as to the child's parents.

Children's Mercy West saw a need in their clinic to add a PCMH support role. The PCMH Coordinator position is held by a registered nurse who is charged with team support, registry management, and IT liaison. Care coordination and care management goals are established for this role, although those functions are not firmly in place as of yet. The Children's Mercy corporation has demonstrated strong support for this role by integrating the PCMH model into the strategic plan for the hospital and also for the outpatient medical services division.

Janet Burton, MBA
Executive Director, Turner House Children's Clinic

Ms. Burton entered the Medical Home Initiative at the beginning of its third year. She found that the PCMH team was well engaged and well informed about the model; however, the staff demonstrated real resistance to change. They found that using the language of being "in the Valley of Despair" and the vision of "crossing the desert" in their transformation work was helpful in shouldering the burden of change. As they embarked on a clinic expansion/remodel project, each staff member ceremoniously swung a sledge hammer as a means of "opening the door" to a new service and leaving the old image behind.

"The PCMH model has made us mindful of what it takes to improve health."

Early on, it was apparent that the Turner House providers wanted to build relationships and create continuity of care. This level of interest made the adoption of the empanelment concept easy. Conversely, the most difficult part of the PCMH journey has been the full implementation of a quality improvement program. Ms.

Burton relates that early on, the staff did not have the skill sets and leadership ability to fully implement the QI program that they had designed. Now, with a solid year of maturity with the program, and a new medical director on board, the multi-disciplinary team has a greater understanding of the relevant chronic conditions in their patient population, a more manageable approach to data collection, and are now using data to address issues and design improvements.

Staffing needs and skill sets were flexed in order to most appropriately move to the patient-centered, team-based model. In the paper-based system, it was possible to use one front desk person with a polite attitude and good clerical skills. With PCMH, adding complexity in terms of new patient registration processes, a new electronic health record system, and additional providers to improve access, enhanced critical thinking skills and computer skills became base requirements. Ms. Burton states that it took a full year to redefine the role of the medical records support person at Turner House. This position morphed into an interpreter/care coordinator, which places the importance of medical records accuracy into care coordination support for patients, newborns on intake, referrals, and follow-up.

Turner House Children's Center found itself in the EHR selection and implementation process simultaneously with PCMH transformation. Ms. Burton states that their knowledge of the PCMH model was helpful in making decisions about necessary functionality and roll-out. Informed with the PCMH foundation, they were able to design EHR templates with structured data fields to support PCMH and meaningful use (MU); this shortened the adoption curve and facilitated the capture of MU incentives at an early stage.

Ms. Burton states that no one in the organization understood how significant PCMH adoption would be in a transforming health care system. She explained that access to care is no longer good enough. Without their successful redesign, Turner House would not be able to respond to the requirements of area foundations as they reset funding criteria to include many of the components of patient-centered care and population health management.

Helen K. Darby, RN BSN MA
Former Chief Clinical Officer, Samuel U. Rodgers Health Center

As a large, multi-site Federally Qualified Heath Center, Samuel U. Rodgers Health Center (SURHC) had a well-developed quality improvement program in place at the outset of the REACH Medical Home Initiative. An active Quality Improvement Committee, under the applied leadership and guidance of the organization's Director of Excellence, lent ready support to SURHC's PCMH transformation team.

SURHC had begun the early implementation stages of their NextGen EHR system when the Medical Home Initiative began. The IT team, while essential to the system roll-out, was not familiar with the PCMH model. Once the PCMH team began planning for PCMH transformation, several layers of EHR functionality had been rolled out. Applying new knowledge of patient-centered care, the organization found it necessary to revise some of the technology-based decision support functions to support new workflows.

Patients verify that the Same Day Access scheduling model improves access to appointments.

SURHC adopted same day access scheduling early on in the initiative, starting at their smaller sites first. Ms. Darby reports that all locations are now using this scheduling model, although it appears to work best at the smaller locations, where there is less need for multi-linguistic interpretation. The staff appreciates the ability to better manage patient appointments, getting patients in earlier than the prior

schedule template allowed, especially the chronic patients for scheduled follow-up visits. The patients at SURHC have recognized the difference in waiting times, with trended patient experience surveys showing improvement in scores relating to "were you able to make an appointment as soon as you wanted."

Team-based care proved to be the most difficult concept to implement at SURHC. Early on, the transformation team was met with provider resistance, which took many months to overcome. In addition, Ms. Darby reports that SURHC experienced a significant amount of turnover in the clinical support roles until they reviewed the patient care team dynamics and evolved from medical assistants to Licensed Practical Nurses. The enhanced clinical support now available to the providers has increased the level of trust within the patient care teams, and improved efficiency as well. Now, with stabilized staffing and new clinical leadership, the teams appear to be taking hold.

