Statewide Initiatives Using PCMH to Transform Care in the Safety Net

Massachusetts

In Massachusetts, increasing provider dissatisfaction was exacerbating an already critical primary care workforce shortage operating in the context of the state's universal coverage mandate. The problem is even more pronounced in community health clinics (CHCs) that are committed to delivering primary care to a low-income, vulnerable population in a fee-for-service system. These CHCs are also under pressure to provide coordinated care with limited resources for populations with complex social, behavioral, and economic issues.

The Massachusetts League of Community Health Centers (MLCHC) is the state's primary care association, a network of both federally qualified and hospital licensed CHCs located throughout the state. The MLCHC is a co-executive sponsor of the Commonwealth Foundation-Qualis Safety Net Medical Home national demonstration (SNMHI) in the state. There are 14 practice sites actively working in SNMHI towards medical home practice transformation and NCQA patient-centered medical home (PCMH) certification.

In addition, the Massachusetts Executive Office of Health and Human Services (EOHHS) implemented a state-sponsored, multi-payer medical home initiative for 45 primary care practices across the state. These include the 14 SNMHI CHC sites, other CHCs, academic practices and private primary care practices. The MLCHC is a member of this project team and collaborates in the planning, implementation, and evaluation of the state medical home initiative.

Goals of both the SNMHI and EOHHS initiatives are to transform primary care practices, especially those serving the safety-net populations, to medical homes as illustrated by planned, proactive primary care that engages patients' and meets patients' needs for access, continuity of care, and care coordination managing safe transitions within the health care system.

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This was not an easy and straightforward task, particularly in fully engaging the practices to participate in the PCMH transformation.

"We knew we needed to engage practice leadership but we underestimated the importance," said Joan Pernice, Director of Clinical Health Affairs at MLCHC. "The practice leaders must be present and visible on the ground throughout the process."

Another goal of the initiative was to spark improvements in patient outcomes. The MLCHC has been engaged in quality improvement for 15 years to improve chronic disease outcomes for patients in the safety-net. However, despite early gains, the measures began to flat-line.

Since participation in the SNMHI and EOHHS initiative, patient satisfaction has significantly improved in surveys as well as anecdotally. Patients are feeling and seeing the difference. Most notably, patients comment on the ease of scheduling an appointment when it is requested and feeling more connected to a care team, understanding they can speak with a nurse or medical assistant as well as their provider. Consumer board members have also noted the changes in practice structure that resulted in increased patient satisfaction.

Provider satisfaction, critical in the context of the workforce shortage, also improved. Through the initiatives, provider satisfaction surveys are administered annually, and from baseline to first year of implementation, there has been an overall score increase of 35% in provider satisfaction. This result reflects a more positive attitude with the work setting, their practice, and with primary care in general. Respondents indicated a more hopeful opinion on the future of primary care within the larger healthcare environment.

Patient clinical outcome improvements are still a struggle, even after 2 years in the initiatives. The initiatives have established a core set of both outcome and process measures to monitor the performance improvement and impact of practice transformation. These include clinical measurement in chronic illness such as diabetes, hypertension, and asthma and operational measures such as access to care, continuity of care, and patient engagement. Yet, standard clinical measures are not demonstrating significant improvement trends. The interpretation of this is that (1) patient clinical improvements take more time to reflect the changes in practice and (2) practice redesign needs to be stabilized and implemented for some period of time before they can impact patient outcomes.

Lessons Learned

- Engaged practice leadership is a critical factor in the success of practice transformation work. The organizational "buy-in" and support of the cultural shift to a patient centered medical home and an organization of continuous quality improvement is an ongoing process that must be led by administrative and clinical leadership.

- Operationalization of team-based care and associated work flows are both critical and foundational. Practice transformation cannot occur without cohesive, functional multi-disciplinary teams.

- It is important to change the understanding of what a team is and the decision making process within the team in a practice. This is especially relevant with integration of care management functions and with integration of behavioral health.

- Care management and care coordination are interrelated (but separate) functions that might prove the most effective in moving the improvement curve on costs and patient clinical outcomes.

- Use of data and reliable reports is essential to monitor performance, gauge impact, and set goals for next phase of redesign work. Data drive performance improvement.

- Change inertia happens and can be difficult to overcome but is not insurmountable.

Thanks to this non-AF4Q community for sharing its bright spot at the AF4Q national meeting in May 2012.