North Central Accountable Community of Health

Patient-Centered Medical Home Assessment (PCMH-A)

Summary of Regional Results
Interim Report
May 24, 2017

QUALIS HEALTH Washington State Department of Health Healthier WASHINGTON

Overview

The purpose of this report is to provide the North Central Accountable Community of Health (ACH) with detailed results based on the administration and analysis of Patient-Centered Medical Home Assessments (PCMH-A) conducted in the North Central region. For questions concerning this report or its contents, please contact Gwen Cox (gwenc@qualishealth.org) or Rick Helms (rickh@qualishealth.org).

The North Central ACH engaged the Practice Transformation Support Hub and Qualis Health to provide technical support to practices in the counties of Chelan, Douglas, Grant and Okanogan, specifically administering and providing feedback of results from the PCMH-A instrument, a tool for supporting and monitoring progress in primary care practice redesign. An initial administration of the PCMH-A instrument data and results are discussed herein for nine primary care clinics, which completed the assessment prior to May 1, 2017. This interim report will be followed by subsequent reports with additional practices engaged in the assessment process. Individual reports are shared with participating agencies with comparison against the regional scores.

The following practices engaged in the assessment process and their results are included in this report:

- Columbia Valley Community Health, Wenatchee
- Columbia Valley Community Health, Chelan
- Family Health Centers, Omak
- Family Health Centers, Twisp
- Family Health Centers, Tonasket
- Lake Chelan Clinic
- Mid Valley Clinic
- Moses Lake Community Health
- Quincy Community Health

Please note: The data contained herein is blinded and does not explicitly identify individual practice scores. However, with the limited number of respondents reported, anonymity of individual clinics cannot be assured. Care should be taken when distributing this report if results are to remain blinded.

Assessment

The PCMH-A was jointly developed by the MacColl Center for Healthcare Innovation at the Group Health Research Institute and Qualis Health as part of the Safety Net Medical Home Initiative (SNMHI), a national demonstration project intended to support medical home transformation among practices serving vulnerable and underserved populations (www.safetynetmedicalhome.org). SNMHI sites included migrant and community health centers, residency clinics, private practices, and other facilities. The PCMH-A is based on a series of Change Concepts for Practice Transformation that comprise the technical assistance framework for the Practice Transformation Support Hub.[1]

[1]Wagner EH, Coleman K, Reid RJ, Phillips K, Abrams MK, Sugarman JR. "The Changes Involved in Patient-Centered Medical Home Transformation." *Primary Care: Clinics in Office Practice* 39(2) (2012): 241-259.

Qualis Health and the Practice Transformation Support Hub utilize the PCMH-A to gather data from primary care practices on transformation activities and readiness for integrated care. The tool was determined to be the best of the available options for assessment because it is appropriate for primary care settings, has a scale that is sensitive to change over time, and provides information that would serve as a helpful starting point for agencies creating action plans for implementing whole person care strategies.

Administration

The PCMH-A is administered by a practice facilitator (Connector/Coach), with a multidisciplinary group (e.g., physicians, nurses, medical assistants, residents, other operations and administrative staff) to build consensus on each of the 36 questions 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" in a practice. Discussions occurring in the consensus building process provide opportunities to identify prospective areas for transformation. Each practice site (or clinic) completed an assessment. Even when directed and supported by organizational leaders, practice transformation happens differently at separate clinic locations. Organizational leaders can compare PCMH-A scores and use this information to share knowledge and cross-pollinate improvement ideas across multiple sites.

The PCMH-A is a *self-assessment tool*, which relies on an honest appraisal by a clinical team of their practice transformation progress and efforts. Inflation or deflation of scores can occur when questions are misunderstood or consensus is inadequately built among the team.

Scoring Summary

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 stages 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 aspects 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.

Summary scores for each Change Concept are computed based on the individual item scores in each section. The practice-specific Change Concept, or subscale score, is the average of the individual PCMH-A item scores for each Change Concept. The practice-specific overall score is the average of all eight subscale scores.