The "shining star" in patient-centered care at SURHC is the addition of the Care Management team. These individuals are responsible for complex care management for patient with diabetes, hypertension, and other chronic conditions. Their efforts in patient outreach, coordinated care, and outcomes tracking have made a significant contribution to the patient care teams, and also to the organization's successful population management efforts. Ms. Darby credits the combined efforts of the Care Managers with bringing the PCMH model to life at SURHC.

The Care Management team is the "shining star" of the PCMH model.

Summary Learnings from PCMH Implementation

- **Engaged leadership is critical to success.** Leadership that does not fully understand the PCMH model and is not available to clear the way for an empowered transformation team will keep the practice from evolving.

- **Safety net clinics can become continuity clinics**. Early observations in the Kansas City clinics revealed reluctance to empanel for fear of limiting access. This was disproven as they understood the rationale and benefits to empanelment. Providers, staff and patients have all benefited from the empanelment work and commitment to continuity of care.

- **The Open Access scheduling methodology can be a barrier to accessing care.** A full, open-access scheduling process can actually limit ability to get an appointment. When rigid rules are in place, such as requiring patients to call in between 7:30 and 8:30 am for an appointment today, all of the available appointment slots are rapidly filled and patients are turned away. This causes the patients to call in the next day, likely to have the same experience. Patients become frustrated and seek care elsewhere. Relaxing the rules a bit to enable patients to call in at any time of day reduces the crush of early morning telephone calls; opening up the schedule for another day for certain types of appointments allows more patient access to the practice.

- **Empanelment requires continuous attention.** Assigning patients to providers is a constant effort to keep pace with the changing provider roster and the changes in patient preferences. Establishing a structure for the empanelment process makes it manageable. One key to manageability is the regular review of panel sizes, influx of new patients, and balancing the mix of patients based on age and complexity.

- **Staffing size and mix are critical to successful PCMH transformation.** A practice with less than 1:1 provider/clinical support staff ratio cannot absorb the work of care coordination and complex care management that are central to the medical home model of care. The practice must invest in additional staff up front in order to see clinical outcomes benefits downstream.

- **New patient orientation visits can be managed effectively in a group setting.** One of the key strategies to controlling No Show events is that of orienting patients about the practice, discussing patients' rights and responsibilities, and conducting eligibility screening before the patient is seen for a clinical encounter. This relieves the burden of tasks at the front desk check-in station, affords privacy to the patient and allows for questions to be asked. Some of the Kansas City practices piloted this orientation process in a group setting, which proved effective and satisfying to new patients.

- **Information systems can impede transformation**. Old legacy systems do not have the defined data fields or reporting capability of the newer practice management and electronic records systems. Some newer systems contain more features capable of supporting the PCMH than others. A practice with an old or underdeveloped system that is unwilling to invest in upgrades to improved functionality will have a difficult time managing the empanelment effort, population health, and data reporting requirements of the patient-centered medical home.

- **PCMH readiness can guide EHR design and implementation**. Understanding the structural and operational components of the patient-centered medical home can help a practice understand the types of technological functions they need. This information is extremely helpful in establishing requirements in the HIT acquisition phase, planning the implementation, and designing reports to support the new transformed practice.

- **Patient experience in its many dimensions is difficult to measure and improve.** There are many patient satisfaction surveys available for implementation, some of which are validated research tools; others are developed by single organizations. With a practice in the throes of redesign, things may appear chaotic and disorganized to the patient because the processes are no longer familiar. It is important to actively engage the patients in the practice's improvement efforts, giving voice to preferences for service delivery options and gaining understanding of the practice's customer service effort. This qualitative input can often provide more information and insight to the practice than survey data.

Other Considerations

Service Integration

The PCMH model sets the stage for integrated and holistic care for all persons, and there is a new appreciation for behavioral factors in chronic disease management. The ideal model of care would bring oral heath and behavioral health into the primary care setting in ways that extend beyond co-location. Cross-referrals between disciplines would be routine; professionals from all three disciplines would practice in the same physical space, allowing warm handoffs and immediate intervention as

needed; and clinical metrics would be folded into the clinical quality outcomes review and action planning.

