NCACH Whole Person Care Collaborative
7/6/16 Planning Meeting Agenda

Purpose of the Meeting:

1. To develop a set of guiding or organizing principles, and next steps for the development of a whole person care learning collaborative for North Central Washington.

2. Meet with Sue Dietz to determine how she might support our collaborative efforts.

Current Status of the Collaborative:

In April, The NCACH board approved moving ahead with the development of a Whole Person Care Collaborative to accelerate the transition of primary care practices in NCW (Okanogan, Chelan, Douglas, Grant Counties) toward the triple aim for the benefit of our citizens and in support of the Health Care Authority's SIM grant and 1115 Waiver objectives. A meeting with an ad hoc group of health care organizations in May supported the direction with the specifics to be determined. We have not met since and are charged with bringing form and structure to this collaborative to allow it to move forward.

Major Assumptions/Rationale for Adoption of Whole Person Care as a lead strategy for NCW.

1. Care Transformation toward PCMH/Whole Person Care and Value Based Payment reforms are being implemented by CMS and the HCA , with support from policy advocates everywhere. In other words:
    a. The move toward Whole Person Care is inexorable, it will involve difficult change in both Medicaid and Medicare and increasingly among private insurers, and the sooner we get moving the better.
    b. There are risks of moving too slowly and advantages to getting ahead of the game.
    c. Many practices in NCW have already invested time and effort in care transformation (PCMH) and are well down the road and others are planning to do so.
    d. But it is important to note that change sufficient to achieve Whole Person Care goes well beyond PCMH certification or other current programs in most clinical settings, even those with a head start.

2. Policy leaders (and therefore CMS & HCA) are pushing Whole Person Care because the research has demonstrated its efficacy in advancing the triple aim. That is, Whole Person Care addresses not only medical problems but also the health-related social issues (such as homelessness, mental illness, domestic violence, and many others) that so often undermine effective medical care. The result is better care, with lower per-capita costs due to the prevention of unnecessary ED visits, hospitalization and other preventable utilization. Whole Person Care should be considered a backbone or infrastructure strategy that will enable many other strategies envisioned by ACHs. It seems like the best and quickest way to move the NCH forward.

3. NCW has a unique opportunity in Washington State because:
    a. We have a small number of organizations with a history of collaboration that provide a large percentage of the care in the region.
    b. We already have agreement in principle among many of these organizations that we can and should collaborate in order to move ahead more quickly and effectively.
    c. There are resources from a number of different sources (*TCPI initiatives, HCA Transformation Hub and others*) that might be repurposed toward a collaborative approach.

4. A collaborative approach can achieve better results, more quickly because:
    a. We can share resources across organizations and deploy them more effectively
    b. Agreements on standardized processes and common clinical approaches will facilitate shared learning and acceleration of change.
    c. We can jointly develop systems and processes (*HIE, care management, call arrangements, urgent care, nurse advice lines, etc.*) that cross organizational boundaries. This can reduce confusion for patients who frequently change insurance or providers and have to navigate system variation.
    d. We can create common measures and reporting mechanisms that chart progress together and promote learning from each other.

5. Moving together will give us more credibility, visibility, and clout with the HCA, MCOs, TCPI sponsors, and perhaps other funders. If we can demonstrate leadership and commitment by doing this together and effectively advance common goals we share with these organizations, we should engender their support. There is strength in numbers if we can maintain a common front.

Discussion Guide on Status relative to Whole Person Care:

1. Where is your organization in the continuum of Whole Person Care transformation?
    a. Know it's important
    b. Actively discussing
    c. Beginning to implement elements of it
    d. Well on our way to PCMH certification
    e. Fully implemented

2. How will we define Whole Person Care and is it important to agree on a standard definition, processes, measures, goals, & outcomes?
    a. What differentiates WPC from PMCH level 3 accreditation?
    b. What are the goals we expect to achieve under WPC?
    c. Is there a particular model (models) of WPC from which we could create our blueprint?

3. What role do you see the ACH WPC collaborative serving and how much authority over management of the process do members want to delegate to the ACH?
    a. Convener of planning & learning sessions
    b. Leads members in discussions to achieve consensus on goals, methods, systems, processes,
    c. Negotiates with funders and contracts for coaches, consultants, & implementation resources on behalf of the members.
    d. Schedules resources on behalf of members.
    e. Develops measurement and evaluation systems and tools to evaluate progress in achieving WPC
    f. Depending on our answers, differing levels of resource may be required to create and manage the collaborative.

