Building and Spreading Medical Homes

Transformed primary care practices – also known as medical or health homes – are the cornerstones of integrated, patient-centered health care delivery systems. Medical homes represent primary care in its most advanced form, where care is delivered by patient-focused care teams armed with the training and tools to provide high quality, efficient, patient-centered care.

As comprehensive systems of care that encompass a wide range of services, California’s public health care systems (PHS) are all working vigorously to build, strengthen and spread medical homes. In fact, all 21 PHS are participating in a five-year pay-for-performance initiative called the Delivery System Reform Incentive Program (DSRIP), a federal initiative that includes, among other system improvements, specific performance milestones tied to the development and expansion of medical homes. If all health care systems achieve all DSRIP milestones, they could earn as much as $3.3 billion in federal incentive payments.

In the first years of the DSRIP, which began in November 2010, most public health care systems devoted significant time and effort creating the infrastructure to enable the development and expansion of medical homes and a subsequent shift to more outcomes driven work and measures. PHS’s medical home efforts include:

- Implementing disease registries to provide teams with the tools and data to provide culturally competent care and better manage population health
- Designing systems where patients are assigned to care teams that take responsibility for keeping their patients healthy
- Using team-based care to maximize and expand the level of care provided to patients

Public health care systems are amassing indispensable lessons regarding medical homes that will benefit other providers engaged in similar endeavors, particularly those involved in other pay-for-performance initiatives. While PHS are meeting their milestones and making major improvements in their delivery of care, it is not only their many achievements that have bolstered their transformation. Rather, it is the lessons they have learned along the way that have proven the most valuable.
Lesson #1. Building medical homes requires investment.

California’s public health care systems have predicated their medical home DSRIP plans on the recognition that the higher-level functions of a medical home cannot be carried out if the foundational pieces are not in place first. It is not possible to provide truly integrated, coordinated care without first investing the necessary time, resources, and redesigned processes to shift the paradigm from a reactive, acute care model to a medical home model in which a team of providers proactively manages a panel of patients and assumes responsibility for their health.

Dr. Thomas Bodenheimer and colleagues from the UCSF Center for Excellence in Primary Care identified ten building blocks for transformed primary care and a successful patient-centered medical home:

1. Engaged Leadership
2. Data Driven Improvement
3. Empanelment
4. Team-Based Care
5. Patient-Team Partnership
6. Population Management
7. Continuity of Care
8. Prompt Access to Care
9. Coordination of Care
10. Template of the Future

Dr. Bodenheimer et al. observed that the first four building blocks enable the remainder to be put in place, which public health care systems have borne out through their experiences. One cannot work on population management or care coordination without first identifying and empaneling a group of patients. Most public health care systems devoted the first several years of the DSRIP to the three foundational elements of data driven improvement, empanelment, and team-based care.

Data-Driven Improvement: Building EHRs and Registries

As Dr. Bodenheimer notes, “Data provide the bedrock of high-performing health practices, enabling clinics to see variation in practice and identify those models that lead to better health outcomes, fiscal

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1 Willard, Rachel and Bodenheimer, Thomas, The Building Blocks of High Performing Primary Care: Lessons from the Field, prepared for the California HealthCare Foundation, April 2012
sustainability, and increased efficiency.”² To enable data driven improvement, many public health care system clinics have implemented electronic health records (EHRs) and registries, which allow them to identify and understand their patient population and engage in quality improvement.*

In this complex process of data-driven improvement, public health care systems’ experiences have varied considerably, including:

a) **The ease with which the data are produced.** Not all public health care systems have EHRs or registries that front-line staff can easily access to generate lists of care team patients due for a given service. Those public health care systems that began their DSRIP-related medical home work with EHRs already in place had a head start in using data to drive improvement. For example, UC Davis Medical Center, which already had an EHR in place for several years, designed an influenza immunization notification report that enables providers and staff to more effectively discuss patient care plans at team huddles during flu season.

b) **The granularity of the data.** Public health care systems have recognized that they cannot just produce data at the system or clinic-level; they must drill down to the individual provider level where accountability lies and change begins. This is the finding at Contra Costa Regional Medical Center, for example, which concluded that standardized provider data would help them sustain their gains, and enable them to achieve or exceed their goals regarding building medical homes.

c) **The dissemination of the data.** Public health care systems have noted the importance of sharing data up, down, and across the organization from the frontlines to the Quality Department and the executive-level leadership. This was true for Alameda Health System in the process of optimizing their EHR. They reported that “the more collaborative the process is, the faster the implementation and the better the results” when there was vertical and horizontal cross-functional collaboration of line staff, providers and managers.³

**Empanelment: Assuming Responsibility for Patients’ Health**

Empanelment—the process of ensuring that every patient has an assigned primary care provider team—is also a foundational building block of high performing medical homes. All public health care systems are empaneling their patients, and eleven have specific DSRIP milestones related to empanelment. Empanelment enables providers to take responsibility for keeping their patients healthy, not just caring for them when they are sick. Every month each provider team sees a report of their assigned patients, which includes key clinical quality measures. Patient assignment provides a systematic way to