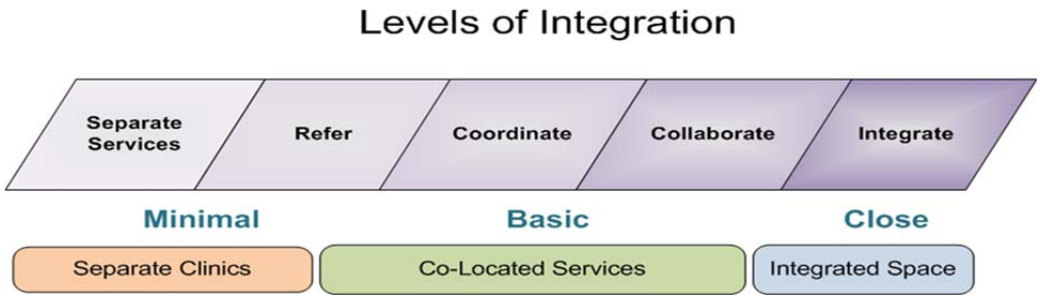
In 2000, the US Surgeon General issued a report, *Oral Health in America*,[23] which cited dental disease as the silent epidemic. In addition to a lack of awareness of the importance of oral health among the public, the report found a significant disparity between racial and socioeconomic groups in regards to oral health and ensuing overall health issues. Based upon these findings, the Surgeon General called for action to promote access to oral health care for all Americans, especially the disadvantaged and minority children found to be at greatest risk for severe medical complications resulting from minimal oral care and treatment.

According to the National Comorbidity Survey[24], 26% of the adult population needs mental health services in any given year, and 59% of that 26% will not receive any services while 80% of them will receive primary care services. Providing a behavioral health specialist in the clinic reduces the stigma of seeking mental health services, thereby improves access to the needed service.

Safety net clinics are well positioned to participate in this call to action for service integration because they serve populations where oral disease, mental health issues, and other chronic conditions are prevalent. Many safety net environments (especially community health centers or Federally Qualified Heath Centers) deliver medical, dental and mental health services on a co-located basis, but not necessarily fully integrated.

The diagram that follows suggests three levels of integration: minimal, in which services are completely separate and referrals are made; basic, in which coordination and collaboration are facilitated through co-location; and close integration in which the oral health and/or behavioral health professional is housed directly in the primary care setting. In the close integration arrangement, the same health record is shared by all disciplines, and the oral heath and behavioral health professionals are available to share in care of the patient when needed.

Figure 6 – Levels of Integration



The operating structures of all of the REACH Medical Home Initiative participants run the gamut of service integration. Two clinics had fully integrated behavioral health services at the outset of the initiative, with plans to improve cross-referrals between disciplines. Three of the participating clinics had either separate dental facilities or co-located services; none had fully integrated oral health care available to patients. Now informed about integration models, they are able to carry a new program design for integrated services into the future.

Cost to Implement the PCMH Model and Operate as a PCMH

Expenses related to PCMH practice transformation depend on a number of factors, some of which will be one-time costs and others will be ongoing. These include the following:

- Need for new staff (e.g., RN care manager)
- Staff training (e.g., team functioning, core competencies)
- Infrastructure/capacity upgrade (e.g., phone system)
- Health Information Technology (e.g., EHR, registry application, interfaces)
- Application for PCMH accreditation (unreimbursed time, application fee)

In 2009, a predictive modeling study was conducted using a combination of factors from the NCQA 2008 PCMH standards, a Medical Group Management Association Cost Survey, and the American College of Physicians Practice Management Checkup Tool for 2006. This study correlated the NCQA PCMH recognition score with practice operating costs and found that low scoring practices spent approximately $16.19 per patient-month and high scoring practices incurred a cost of $16.57 per patient-month, based on a panel size of 2,640 patients per provider.[25] Looking at this less than 3% (38 cents) per patient per month increase in operating costs from low-scoring [NCQA Level 1 recognized] to high-scoring [NCQA Level 3 recognized] practices, one might infer that practices could easily absorb the transformation and ongoing operating costs. However, these costs translate to time away from the production cycle of providing patient encounters.

Some practices build efficiency through alternative visits types that are not reimbursed. While improving access to care, the adoption of telephone visits, nurse visits, and group visits remain unreimbursable by many health plans; therefore, the costs must be absorbed by the practice.

Central to the PCMH model is that of a quality improvement program. It is essential that staff members participate in improvement efforts, and time must be afforded to allow them to attend meetings, run small tests of change, analyze population-health reports, and conduct outreach to patients. These activities must be done at a time when their services are not required in the clinic workflow, which shifts costs to an unreimbursable status.

The evidence on PCMH operating costs is limited and often anecdotal. For practices operating on small margins, even small costs can be problematic budgetarily. Nevertheless, PCMH transformation must be considered an investment in the future of the practice because of the changing landscape in health care reimbursement which will include pay for quality and value, rather than pay for volume.