Primary Care Transformation Collaborative

Meeting Agenda

Wednesday, July 6, 2016, 11:00 AM – 1:00 PM

Chelan-Douglas Health District, 200 Valley Mall Parkway, East Wenatchee

Conference Call: **1-866-906-9330** **Participant Conference Code:** **636-1827#**

PCT Collaborative DocVault Page: http://www.mydocvault.us/2016-primary-care-initiative.html

Meeting Agenda				
Meeting Facilitators: Barry Kling & Peter Morgan **Meeting Notes: Cathy Meuret**		**Invitees:** Theresa Sullivan, Doug Wilson, MD, Kevin Abel, Diane Blake, Peter Rutherford, MD, Sheila Chilson, Jimmy Wallace, MD, Jeff Davis, Jesus Hernandez, Brad Hankins, Peter Bucknum, David Olson, Sue Dietz. **Absent:**		
Topic	**Purpose**	**Who**	**Time**	**Notes/Agreements**
Introduction and Agenda Overview	Introductions, review and approval of agenda.	Barry & Peter	15	
Background on Whole Person Care	• Refresh our memory and reach common understanding of why we chose WPC and our general expectations of the strategy. • Agree on or change assumptions/rationale for WPC in this document and Barry document submitted to HCA. • Answer questions Sue may have about our current status.	All	30	
Define Role of the WPC Collaborative	Each member describes: • Their organization's position on progress toward WPC • Benefits they see from participation • Specific roles they would like the ACH & collaborative to play • Specific suggestions	All	30	
Rural Health TCPI	• Gain understanding of the work Sue is leading and the implications and opportunities for the WPC collaborative. • Describe possible role Sue might play in helping to organize our collaborative.	Sue	30	
Summary & Next Steps	Respond to questions	Peter	10	

SAFETY NET MEDICAL HOME INITIATIVE

PATIENT-CENTERED MEDICAL HOME ASSESSMENT (PCMH-A)

Organization name

Site name

Date completed

QUALIS HEALTH

The COMMONWEALTH FUND

GroupHealth

MacColl Center for Health Care Innovation

Introduction To The PCMH-A

The PCMH-A is intended to help sites understand their current level of "medical homeness" and identify opportunities for improvement. The PCMH-A can also help sites track progress toward practice transformation when it is completed at regular intervals.

The PCMH-A was developed by the MacColl Center for Health Care Innovation at the Group Health Research Institute and Qualis Health for the Safety Net Medical Home Initiative (SNMHI). The PCMH-A was extensively tested by the 65 sites that participated in the SNMHI, including federally qualified health centers (FQHCs), residency practices, and other settings, and is in use in a number of regional and national initiatives.

Before you Begin

Identify a multidisciplinary group of practice staff

We strongly recommend that the PCMH-A be completed by a multidisciplinary group (e.g., physicians, nurses, medical assistants, residents, other operations and administrative staff) in order to capture the perspectives of individuals with different roles within the practice and to get the best sense possible of 'the way things really work.' We recommend that staff members complete the assessment individually, and that you then meet together to **discuss the results**, produce a consensus version, and develop an action plan for priority improvement areas. We discourage sites from completing the PCMH-A individually and then averaging the scores to get a consensus score without having first discussed as a group. The discussion is a great opportunity to identify opportunities and priorities for PCMH transformation.

Have each site in an organization complete an assessment

If an organization has multiple practice sites, each site should complete a separate PCMH-A. Practice transformation, even when directed and supported by organizational leaders, happens differently at the site level. Organizational leaders can compare PCMH-A scores and use this information to share knowledge and cross-pollinate improvement ideas.

Consider where your practice is on the PCMH journey

Answer each question as honestly and accurately as possible. There is no advantage to overestimating or upcoding item scores, and doing so may make it harder for real progress to be apparent when the PCMH-A is repeated in the future. It is fairly typical for teams to begin the PCMH journey with average scores below "5" for some (or all) areas of the PCMH-A. It is also common for teams to initially believe they are providing more patient-centered care than they actually are. Over time, as your understanding of patient-centered care increases and you continue to implement effective practice changes, you should see your PCMH-A scores increase.

Check your computer to make sure you have Adobe Reader or Adobe Acrobat.

To complete this interactive PDF you will need Adobe Reader or Adobe Acrobat installed on your computer. Adobe Reader is free software, available here.

Directions for Completing the Assessment

1. Before you begin, please review the Change Concepts for Practice Transformation.

2. For each row, **click the point value** that best describes the level of care that currently exists in the site. The rows in this form present key aspects of patient-centered care. Each aspect is divided into levels (A through D) showing various stages in development toward a patient-centered medical home. The levels are represented by points that range from 1 to 12. The higher point values within a level indicate that the actions described in that box are more fully implemented.

