

Safety Net Medical Home Initiative
CHANGE CONCEPTS
Updated February 19, 2009

The change concepts that guide our practice improvement plan are presented below. The Institute for Healthcare Improvement (IHI) defines a change concept as “a general idea - with proven merit and a sound scientific or logical foundation - that can stimulate specific ideas for changes that lead to improvement.” These provisional change concepts provide our current framework to support the PCMH model of care. Training and technical assistance will center on helping Regional Coordinating Centers and their partner clinics work together to improve care by making these incremental changes at both the practice- and regional-level.

Engaged Leadership

PCMH practices:

- Provide visible and sustained leadership to lead overall culture change as well as specific strategies to improve quality and spread and sustain change.
- Establish a QI team that meets regularly and guides the effort.
- 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.

Quality Improvement (QI) Strategy

PCMH practices:

- 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.
- Obtain feedback from patients/family about their healthcare experience and use this information for quality improvement.
- Ensure that patients, families, providers, and care team members are involved in quality improvement activities.
- Optimize use of health information technology to:
 - Schedule appointments and monitor access to care.
 - Define and understand their patient population, including subpopulations.
 - Define and track care of individual patients and subpopulations, including referrals and abnormal lab/imaging results.
 - Provide patient-specific educational materials.
 - Provide individual care reminders.
 - Provide patient summary data at time of visit.

- Enable feedback to team and for external reporting on processes of care and population outcomes.
- In addition, PCMH practices strive to use technology to improve communication between patients and practices through:
 - Online/web-based interactive support for care.
 - A means of secure communication with patients and caregivers, allowing them to build personal health records.
 - Remote monitoring.

Empanelment

PCMH practices:

- Determine and understand which patients should be empanelled in the medical home and which require temporary, supplemental, or additional services.
- Use panel data and registries to proactively contact, educate, and track patients by disease status, risk status, self-management status, community and family need.
- Understand practice supply and demand, and balance patient load accordingly.

Patient-Centered Interactions

PCMH practices:

- 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.

Organized, Evidence-Based Care

PCMH practices:

- Use planned care according to patient need.
- 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 at the time of the visit.

Continuous and Team-Based Healing Relationships

PCMH practices:

- Link patients to a provider and care team so both patients and provider/care team 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.
- Cross-train care team members to maximize flexibility and ensure that patients' needs are met.

Enhanced Access

PCMH practices:

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

Care Coordination

PCMH practices:

- Link patients with community resources to facilitate referrals and respond to social service needs.
- Provide care management services for high risk patients.
- Integrate behavioral health and specialty care into care delivery through co-location or referral protocols.
- 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/families.