Reimbursement

Some of the participants in the REACH Medical Home Initiative were structured as a free clinic model. In this instance, billing data were not being captured and there was no health plan partnership. Looking ahead to 2014 and the provisions of the Affordable Care Act which expands Medicaid eligibility, these free clinics considered, or made plans to convert to, a fee-for-service model as Medicaid providers in order to retain their clientele.

As primary care practices invest in adopting the PCMH model, health plans must follow suit and revise their reimbursement schema in such a way as to offset the operating costs of care management within the practice setting. In addition, revisions

to the Federally Qualified Heath Centers' prospective payment rate may be necessary in order to secure adequate reimbursement for the provision of comprehensive care through the PCMH model.

INSIGHTS

Based on the field experience of this initiative as well as review of literature and similar case studies, the following insights are offered to health care systems, primary care associations, and foundations as they consider developing or participating in a local, regional or national medical home initiative.

For Clinics, Health Centers, and Private Practices

1. Visible and sustained leadership is essential to lead overall culture change as well as to drive specific strategies to improve quality and spread and sustain change. Direct involvement of top- and middle-level leaders is most critical to successful system redesign.[26] Effective leaders will have knowledge and skills in:

    - Systems thinking: Capacity to understand the practice as a series of interrelated processes that determine performance.
    - Envisioning change: Recognizing the gap between current and optimal practice and promising changes to close the gap.
    - Change management: Implementing proven strategies for quality improvement and engaging staff in the process.[27]

2. The executive director and medical director must be involved in all trainings, or at least review and understand the training content. The leadership must align PCMH transformation with organizational priorities and strategy. It is extremely difficult for the transformation team to effect change when the leadership does not understand the model and/or has not fully empowered the team to move the organization in a new direction.

3. Transformation takes time. In the REACH Medical Home Initiative, the PCMH picture started to gel in Year 2 and was solid in Year 3 as the clinics' PCMH teams began to synthesize and understand the unique and interrelated components of the PCMH model. This important evolution should not be rushed. The value of transformation should not be ignored, and should not be superseded by the early desire for accreditation. Each operational component must be dissected and brought into an efficient and effective level of functioning with the industry standards in mind. Embarking on the accreditation application too early will result in frustration and confusion, and it is likely that the health center will not go back to the transformation steps once the application is completed.

4. For this type of transformation effort, expect to see progress along with occasional backsliding. The practice sites will experience slow-downs from time to time due to turnover on the transformation team, attrition of providers and/or other key staff, and intermittent technology limitations. In these situations, it is important to have a plan to regroup, recover and restart with the shortest delay

possible. Shifting the focus may be necessary, but the practice should not stop its forward momentum towards redesign.

5. Transformation takes teamwork and is fully developmental. Each team member is learning new roles, ceding old roles, and learning to work together in a different way. Evaluate the team's chemistry and composition. Have the right people been brought together as teams? Are all of the skills available to conduct efficient patient care? Evaluate the teams' skills and competencies, and implement training to bring the skills levels up to a level which supports effective and efficient team functioning.

6. Expect staffing needs to change and training needs to increase. As the practice adopts the PCMH model, once-simple processes become more complex. A good example is that of orienting new patients to the clinic. At an earlier time, a simple handout might have been used. In the PCMH era, this orientation becomes an educational session and an opportunity for patient engagement. Staff will need new skills to fully implement the new patient orientation process.

7. Do not underestimate the important role that health information technology tools play in supporting clinical and business operational processes and improvement work. The planning effort toward selection and implementation of a new EHR system is important and should not be truncated. Fully understanding what the practice needs the system to do will ensure that the practice designs and implements a system that is built with its practice needs in mind.

8. Move away from manual chart audits and adopt condition-specific registry tools, either as part of the EHR system or a registry application. Build data entry into your routine patient care work flows. Design reports around metrics of interest, and encourage data sharing in unblinded fashion. This level of transparency allows the participants to collaborate on successes and identify barriers to achieving high performance goals.

9. Enter into a dialogue with your local health plans. Understand which, if any, alternative visit types are covered under their plans. Offer to become a pilot site for a service not yet identified as a plan benefit, such as group visits.

For Collaboratives

1. Select an assessment tool that fits the vision of the collaborative. If you are headed towards accreditation, perhaps initiate the collaborative with an assessment tool that measures current state of operations against the published standards of the accrediting body. Study the various assessment tools available in the field and select the best one for the group, as they are all different.

2. Determine a measurement set and reporting cycle that fits the group. Use standardized data definitions and develop a user-friendly reporting tool.