3. **Review your subscale and overall score on page 15.** These subscale and overall scores are automatically calculated based on the responses entered. Average scores by Change Concept (subscale scores) and an overall average score are provided. Using the scores to guide you, discuss opportunities for improvement.

4. **Save your results** by clicking the "save" button at the end of the form. To clear your results, and retake the assessment, click on "clear" button at the end of the form.

SAVE CLEAR

PART 1: ENGAGED LEADERSHIP

1a. Provide visible and sustained leadership to lead overall culture change as well as specific strategies to improve quality and spread and sustain change.
1b. Ensure that the PCMH transformation effort has the time and resources needed to be successful.
1c. Ensure that providers and other care team members have protected time to conduct activities beyond direct patient care that are consistent with the medical home model.
1d. Build the practice's values on creating a medical home for patients into staff hiring and training processes.

Items	Level D	Level C	Level B	Level A
1. Executive leaders	…are focused on short-term business priorities. 1 2 3	…visibly support and create an infrastructure for quality improvement, but do not commit resources. 4 5 6	…allocate resources and actively reward quality improvement initiatives. 7 8 9	…support continuous learning throughout the organization, review and act upon quality data, and have a long-term strategy and funding commitment to explore, implement and spread quality improvement initiatives. 10 11 12
2. Clinical leaders	…intermittently focus on improving quality. 1 2 3	…have developed a vision for quality improvement, but no consistent process for getting there. 4 5 6	…are committed to a quality improvement process, and sometimes engage teams in implementation and problem solving. 7 8 9	… consistently champion and engage clinical teams in improving patient experience of care and clinical outcomes. 10 11 12
3. The organization's hiring and training processes	…focus only on the narrowly defined functions and requirements of each position. 1 2 3	…reflect how potential hires will affect the culture and participate in quality improvement activities. 4 5 6	…place a priority on the ability of new and existing staff to improve care and create a patient-centered culture. 7 8 9	…support and sustain improvements in care through training and incentives focused on rewarding patient-centered care. 10 11 12
4. The responsibility for conducting quality improvement activities	…is not assigned by leadership to any specific group. 1 2 3	…is assigned to a group without committed resources. 4 5 6	…is assigned to an organized quality improvement group who receive dedicated resources. 7 8 9	…is shared by all staff, from leadership to team members, and is made explicit through protected time to meet and specific resources to engage in QI. 10 11 12

Total Health Care Organization Score 0

Average Score (Total Health Care Organization Score/4) 0.0

PART 2: QUALITY IMPROVEMENT (QI) STRATEGY

2a. Choose and use a formal model for quality improvement.
2b. Establish and monitor metrics to evaluate improvement efforts and outcome; ensure all staff members understand the metrics for success.
2c. Ensure that patients, families, providers, and care team members are involved in quality improvement activities.
2d. Optimize use of health information technology to meet Meaningful Use criteria.

Items	Level D	Level C	Level B	Level A
5. Quality improvement activities	…are not organized or supported consistently. 1 2 3	…are conducted on an ad hoc basis in reaction to specific problems. 4 5 6	…are based on a proven improvement strategy in reaction to specific problems. 7 8 9	…are based on a proven improvement strategy and used continuously in meeting organizational goals. 10 11 12
6. Performance measures	…are not available for the clinical site. 1 2 3	…are available for the clinical site, but are limited in scope. 4 5 6	…are comprehensive—including clinical, operational, and patient experience measures—and available for the practice, but not for individual providers. 7 8 9	…are comprehensive—including clinical, operational, and patient experience measures—and fed back to individual providers. 10 11 12
7. Quality improvement activities are conducted by	…a centralized committee or department. 1 2 3	…topic specific QI committees. 4 5 6	…all practice teams supported by a QI infrastructure. 7 8 9	…practice teams supported by a QI infrastructure with meaningful involvement of patients and families. 10 11 12
8. An Electronic Health Record that supports Meaningful Use	…is not present or is being implemented. 1 2 3	… is in place and is being used to capture clinical data. 4 5 6	…is used routinely during patient encounters to provide clinical decision support and to share data with patients. 7 8 9	… is also used routinely to support population management and quality improvement efforts. 10 11 12

Total Health Care Organization Score 0

Average Score (Total Health Care Organization Score/4) 0.0

PART 3: EMPANELMENT

3a. Assign all patients to a provider panel and confirm assignments with providers and patients; review and update panel assignments on a regular basis.
3b. Assess practice supply and demand, and balance patient load accordingly.
3c. Use panel data and registries to proactively contact, educate, and track patients by disease status, risk status, self-management status, community and family need.