Summary of Results

This report summarizes PCMH-A scores for practices the North Central region which completed the assessment prior to May 1, 2017. This report presents the scores of nine practices, each with an initial administration of the assessment. (*See Figure 1*)

Success: Enhanced Access (Median: 9.50/12.00)

- 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.
- Provide scheduling options that are patient- and family-centered and accessible to all patients.
- Help patients attain and understand health insurance coverage.

All practices scored themselves at a Level C or above regarding enhanced access to the care team. The majority of clinics surveyed report having same-day appointment availability, and the majority represent themselves as ensuring patients are seen in a timely manner for their presenting concerns and work hard to respond to patient questions or concerns as soon as possible (most often same-day). The clinics present that they meet and often exceed access standards and processes for patient access across the North Central area; it is unknown if patient perceptions of access match this report. Additionally, many clinics reported providing navigation to existing and potential healthcare coverage for their patients to ensure they are all covered appropriately.

Success: Patient-Centered Interactions (Median: 9.17/12.00)

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

All practices surveyed have a strong awareness of the importance of patient-centered interactions and are interested in improving services to provide better care for patients. With a high median score, the vast majority of practices are making concerted efforts to ensure patients are actively involved in decision-making about their own care. Additionally, there is a strong awareness of the importance of space and movement toward creating patient-focused clinic spaces. It is evident that the surveyed clinics are part of small communities and are passionate about serving their family, friends and neighbors.

Success: Continuous Team-Based Healing Relationships (Median: 9.00/12.00)

- Establish and provide organizational support for care delivery teams accountable for the patient population/panel.
- Link patients to a provider and care team so both patients and provider/care team recognize each other as partners in care.

- Ensure that patients are able to see their provider or care team whenever possible.
- Define roles and distribute tasks among care team members to reflect the skills, abilities, and credentials of team members.

Practices possess highly-engaged care teams, who work together to ensure patients get the best care possible. The majority of clinics report operating with limited resources and under budgetary constraints, but dedicated staff are available to assist patients. In observation, this often means nurses are completing tasks that are traditionally performed by medical assistants, such as rooming patients and gathering vital signs.

Area of Improvement: Engaged Leadership (Median: 7.25/12.00)

- Provide visible and sustained leadership to lead overall culture change as well as specific strategies to improve quality and spread and sustain change.
- Ensure that the PCMH transformation effort has the time and resources needed to be successful.
- 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.
- Build the practice's values on creating a medical home for patients into staff hiring and training processes.

The perception of leadership engagement is varied among respondents. The median score of 7.25, with several agencies scoring themselves 5.00 or lower, indicates a need for some leaders to refocus energies in support of practice transformation and provide: visibility and resources for transformation activities, support for continuous learning opportunities, and protected time for integration and quality improvement activities. In observation, several leaders were vocally supportive of transformation and quality improvement activities, but the staff reported not having protected time for these activities. A few staff and providers came on their own time to complete the assessment with the group, as the time could not be carved out of their workdays.

Area of Improvement: Empanelment (Median: 7.75/12.00)

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

A foundation for practice transformation and behavioral health integration activities is empanelment. A lack of formal empanelment was common in many of the clinics assessed; few clinics represented that they were utilizing empanelment features in the EHR systems. For those utilizing empanelment, the process is not occurring in the most efficient way (e.g. load balancing between partner providers is not occurring). Going further and utilizing population health strategies and registries is not occurring in the vast majority of practice sites.

Area of Improvement: Quality Improvement Strategy (Median: 8.25/12)

- Choose and use a formal model for quality improvement.

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

Although there is a strong median score, multiple clinics assessed themselves at a score of 5 or below (Level C or Level D). Implementation of formal quality improvement strategies and plans are essential to the implementation of whole-person care; however, several clinics voiced a concern that they do not have time to make changes to their existing processes and engage in meaningful quality improvement initiatives. Many voiced frustration with inefficiencies which exist with staff, tasks, and workflows, but lack the structure of quality improvement or time to make meaningful and lasting changes.