3. Evaluate the providers' trust in support staff early on. If it is low, consider adding a special set of trainings targeting medical assistants in order to increase their competencies and enable them to better support patient care.

4. Encourage data sharing in unblinded fashion, but only after establishing group norms around how data will be shared and used outside the collaborative.

5. Include a training pathway for building bridges to other key community stakeholders, such as emergency department managers and hospitals. These important relationships will support care coordination and result in downstream savings in healthcare costs, but clinics often do not know where to begin.

6. Develop partnerships with local health plans. Help the health plans understand what it takes to implement the PCMH model. Become part of the conversation around payment reform that rewards clinical practices for achievements in quality of care.

Especially for Funders

The philanthropic community can contribute to improvements in access to health care, improved systems of care, and reduction of health disparities by investing in programs and collaboratives that show promise in their design of patient-centered, coordinated care across a community. Many of the key findings represented in this paper are operational in nature and can be implemented in health centers where there is a vision and will to move towards patient-centered, well-coordinated care through the PCMH model. Grant dollars are needed to invest in and evaluate pilot programs aimed at developing collaborative models in which medical, dental and behavioral health providers work together to support their patients' wellness and chronic care needs.

During the four years reflected in this document, REACH awarded approximately $201,000 in supplemental grants to clinics to support EHR implementation, an oral health record interface, and certification of bilingual medical interpreters.

During the four years reflected in this document, REACH awarded approximately $201,000 in supplemental grants to clinics to support EMR implementation, an oral health record interface, and certification of bilingual medical interpreters.

1. As you review your investment reserves, recognize that the PCMH effort will require funding for at least 2-3 years. Planned and directed technical assistance over this time will enable the participants to achieve benchmark performance in patient-centered care. For the REACH Foundation, funds allocated for this collaborative-type initiative fall outside other grant processes available through the foundation. The Foundation invested approximately $845,000 in this multi-year initiative; 35% was targeted towards group learning workshops, 45% was aimed at individual site-specific consultation, and 15% was directed at assessment, monitoring, and reporting activities.

2. Carefully select the participants in a collaborative environment. Commit to the philosophy that the collaborative will be a "coalition of the willing." Negative attitudes can impede the progress of those who are striving for success. As the initiative commences, consider obtaining written commitments to the transformation work, also establish ground rules and expectations of participants.

3. Consider financial incentives to participants in a collaborative. There may be components that a clinic cannot achieve without a financial boost, such as purchase of a chronic condition registry application or a technology interface between the laboratory and the clinic's electronic record system. Support may be needed for a technical consultant to design customized reports that will enable the quality improvement work to move forward. These one-time expenditures can facilitate the improvement effort within the clinic setting, enabling the transformation team to apply their knowledge to achieve benchmark performance into the future.

4. Consider additional support for clinics that are struggling with core operational processes to help them improve operations and infrastructure, and build capacity for high-performance. Providing an on-site or remote consultant to help an organization with tasks such as building the quality improvement work plan or revising the clinic schedule may be a welcome relief to the clinic's planning team, and may also serve as a catalyst for the PCMH transformation process. Require a measurement process with outcomes demonstrating capacity for self-sufficiency and sustainability.

5. Understand that the PCMH model is expensive to maintain. The Care Management function is central to the patient care team; this individual is ideally a registered nurse. In many markets, the RN is an expensive resource and the clinic may not be able to support the position financially. Consider supporting this essential staffing resource for the participating clinics for 1-2 years. During this timeframe, the practice will fully integrate the new staff into their operating workflows, which will result in more patients served, generating additional revenue to make the position sustainable.

6. Require data from the participating clinics that allow the funder to follow progress, understand obstacles, and determine the overall impact of the initiative on the communities served. Engender trust between the funder and the participants that the data will not be used punitively**.**

7. While achieving accreditation (through NCQA or another entity) is generally a desired outcome, the end goal is transformation and sustainable system change, both in the organizational culture and at the practice operations level.

8. Review and understand the benefit models of the health plans in your area. Invite a dialogue with the health plan medical directors and advocate for reimbursement for alternative visit types, such as care coordination, telehealth, group visits, and nurse visits.

9. Consider the impact on foundation resources in staffing the project, and for project management.

CONCLUSION

Building a strong primary care sector is now a major goal of American health care policy.[28] There is clear evidence that the PCMH model is an effective direction for improvements in primary care,[29] and that those improvements are feasible and imperative in the safety net sector as in private practice.[30] The experience in the REACH Foundation's Medical Home Initiative in metropolitan Kansas City has shown that safety net practices—whether structured as a federally qualified health center, free clinic, hospital system-based outpatient center, academically oriented health center, or nurse-managed clinic—can indeed adopt and successfully implement the rigor of the PCMH model, determine strategies for sustainability, and attain formal PCMH accreditation.