Items	Level D	Level C	Level B	Level A
9. Patients	…are not assigned to specific practice panels. 1 2 3	…are assigned to specific practice panels but panel assignments are not routinely used by the practice for administrative or other purposes. 4 5 6	…are assigned to specific practice panels and panel assignments are routinely used by the practice mainly for scheduling purposes. 7 8 9	…are assigned to specific practice panels and panel assignments are routinely used for scheduling purposes and are continuously monitored to balance supply and demand. 10 11 12
10. Registry or panel-level data	…are not available to assess or manage care for practice populations. 1 2 3	…are available to assess and manage care for practice populations, but only on an ad hoc basis. 4 5 6	…are regularly available to assess and manage care for practice populations, but only for a limited number of diseases and risk states. 7 8 9	…are regularly available to assess and manage care for practice populations, across a comprehensive set of diseases and risk states. 10 11 12
11. Registries on individual patients	…are not available to practice teams for pre-visit planning or patient outreach. 1 2 3	…are available to practice teams but are not routinely used for pre-visit planning or patient outreach. 4 5 6	…are available to practice teams and routinely used for pre-visit planning or patient outreach, but only for a limited number of diseases and risk states. 7 8 9	…are available to practice teams and routinely used for pre-visit planning and patient outreach, across a comprehensive set of diseases and risk states. 10 11 12
12. Reports on care processes or outcomes of care	…are not routinely available to practice teams. 1 2 3	…are routinely provided as feedback to practice teams but not reported externally. 4 5 6	…are routinely provided as feedback to practice teams, and reported externally (e.g., to patients, other teams or external agencies) but with team identities masked. 7 8 9	…are routinely provided as feedback to practice teams, and transparently reported externally to patients, other teams and external agencies. 10 11 12

Total Health Care Organization Score 0

Average Score (Total Health Care Organization Score/4) 0.0

PART 4: CONTINUOUS & TEAM-BASED HEALING RELATIONSHIPS

4a. Establish and provide organizational support for care delivery teams accountable for the patient population/panel.
4b. Link patients to a provider and care team so both patients and provider/care team recognize each other as partners in care.
4c. Ensure that patients are able to see their provider or care team whenever possible.
4d. Define roles and distribute tasks among care team members to reflect the skills, abilities, and credentials of team members.

Items	Level D	Level C	Level B	Level A
13. Patients are encouraged to see their paneled provider and practice team	…only at the patient's request. 1 2 3	…by the practice team, but is not a priority in appointment scheduling. 4 5 6	…by the practice team and is a priority in appointment scheduling, but patients commonly see other providers because of limited availability or other issues. 7 8 9	…by the practice team, is a priority in appointment scheduling, and patients usually see their own provider or practice team. 10 11 12
14. Non-physician practice team members	…play a limited role in providing clinical care. 1 2 3	…are primarily tasked with managing patient flow and triage. 4 5 6	…provide some clinical services such as assessment or self-management support. 7 8 9	…perform key clinical service roles that match their abilities and credentials. 10 11 12
15. The practice	…does not have an organized approach to identify or meet the training needs for providers and other staff. 1 2 3	…routinely assesses training needs and ensures that staff are appropriately trained for their roles and responsibilities. 4 5 6	…routinely assesses training needs, ensures that staff are appropriately trained for their roles and responsibilities, and provides some cross training to permit staffing flexibility. 7 8 9	…routinely assesses training needs, ensures that staff are appropriately trained for their roles and responsibilities, and provides cross training to ensure that patient needs are consistently met. 10 11 12

Total Health Care Organization Score 0

Average Score (Total Health Care Organization Score/3) 0.0

PART 5: ORGANIZED, EVIDENCE-BASED CARE

5a. Use planned care according to patient need.
5b. Identify high risk patients and ensure they are receiving appropriate care and case management services.
5c. Use point-of-care reminders based on clinical guidelines.
5d. Enable planned interactions with patients by making up-to-date information available to providers and the care team at the time of the visit.