Additional Discussion

Care Coordination

Understanding of change concepts is critical to accurate scoring. Additionally, scores tend to fluctuate over time with the care team's increase in understanding of the change concepts in action in the clinical setting. For example, although Care Coordination scores were relatively high (Median: 9.33/12.00), the Connector/Coach observed consensus scoring higher than was represented in descriptions of activities occurring in multiple clinic sites. Much of the coordination occurring in clinics assessed involves managing referrals and feedback, with few clinics discussing how to make coordination work effectively in the clinical environment and move away from task orientation. Additional education may be required on Care Coordination concepts in several agencies, so they can consider implementation of care management strategies with their population. This will be addressed in individual clinic reports and action planning.

Behavioral Health Integration

Responses show high variability between clinics on the two questions directed at behavioral health integration in the primary care setting. *(See Figure 2)*

Behavioral health outcomes measurement shows practices gathering but not utilizing data. Many practices are administering screening tools for behavioral health (most notably, the PHQ-9), but the results of these screening tools are not utilized in patient care. The data is collected and present in the patient record for many clinics; however, practitioners, in many cases, are not actively utilizing this data to drive treatment decisions and improve behavioral health symptoms.

The availability of behavioral health resources is scored very high overall, (Median: 10.00/12.00), as community resources are present for patients with mild to moderate, as well as those with severe and persistent, mental illness. On-site behavioral health professionals are available at approximately half of the reporting clinic sites, with many of these being part time. However, multiple clinics voiced difficulty accessing these services in a timely manner, even those with co-located services. Additionally, these professionals are often not part of the care team, but work in parallel to the medical teams. Psychiatric prescribers are often not available in the area. Primary care providers may prescribe medications for behavioral health diagnoses, but often lack available support for psychiatric diagnosis and prescribing consultation.

Limitations

There are notable limitations for the data presented in this report. Primarily, the small number of clinics involved in the initial data collection for this interim report presents a limitation, as they may or may not be representative of the community at-large. Lastly, multiple Federally-Qualified Health Centers (FQHCs) are included in this cohort of respondents. By nature, FQHCs are poised to potentially score higher on many of the PCMH-A questions, as they traditionally have the fundamental framework for establishing Patient Centered Medical Homes.

Conclusions

The clinics assessed in the North Central region possess many strengths, which poise them appropriately to further the journey of practice transformation and providing whole person care. Additional gains can be made, with assistance from the Accountable Community of Health and the Practice Transformation Support Hub in: 1) actively engaging leadership and how they can best support their teams in transformation; 2), defining and implementing strategies for patient empanelment; 3) implementing a quality improvement strategy and high leverage improvements; and 4) providing technical assistance in the implementation of care coordination strategies in the clinical environment.

Additional clinic locations will be added to this report, as the data becomes available in May and June 2017. A discussion of the findings in this report will be discussed with the North Central Accountable Community of Health leadership. This discussion will include next steps and opportunities for Qualis Health and the Practice Transformation Support Hub to provide technical assistance to practices in the North Central region.

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Appendix 1: Change Concepts for Practice Transformation

LAYING THE FOUNDATION

ENGAGED LEADERSHIP

- Provide visible and sustained leadership to lead overall cultural change, as well as specific strategies to improve quality and spread and to sustain change.
- Ensure that the PCMH transformation effort has the time and resources needed to be successful.
- 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.
- Build the practice's medical home values into staff hiring and training processes.

QUALITY IMPROVEMENT (QI) STRATEGY

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

BUILDING RELATIONSHIPS

EMPANELMENT

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

CONTINUOUS & TEAM-BASED HEALING RELATIONSHIPS

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

CHANGING CARE DELIVERY

ORGANIZED, EVIDENCE-BASED CARE

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

PATIENT-CENTERED INTERACTIONS

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

REDUCING BARRIERS TO CARE

ENHANCED ACCESS

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

CARE COORDINATION

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

Appendix 2: Change Concepts for Practice Transformation (graphic)