New payment structures are being piloted in several states that recognize the value of a PCMH, including typically non-reimbursable services such as outreach, care coordination, patient education, telephone visits, group visits, and expanded support

services. These new models recognize the case mix differences in a patient population, and support population health management as a core function of the practice. Some programs involve a simple pay-for-quality approach based on industry standards of care and adopted performance thresholds. More advanced reimbursement strategies allow providers and practices to share in cost savings from reduced hospitalizations and emergency department visits.[31]

Governmental payers, the employer community and commercial health insurance companies are all pushing for more integrated health care delivery systems where physicians and hospitals are held accountable for the overall cost and quality of care.[32] These Accountable Care Organizations have at their core a patient-centered medical home operation. It is imperative that all clinical practice models learn to participate in systems requiring more communication, care coordination and quality measurement reporting. As a key player in the ACO structure, the formally recognized PCMH will be an attractive local health care partner as ACO's develop across the nation.

Whether the perspective is that of the primary care provider, the executive leader, or the CFO, the PCMH model makes good sense. The benefits are many: Patients will have a better experience, and improved outcomes, from the focus on comprehensive accessible health care. Providers and clinic staff will become more organized and effective in their processes of care delivery, and their job satisfaction will increase. The organization will benefit through efficiencies, cost savings, and revenue enhancements.

APPENDIX 1: PARTICIPANTS

Cabot Westside Health Center
www.saintlukeshealthsystem.org/locations/cabot-westside-medical-and-dental-center

Cabot Westside Health Center is a not-for-profit safety net clinic affiliated with Saint Luke's Health System. Cabot recently celebrated its 100 year anniversary, serving Kansas City residents since 1906.

Services include adult, family and pediatric medicine, and also general dentistry. Cabot also serves as a provider agency for Women, Infants and Children (WIC) nutrition program. Cabot provided care to 7900 unduplicated patients in 2012, generating over 25,000 patient visits. The majority of Cabot's patients are Hispanic (over 90%), with 65% speaking only Spanish. Cabot Westside accepts most health insurance plans, but over 30% of its budget is dedicated to care for the uninsured.

Saint Luke's Health System included PCMH transformation in its strategic plan and intends achievement of all outpatient facilities in the near future. Cabot Westside Health Center attained the first NCQA PCMH Recognition, Level 3, for the organization in December 2011.

In 2013, Cabot Westside Health Center was acquired by a Samuel U. Rodgers Health Center (also a participant in the REACH Medical Home Initiative), which operates several clinic locations in Missouri.

Children's Mercy West
www.childrensmercy.org

Children's Mercy West, also known as the Cordell Meeks, Jr. Clinic, opened its doors in 2007 and provides primary care for 7,500 patients. This clinic is a division of the Children's Mercy Hospitals and Clinics system. The comprehensive health care environment includes clinical services in outpatient and hospital settings, as well as research and teaching efforts designed to serve children and the community. The organization's faculty of 600 pediatricians and researchers across more than 40 subspecialties are actively involved in clinical care, pediatric research, and educating the next generation of pediatric subspecialists.

An early adopter of the PCMH model, the clinic implemented team-based care well in advance of the other outpatient clinics in the Children's Mercy system. Children's Mercy West received Level 3 NCQA PCMH Recognition in February 2012.

Duchesne Clinic
www.duchesneclinic.org

The Duchesne Clinic is an affiliate of the Sisters of Charity of Leavenworth Health System, which also supports multiple hospitals and clinics, including the St. Vincent Clinic in Leavenworth, which is smaller. The Sisters of Charity of Leavenworth Health System operates in Kansas, Montana, Colorado and also St. Johns Hospital in Santa Monica, CA. The corporation is committed to the Medical Home model of care. The organization's goal is to make the Duchesne Clinic a medical home first and then consider moving the concept to the other clinics in the organization.

Services at Duchesne clinic include general primary care, well woman care, chronic disease management, and medication assistance. Demographics reveal a patient population of 2,244 unduplicated patients in 2010, providing over 12,000 patient visits.

The clinic relies heavily on volunteer specialists who provide services in their clinic. There are 25-30 physicians who provide care through individual schedules, including internists, gynecologist, cardiologist, surgeons, ENT and psychiatrists.