Items	Level D	Level C	Level B	Level A
16. Comprehensive, guideline-based information on prevention or chronic illness treatment	…is not readily available in practice. 1 2 3	…is available but does not influence care. 4 5 6	…is available to the team and is integrated into care protocols and/or reminders. 7 8 9	…guides the creation of tailored, individual-level data that is available at the time of the visit. 10 11 12
17. Visits	…largely focus on acute problems of patient. 1 2 3	…are organized around acute problems but with attention to ongoing illness and prevention needs if time permits. 4 5 6	…are organized around acute problems but with attention to ongoing illness and prevention needs if time permits. The practice also uses subpopulation reports to proactively call groups of patients in for planned care visits. 7 8 9	…are organized to address both acute and planned care needs. Tailored guideline-based information is used in team huddles to ensure all outstanding patient needs are met at each encounter. 10 11 12

continued on page 9

PART 5: ORGANIZED, EVIDENCE-BASED CARE

5a. Use planned care according to patient need.
5b. Identify high risk patients and ensure they are receiving appropriate care and case management services.
5c. Use point-of-care reminders based on clinical guidelines.
5d. Enable planned interactions with patients by making up-to-date information available to providers and the care team at the time of the visit.

Items	Level D	Level C	Level B	Level A
18. Care plans	…are not routinely developed or recorded. 1 2 3	…are developed and recorded but reflect providers' priorities only. 4 5 6	…are developed collaboratively with patients and families and include self-management and clinical goals, but they are not routinely recorded or used to guide subsequent care. 7 8 9	…are developed collaboratively, include self-management and clinical management goals, are routinely recorded, and guide care at every subsequent point of service. 10 11 12
19. Clinical care management services for high-risk patients	…are not available. 1 2 3	…are provided by external care managers with limited connection to practice. 4 5 6	…are provided by external care managers who regularly communicate with the care team. 7 8 9	…are systematically provided by the care manager functioning as a member of the practice team, regardless of location. 10 11 12
20. Behavioral health outcomes (such as improvement in depression symptoms)	…are not measured. 1 2 3	…are measured but not tracked. 4 5 6	…are measured and tracked on an individual patient-level. 7 8 9	…are measured and tracked on a population-level for the entire organization with regular review and quality improvement efforts employed to optimize outcomes. 10 11 12

Total Health Care Organization Score 0

Average Score (Total Health Care Organization Score/5) 0.0

PART 6: PATIENT-CENTERED INTERACTIONS

6a. Respect patient and family values and expressed needs.
6b. Encourage patients to expand their role in decision-making, health-related behaviors, and self-management.
6c. Communicate with their patients in a culturally appropriate manner, in a language and at a level that the patient understands.
6d. Provide self-management support at every visit through goal setting and action planning.
6e. Obtain feedback from patients/family about their healthcare experience and use this information for quality improvement.

Items	Level D	Level C	Level B	Level A
21. Assessing patient and family values and preferences	…is not done. 1 2 3	…is done, but not used in planning and organizing care. 4 5 6	…is done and providers incorporate it in planning and organizing care on an ad hoc basis. 7 8 9	…is systematically done and incorporated in planning and organizing care. 10 11 12
22. Involving patients in decision-making and care	…is not a priority. 1 2 3	…is accomplished by provision of patient education materials or referrals to classes. 4 5 6	…is supported and documented by practice teams. 7 8 9	…is systematically supported by practice teams trained in decision-making techniques. 10 11 12
23. Patient comprehension of verbal and written materials	…is not assessed. 1 2 3	…is assessed and accomplished by ensuring that materials are at a level and language that patients understand. 4 5 6	…is assessed and accomplished by hiring multi-lingual staff, and ensuring that both materials and communications are at a level and language that patients understand. 7 8 9	…is supported at an organizational level by translation services, hiring multi-lingual staff, and training staff in health literacy and communication techniques (such as closing the loop) ensuring that patients know what to do to manage conditions at home. 10 11 12

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PART 6: PATIENT-CENTERED INTERACTIONS (CONTINUED)

6a. Respect patient and family values and expressed needs.
6b. Encourage patients to expand their role in decision-making, health-related behaviors, and self-management.
6c. Communicate with their patients in a culturally appropriate manner, in a language and at a level that the patient understands.
6d. Provide self-management support at every visit through goal setting and action planning.
6e. Obtain feedback from patients/family about their healthcare experience and use this information for quality improvement.