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² Ibid, page 7

* Efforts related to EHR implementation were not tied to DSRIP milestones, but are part of the Medicaid EHR Incentive Program

³ Alameda Health System DSRIP Narrative Report, DY 8
encourage patients to see their own primary care provider team, and it enables the public health care system to better measure performance, as well as to manage supply and demand.4

There is no accepted standard panel size for the safety net. In general, safety net patients have multiple chronic diseases and other psycho-social issues (such as low literacy, poverty, and homelessness) which play a role in determining how many patients a given provider care team can reasonably manage. Hence, it can take as long as a year to define what “active patients” are, decide on appropriate panel sizes, risk stratify, assign patients to medical homes, and develop the ability to produce monthly provider panel reports. Especially noteworthy is Los Angeles County Department of Health Services’ empanelment of more than 300,000 patients to specific provider-led teams at county-based and community clinics.

Team-Based Care: Providing Better Care More Effectively

The third foundational building block that many public health care systems have tackled through DSRIP projects is the establishment of team-based care in which every team member—provider, medical assistant, nurses, and others—shares responsibility for the health of their panel of patients and works at the top of their license and abilities. For example, Arrowhead Regional Medical Center’s McKee Family Health Center reorganized staff into primary care team pods and “podlets,” changing job descriptions to reflect the new duties. Nurses provide patient care via in-person clinic visits and through phone and e-mail visits. Licensed Vocational Nurses (LVNs) serve as panel managers for the pods, monitoring panel size and quality metrics. Clinic Assistants perform self-management support, patient education on basic conditions, and medication reconciliation. Clerks coordinate referrals and help ensure compliance with evidence-based guidelines for preventative services by running reports and contacting patients in need of these services, increasing the team’s capacity to see more patients. These changes have allowed non-clinical staff to develop closer relationships with patients, with both staff and patients more satisfied.

This type of wholesale change to staffing models and job descriptions is necessary in order to most effectively function as medical homes. For public health care systems that need to work through county human resources, this can be a lengthy process. It is important to realize that the transition to team-based care in the public sector can be a protracted one and may require partnership with local unions.

Lesson #2: Building medical homes requires staff buy-in and commitment.

The successful transformation from primary care clinic to medical home cannot be achieved through a top-down approach. Staff must be fully engaged in changing the way they provide care. For example, to fully gain support for the medical home delivery model, San Mateo Medical Center clinic leadership met weekly for nearly a year with staff to discuss the significant scheduling and changes in job duties necessary to provide team care.

Staff commitment and excitement will accelerate adoption of the medical home model. This was the case at the UCSF Primary Care Clinic (UPC), where training medical assistants and health workers in panel management and health coaching resulted in an enthusiastic response from physician leaders and staff to pursue NCQA PCMH recognition, one of their DSRIP milestones.5

Lesson #3: Spreading medical homes requires shared peer learning.

For many public health care systems, the daunting journey of evolving primary care clinics into medical homes has been made less arduous and more expedient by sharing experiences and best practices with one another. For example, throughout 2012 and 2013, Bay Area public health care system ambulatory leaders have met regularly in conversations facilitated by CAPH’s improvement affiliate, the California Health Care Safety Net Institute (SNI). This group has shared their experiences – and spread best practices – about care team optimization, standing orders, physician wellness and primary care capacity post-EHR implementation, among other highly relevant medical home issues. They have also discussed how to streamline their processes in order to increase primary care capacity. For example, clinic leaders in the San Francisco Department of Public Health plan to pilot a successful telephone consultation clinic developed at Contra Costa Regional Medical Center as a novel model of improving access.

SNI-facilitated DSRIP learning sessions and other convening opportunities have identified common practices, key drivers of success, and have spurred peer-to-peer problem solving. For instance, eight public health care systems are implementing Lean, a set of management principles and practices that drive greater efficiencies and reduced waste. Through close collaboration, half of these systems are planning primary care and medical home improvement Lean “events” in the upcoming DSRIP demonstration year, which will undoubtedly accelerate transformation to more sophisticated medical homes.

DSRIP Support Lays the Foundation

Through DSRIP support, public health care systems are solidifying their foundations and spreading medical homes to care for their patients better than ever before. Their lessons learned in building and spreading medical homes in the early years of the DSRIP will reap benefits in later years, particularly as millions of newly covered and remaining uninsured patients seek primary care in safety net clinics. In order to respond to increased demand and competitiveness in the new market, public health care

5 National Committee on Quality Assurance Primary Care Medical Home accreditation
systems must increase their capacity, efficiency and patient-centeredness. And, essential to their success are the three fundamental lessons shared here: 1) investment in the foundational building blocks of data-driven improvement, empanelment and team-based care; 2) staff engagement; and 3) spread through shared learning.