Health Partnership Clinic of Johnson County
www.hpcjc.org

Health Partnership Clinic has a patient base of approximately 3,000 unduplicated users, and produced over 10,000 patient visits in 2010. Their patient population includes 50% immigrants (Mexico, India, Russia, Central and South America). The clinic is experiencing significant growth, charting 40% increase in new patients in 2010.

Health Partnership Clinic formerly operated as a free clinic until its designation as a Federally Qualified Health Center in 2012. The clinic relies heavily on many volunteer primary care providers and specialists who provide services in their clinic. HPC obtained Level 1 NCQA PCMH Recognition in January 2011; this was upgraded to Level 3 in June 2012.

Kansas City CARE Clinic (formerly Kansas City Free Health Clinic)
www.kccareclinic.org

Kansas City CARE Clinic has a long history of success in providing care to the uninsured in the Kansas City metropolitan area. In 2012, they provided nearly 50,000 visits to a population of 15,000, most of whom are adults. Services include general medicine, behavioral health, and dental care. KC CARE Clinic is a primary contractor for federally sponsored HIV care KC Care Clinic is also a participant in several clinical research trials for HIV and hepatitis C. They employ a staff of 105 employees, and over 1,200 volunteers provide additional service delivery support.

Originally operating under the name of KC Free Health Clinic, the organization did not accept health insurance and new/existing patients with insurance coverage were referred to other sources of primary care. KC Free moved to a fee-based business model in 2012 in response to components of healthcare reform which would transition existing patients to Medicaid coverage. With the new business model, these patients can remain with their care providers at this safety net primary care location.

Samuel U. Rodgers Health Center
www.rodgershealth.org

Over 40 years ago, Samuel U. Rodgers Health Center (SURHC) was the first community health center in Missouri, and the fourth in the United States. It is one of three federally qualified health centers (FQHC) in Kansas City at this time. Last year, SURHC provided medical, dental and behavioral health services to over 21,000 patients at its eight locations.

The leadership at Samuel U. Rodgers Health Center is highly committed to quality of care. The organization's structured quality improvement program provided a solid framework upon which to advance the transition to becoming a patient-centered

medical home. SURHC added to its family of health centers in 2013 with the acquisition of Cabot Westside Medical and Dental Clinics.

Silver City Health Center
www.silvercityhealthcenter.org

The Silver City Health Center was purchased by Kansas University Medical Center (KUMC) in 1996 and was run by medical residents for nearly a decade. The clinic was purchased by Kansas University Health Partners (KUHP) in 2006, and as an affiliate of KUMC, Silver City is a "faculty practice". It is also distinguished as a nurse-managed practice, in that advanced practice nurses (nurse practitioners) provide health care services to the patient population.

With an active patient base of approximately 2,500, the clinic provided over 7,500 visits. An estimated 50% of Silver City's patients are Spanish-speaking; all medical assistants and patient service representatives are bilingual in this language. Services include comprehensive primary care, including pharmacy assistance and referral coordination, health education and community outreach aimed at prevention, and tailored programs aimed at reducing the effects of chronic disease.

Long committed to patient-centered care and health care quality, adoption of the medical home model met with early success. Silver City Health Center received Level 3 NCQA PCMH recognition in March 2011.

Sojourner Health Clinic
www.sojournerclinic.org

The Sojourner Health Clinic is a service-based learning project affiliated with the University of Missouri Kansas City School of Medicine. Launched in 2004, it is operated by medical students, with oversight by a UMKC faculty physician sponsor. Serving primarily a homeless population, the clinic operates in a church and holds clinic hours on Sunday afternoons only. The Sojourner Health Clinic provides its patients with health education, disease management, diagnosis, immunizations, screenings, and medications free of charge. The clinic sees between 20 and 25 patients each session, most of whom are repeat patients. The total active patient population is estimated at 300, and over 700 patient visits were provided last year.

Because of its business model, Sojourner Health Clinic is not likely to become an NCQA-recognized patient-centered medical home. However, this clinic functions in many ways as a medical home to its clientele. Its affiliation with a medical school and its administration by volunteer medical students offers a tremendous opportunity to introduce the volunteer students to the concepts and standards of a Medical Home, which can then be carried into the communities they serve as they become licensed physicians.

Turner House Children's Clinic
www.thcckc.org

Turner House Children's Clinic has been providing comprehensive pediatric services to underserved children in Kansas City for more than 20 years. Turner House Children's Clinic provides well-child exams, acute and chronic care, immunizations, referrals to specialists and on-site Medicaid enrollment. The clinic is open for daytime, evening and Saturday appointments.