Items	Level D	Level C	Level B	Level A
24. Self-management support	…is limited to the distribution of information (pamphlets, booklets). 1 2 3	…is accomplished by referral to self-management classes or educators. 4 5 6	…is provided by goal setting and action planning with members of the practice team. 7 8 9	…is provided by members of the practice team trained in patient empowerment and problem-solving methodologies. 10 11 12
25. The principles of patient-centered care	…are included in the organization's vision and mission statement. 1 2 3	…are a key organizational priority and included in training and orientation. 4 5 6	…are explicit in job descriptions and performance metrics for all staff. 7 8 9	…are consistently used to guide organizational changes and measure system performance as well as care interactions at the practice level. 10 11 12
26. Measurement of patient-centered interactions	…is not done or is accomplished using a survey administered sporadically at the organization level. 1 2 3	… is accomplished through patient representation on boards and regularly soliciting patient input through surveys. 4 5 6	… is accomplished by getting frequent input from patients and families using a variety of methods such as point of care surveys, focus groups, and ongoing patient advisory groups. 7 8 9	…is accomplished by getting frequent and actionable input from patients and families on all care delivery issues, and incorporating their feedback in quality improvement activities. 10 11 12

Total Health Care Organization Score 0

Average Score (Total Health Care Organization Score/6) 0.0

PART 7: ENHANCED ACCESS

7a. Promote and expand access by ensuring that established patients have 24/7 continuous access to their care team via phone, email or in-person visits.
7b. Provide scheduling options that are patient- and family-centered and accessible to all patients.
7c. Help patients attain and understand health insurance coverage.

Items	Level D	Level C	Level B	Level A
27. Appointment systems	…are limited to a single office visit type. 1 2 3	…provide some flexibility in scheduling different visit lengths. 4 5 6	… provide flexibility and include capacity for same day visits. 7 8 9	…are flexible and can accommodate customized visit lengths, same day visits, scheduled follow-up, and multiple provider visits. 10 11 12
28. Contacting the practice team during regular business hours	…is difficult. 1 2 3	…relies on the practice's ability to respond to telephone messages. 4 5 6	…is accomplished by staff responding by telephone within the same day. 7 8 9	…is accomplished by providing a patient a choice between email and phone interaction, utilizing systems which are monitored for timeliness. 10 11 12
29. After-hours access	...is not available or limited to an answering machine. 1 2 3	…is available from a coverage arrangement without a standardized communication protocol back to the practice for urgent problems. 4 5 6	…is provided by coverage arrangement that shares necessary patient data and provides a summary to the practice. 7 8 9	…is available via the patient's choice of email, phone or in-person directly from the practice team or a provider closely in contact with the team and patient information. 10 11 12
30. A patient's insurance coverage issues	…are the responsibility of the patient to resolve. 1 2 3	…are addressed by the practice's billing department. 4 5 6	…are discussed with the patient prior to or during the visit. 7 8 9	…are viewed as a shared responsibility for the patient and an assigned member of the practice to resolve together. 10 11 12

Total Health Care Organization Score 0

Average Score (Total Health Care Organization Score/4) 0.0

PART 8: CARE COORDINATION

8a. Link patients with community resources to facilitate referrals and respond to social service needs.
8b. Integrate behavioral health and specialty care into care delivery through co-location or referral protocols.
8c. Track and support patients when they obtain services outside the practice.
8d. Follow-up with patients within a few days of an emergency room visit or hospital discharge.
8e. Communicate test results and care plans to patients/families.

Items	Level D	Level C	Level B	Level A
31. Medical and surgical specialty services	…are difficult to obtain reliably. 1 2 3	…are available from community specialists but are neither timely nor convenient. 4 5 6	…. are available from community specialists and are generally timely and convenient. 7 8 9	…are readily available from specialists who are members of the care team or who work in an organization with which the practice has a referral protocol or agreement. 10 11 12
32. Behavioral health services	…are difficult to obtain reliably. 1 2 3	…are available from mental health specialists but are neither timely nor convenient. 4 5 6	…are available from community specialists and are generally timely and convenient. 7 8 9	…are readily available from behavioral health specialists who are on-site members of the care team or who work in a community organization with which the practice has a referral protocol or agreement. 10 11 12
33. Patients in need of specialty care, hospital care, or supportive community-based resources	…cannot reliably obtain needed referrals to partners with whom the practice has a relationship. 1 2 3	…obtain needed referrals to partners with whom the practice has a relationship. 4 5 6	…obtain needed referrals to partners with whom the practice has a relationship and relevant information is communicated in advance. 7 8 9	…obtain needed referrals to partners with whom the practice has a relationship, relevant information is communicated in advance, and timely follow-up after the visit occurs. 10 11 12

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PART 8: CARE COORDINATION (CONTINUED)

8a. Link patients with community resources to facilitate referrals and respond to social service needs.
8b. Integrate behavioral health and specialty care into care delivery through co-location or referral protocols.
8c. Track and support patients when they obtain services outside the practice.
8d. Follow-up with patients within a few days of an emergency room visit or hospital discharge.
8e. Communicate test results and care plans to patients/families.

Items	Level D	Level C	Level B	Level A
34. Follow-up by the primary care practice with patients seen in the Emergency Room or hospital	...generally does not occur because the information is not available to the primary care team. 1 2 3	…occurs only if the ER or hospital alerts the primary care practice. 4 5 6	…occurs because the primary care practice makes proactive efforts to identify patients. 7 8 9	…is done routinely because the primary care practice has arrangements in place with the ER and hospital to both track these patients and ensure that follow-up is completed within a few days. 10 11 12
35. Linking patients to supportive community-based resources	…is not done systematically. 1 2 3	…is limited to providing patients a list of identified community resources in an accessible format. 4 5 6	…is accomplished through a designated staff person or resource responsible for connecting patients with community resources. 7 8 9	…is accomplished through active coordination between the health system, community service agencies and patients and accomplished by a designated staff person. 10 11 12
36. Test results and care plans	…are not communicated to patients. 1 2 3	…are communicated to patients based on an ad hoc approach. 4 5 6	…are systematically communicated to patients in a way that is convenient to the practice. 7 8 9	…are systematically communicated to patients in a variety of ways that are convenient to patients. 10 11 12

Total Health Care Organization Score 0

Average Score (Total Health Care Organization Score/6) 0.0

SAVE CLEAR

Scoring Summary

Change Concept	Average Subscale Score
1. Engaged Leadership	0.0
2. Quality Improvement (QI) Strategy	0.0
3. Empanelment	0.0
4. Continuous and Team-Based Healing Relationships	0.0
5. Organized, Evidence-Based Care	0.0
6. Patient-Centered Interactions	0.0
7. Enhanced Access	0.0
8. Care Coordination	0.0
Average Program Score (Sum of Average Scores for all 8 Change Concepts/8)	0.0

What Does It Mean?

The PCMH-A includes 36 items and eight sections each scored on a 1 to 12-point scale. Scores are divided into four levels, A through D. The overall score is the average of the eight subscale or Change Concept scores. For each of the items, Level D scores reflect absent or minimal implementation of the key change addressed by the item. Scores in Level C suggest that the first stage of implementing a key change may be in place, but that important fundamental changes have yet to be made. Level B scores are typically seen when the basic elements of the key change have been implemented, although the practice still has significant opportunities to make progress with regard to one or more important aspects of the key change. Item scores in the Level A range are present when most or all of the critical aspect of the key change addressed by the item are well established in the practice. Average scores for each Change Concept, and for all 36 items on the PCMH-A, can also be categorized as Level D through A, with similar interpretations. That is, even if a few item scores are particularly low or particularly high, on balance practices with average scores in the Level D range have yet to implement many of the fundamental key changes needed to be a PCMH, while those with average scores in the Level A range have achieved considerable success in implementing the key design features of the PCMH as described by the Change Concepts for Practice Transformation.

Recommended citation:
Safety Net Medical Home Initiative. The Patient-Centered Medical Home Assessment Version 4.0. Seattle, WA: The MacColl Center for Health Care Innovation at Group Health Research Institute and Qualis Health; September 2014.

For more information about this assessment, please contact
Judith Schaefer, MPH, at the MacColl Center for Health Care Innovation,
by calling 206-287-2077, or by emailing schaefer.jk@ghc.org.

Safety Net Medical Home Initiative

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The objective of the Safety Net Medical Home Initiative was to develop and demonstrate a replicable and sustainable implementation model to transform primary care safety net practices into patient-centered medical homes with benchmark performance in quality, efficiency, and patient experience. The Initiative was administered by Qualis Health and conducted in partnership with the MacColl Center for Health Care Innovation at the Group Health Research Institute. Five regions were selected for participation (Colorado, Idaho, Massachusetts, Oregon and Pittsburgh), representing 65 safety net practices across the U.S. For more information about the Safety Net Medical Home Initiative, refer to: www.safetynetmedicalhome.org.

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SUMMARY

The work of primary care providers (PCPs) and their organizations is being incented to change, because the payment methodology used by Medicaid (and increasingly by Medicare and private payers) will be changing significantly in the very near future. These incentive changes recognize the value of "whole person care," which refers to care that better meets the needs of patients by addressing not only acute medical problems but also chronic health conditions, the provision of preventative health services, addressing behavioral health needs and the social problems often associated with medical problems. This broader approach has been shown to improve care by overall improving a patient's health and quality of life, as well as reducing unnecessary office visits, ER visits, hospital admissions and specialty referrals.