The clinic supports a patient population of over 4,200, producing over 9,000 patient visits in the past year. Demographics reveal that the patient mix is over 80% Hispanic; uninsured patients are estimated at 46%, patients with Medicaid 54%. Over the past few years, Turner House has experienced growth in physical space as well as provider staff. Volunteer providers supplement the schedule to enhance access to care.

The corporation operates on a traditional private practice business model, and its leaders are committed to the Medical Home model of care. Turner House achieved NCQA PCMH Recognition, Level 3, in November 2012.

APPENDIX 2: IDENTIFIED TECHNICAL ASSISTANCE NEEDS

NCQA Standard	CLINIC 1	CLINIC 2	CLINIC 3	CLINIC 4	CLINIC 5	CLINIC 6	CLINIC 7	CLINIC 8
1. Access								
A. Access During Office Hours	x		x		x	x		x
B. Access After Office Hours	x		x	x		x		x
C. Electronic Access	x			x	x	x		x
D. Continuity / Empanelment	x	x	x		x	x		x
E. Cult and Ling Appropriate Services								
F. Organization of Team		x			x	x		x
2. Population Management								
A. Patient Information								
B. Clinical Data								
C. Comprehensive Health Assessment								
F. Using Data for Population Management	x	x		x	x	x	x	x
3. Care Management								
A. Implement Evidence-Based Guidelines	x	x	x	x	X	x	x	x
B. Identify High Risk Patients								
C. Manage Care	x	x	x	x	x	x		x
D. Manage Conditions		x	x		x	x		x
E. E-Prescribing			x	x		x		x
4. Patient Self-Management Support								
A. Self-Care Process	x	x	x	x	x	x	x	x
B. Referrals to Community Resources								
5. Test and Referral Tracking								
A. Test Tracking & Follow-up	x		x	x	x	x		x
B. Referral Tracking & Follow-up	x		x		x			x
C. Care Transitions	x	x	x	x	x	x	x	x
6. Performance Reporting & Improvement								
A. Measures of Performance		x		x		x	x	x
B. Patient/Family Feedback	x	x	x	x	x	x	x	x
C. Implements CQI	x		x			x	x	x
D. Demonstrates CQI	x	x	x	x		x	x	x
E. Performance Reporting	x	x	x	x	x	x	x	x
F. Report Data Externally								
Other								
NCQA Standards	x	x	x	x	x	x	x	x
EHR Planning	x	x		x	x	x		x
Use of IZ Registry	x							
Front Desk Time study			x			x		x
Dispensary/Meds/Samples Mgmt	x							x
Patient Registration	x			x	x	x		x
Skills Building for MA's	x	x	x	x	x	x		x

APPENDIX 3: OTHER LOCAL/REGIONAL PATIENT-CENTERED CARE INITIATIVES

Missouri Medical Home Collaborative

In 2011, the Missouri Medical Home Collaborative (MMHC) was launched, funded by the Missouri Foundation for Health and the Health Care Foundation of Greater Kansas City, with state oversight by MO HealthNet. Fifty clinic sites are participating in the MMHC, which is guided by the Ballit Health consulting group and includes 9 full-day learning sessions over the 2 year project period, plus telephonic consultation. In addition to PCMH concepts and transformation, key areas of emphasis in this collaborative were Clinical Care Management and Care Coordination, data collection and reporting, and development of a payment model.

Kansas Association for the Medically Underserved (KAMU) Medical Home Initiative

In 2010, KAMU launched its first learning collaborative for its member clinics, which involved technical assistance primarily through distance learning efforts. In 2012, building on its prior experience, and with the sponsorship of the Kansas Health Foundation, KAMU launched a new collaborative of 10 additional participating clinics to embark on an intensive program of technical assistance towards adoption of the PCMH model and successful formal applications for NCQA PCMH Recognition. The technical assistance model in this initiative provided a blend of technical assistance modalities, including in-person group workshops and webinars.

The Kansas Patient-Centered Medical Home Initiative (PCMHI)

Several professional associations formed a consortium to develop the PCMHI, which launched as a 24-month project in July 2011 and served as a focal point for health care transformation in Kansas. The project includes eight physician-led practices as part of a larger PCMH Initiative. The project provides education and information regarding the PCMH and encourages practices to move to the PCMH model to improve population health and clinical outcomes.

The collaborating partners are: Kansas Chapter of the American Academy of Pediatrics, Kansas Academy of Family Physicians, Kansas Association of Osteopathic Medicine, Kansas Chapter of the American College of Physicians and Kansas Medical Society. Major funding is provided by the United Methodist Health Ministry Fund, Sunflower Foundation and the Kansas Health Foundation. In addition, Blue Cross Blue Shield pledged payer support for the initiative.

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