The new payment models will emphasize health care entity accountability for high value care (outcomes divided by cost) by using capitated and "bundled" payments, rather than current fee-for-service payment models. Many primary care organizations will find it a challenge to provide the needed care while surviving financially under these new conditions.
We are using the term Whole Person Medical Home (WPMH) for a primary care organization or practice that has successfully adopted such an approach. We are proposing the creation of a North Central Washington Primary Care Transformation Collaborative that will utilize a collaborative approach to implementation of this care model in North Central Washington, in different legal entity practices.

WHAT IS A WHOLE PERSON MEDICAL HOME?

A homeless diabetic patient is unlikely to successfully manage diabetes without a stable living situation, and appropriate nutrition. A patient facing domestic violence, untreated substance abuse, food insecurity or many other health-related social problems is in a similar dilemma. The PCP cannot solve all of these health determinants, but is in a unique position to be able to guide the patient to a team capable of providing the appropriate assistance, including community health workers, housing specialists, mental health providers and others. With the requirement for face-to-face encounters lifted under payment methodologies other than FFS, PCPs would have the ability to use their time, as well as the rest of the team's efforts in the patient's best interest. Only patients requiring face to face visits with the PCP to meet their needs would be seen in person; more would be in touch via email and phone, and the PCP would have an increased opportunity to assure that health related psychological and social issues are addressed more appropriately. This approach has much in common with the Patient Centered Medical Home, but goes well beyond it. There is substantial evidence that this approach does improve value in healthcare. In addition, PCPs and their staff find that this is a more satisfying way to practice. But the transition is not easy.

HOW WOULD THE PRIMARY CARE COLLABORATIVE HELP?

Preparing for these changes is both complex and risky. Everything from compensation plans and PCPs' work flow, to IT systems and the physical arrangement of offices may have to change. Organizations that move away from fee-for-service care to prepare for new payment systems will need to invest resources in this change process, and will likely have an added penalty in the form of reduced fee-for-service reimbursement during the transition. Organizations that delay the transition to value based payments, and the associated work process adjustments, until the new payment measures are instituted risk a significant disruption of their business model when the new system is implemented.

While each organization or practice must work out these adjustments for itself, collaborative efforts across organizations in North Central Washington can reduce the risks to individual organizations. We can share the positive learnings, and the failures, producing a better care system for all the area's residents. There are many options for collaboration, while maintaining business and financial data confidentiality. All rural primary care providers will need to work collaboratively with other organizations to address whole person service needs. These cannot be met independently. We need to establish a common processes for care coordination with hospitals, specialists, behavioral health organizations, and social service organizations. There is no other way to have a successful, long term viable health care system in North Central Washington.

As examples, the Collaborative may address the following:

1. Access to after-hours phone or on-line advice from a nurse (who can utilize the patient's medical record, and is usually backed by a PCP and often by a pharmacist) helps patients succeed with their treatments while avoiding unnecessary ER visits. But small clinics often cannot afford to do this on their own. Cooperative efforts to implement such services can be developed by the Collaborative.

2. Well over a dozen organizations in the state already have special grants to provide consultation and training to providers, but they are not well coordinated. The Collaborative can be a mechanism through which these training and consultation resources can be matched to the needs of Collaborative members, without each provider organization having to deal with a dozen transformation projects. More effective sharing of training and consultation services will result.

3. Primary care organizations can collaborate to develop IT capabilities they will need to track Whole Person Care screening data, activities such as Community Health Worker home visits, and metrics/standards such as those that come with integrated Medicaid contracts.

4. Developing transition plans and dealing with change management issues will be important for every provider organization. Without straying into business issues that must remain confidential, Collaborative members will have opportunities to learn from each other in developing and refining these efforts.

5. By covering a large proportion of the region's population, the Collaborative will be well positioned to attract outside funding to support the transition.

BECOME A PART OF THE COLLABORATIVE

Join this effort, or learn more about it, by contacting one of these founding members:

Peter Rutherford, CEO, Confluence Health, peter.rutherford@confluencehealth.org
Peter Morgan, Board Member, Family Health Centers, ptrmrgn@gmail.com
Patrick Bucknum, CEO, Columbia Valley Community Health, pbucknum@cvch.org
Kevin Abel, CEO, Lake Chelan Community Hospital, kabel@lcch.net

Administrative support and staffing for the Collaborative will be provided by the North Central Accountable Community of Health. At this point no costs or fixed obligations have been established for membership, though we expect that members will hold one another to some level of accountability for participation and progress toward transformation objectives.

RESOURCES

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SOME ASPECTS OF A WHOLE PERSON MEDICAL HOME