L11: How to Transform Your Practice into a Medical Home

Sunday, December 8, 2013

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Agenda

- Welcome and Introductions
- Patient Centered Medical Home (PCMH) framework and key change concepts
- How PCMH was implemented as part of MA CHIPRA Demonstration
- Family Partner Group Exercise
- Community Resources Spider Web Exercise

Session Objectives

- Identify the elements and benefits of the PCMH
- Determine the barriers and challenges that must be overcome to implement this model in their own practice
- Develop a plan for designating and training a local leader to transform their practice into a medical home
WELCOME AND INTRODUCTIONS

WHAT IS A MEDICAL HOME?
CHARLES HOMER, MD, MPH
Medical Home

Medical Home Model developed by American Academy of Pediatrics (AAP) was in 1967 to deliver primary care that is accessible, compassionate, and culturally effective.

- Creates comprehensive and collaborative working relationships between numerous clinicians, their patients, and families.
- Integrates preventive services, acute illness management, and chronic condition management.
- Key strategy to meet the needs of CYSHCN

Patient-Centered Medical Home

Model of primary care that is:

patient-centered
comprehensive
team-based
coordinated
accessible
focused on quality and safety
Why Implement the Medical Home Model?

Benefits of Patient-Centered Medical Homes include:

- **Triple Aim** outcomes of better health, better care and lower costs are achieved

- Short- and long-term savings for patients, employers, health plans and policy makers
  - Lowers costs and spending by reducing factors such as:
    - Inpatient visits
    - Emergency room use
    - Hospital readmissions

- Improves both patient and physician satisfaction

Medical Home Change Concepts

[Image: http://www.improvingchroniccare.org/downloads/snmhi_change_concepts.png]
CHIPRA Learning Collaborative Driver Diagram

Outcomes

Create Pediatric Medical Home
- Improved:
  1. Clinical outcomes
  2. Family experience
  3. Team experience
  4. Efficiency & reduced costs

Primary Drivers

- Linkage to and Mobilization of Community Resources
- Family & Youth Centered Care
- Comprehensive Coordinated Care
- Continuous Medical Home Care Team
- Systems Improvement
- Engaged Leadership

Engaged Leadership

To support successful transformation, organizational leadership should:

- Actively support medical home implementation
- Plan in advance for sustainability and spread
- Develop partnerships, alliances, cooperative relationships and advocacy that support better health for patients (foundation for medical neighborhood)
- Align policy and procedures with medical home goals and philosophy
- Develop systems to use and share data transparently
- Develop an improvement strategy that is shared across the organization
Systems Improvement

• Develop and use a functional electronic health record (EHR) or other information technology (IT) system
• Use registry for population management
• Implement quality improvement methods and use data for learning and improving
• Streamline clinic flow
• Promote medication safety
• Support evidence-based care at point of care
• Improve access to care
• Improve office efficiency

Continuous Medical Home Care Team

• Define roles and responsibility of care team
• Enhance internal communication
• Prepare in advance for visits
• Ensure a continuous care team for family
• Provide access outside of clinical encounters
• Enhance access at high need times
**Comprehensive, Coordinated Care**

- Engage family in all transition into adult life plans (include schools, hospital)
- Provide preventive care and anticipatory guidance
- Give evidence based recommendations to families when setting treatment goals
- Coordinate care with specialists, mental health, oral health, and other community providers
- After hospitalization work closely with family
- Develop care plans for children and youth with special healthcare, behavioral health, and social needs

**Linkage to and Mobilization of Community Resources**

- Link families to community support
- Create support systems with community programs, service agencies, employers and public organizations, schools, American Academy of Pediatrics chapter, Family Voices
- Share best practices and evidence-based interventions with community agencies and public organizations
- Partner with organizations that support key ethnic groups in your community
- Build knowledge of community services within your practice
Family and Youth Centered Care

• Treat family as equal partners in care
• Share information and make information easy for family to access
• Include family members on improvement team
• Create a family advisory group
• Develop health literate education materials
• Develop culturally sensitive care
• Develop a way to identify and meet family concerns and priorities
• Help families connect with advocacy networks and training opportunities

FAMILY ENGAGEMENT
ELAINE FITZGERALD, DRPH, MIA
Importance of family engagement

- Family members are a catalyst for change
- Each family member’s journey is personal and life changing
- Families are invested in the outcomes
- Parents/families today are working at the national, state, and local levels to affect change
- Families reflect the cultural diversity of unique to each community
- Family members respond to encouragement from the professionals they work with
- Family members have skills to be valued

Family and Youth Centered Care

Drivers of Change:

- Treat family as equal partners in care
- Share information and make information easy for family to access
- Include family members on improvement team
- Create a family advisory group
- Develop health literate education materials
- Develop culturally sensitive care
- Develop a way to identify and meet family concerns and priorities
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Practice Level Changes
Treat Family as Equal Partners in Care

Recommended Changes

Provide new families practice orientation, including best way to navigate clinic systems

Small Tests of Change

1. Develop new family orientation packet in collaboration with Patient Family Advisory Council

2. Expand orientation from just newborns to older “new” patients

Recommended Changes

Family sets goals with care team regarding their child (e.g. strengths, pain, fear, anxiety, goals, behavior)

Small Tests of Change

1. Care coordinator and patient navigator identified a care plan template; PDSA developed to test with 1 complex patient

2. Included Goal of Treatment on asthma action plans set with family; reviewing goals at follow-up
Practice Level Changes
Create a Family Advisory Group

Recommended Changes
Create patient advisory group that participates in strategic planning, meets periodically; and is involved with practice improvement team

Small Tests of Change
Patient Advisory Group established with consistent meeting times; identified changes:
- Create brochure with a list of available clinic resources
- Provide input on re-designing waiting room and front desk kiosk

Family Partners on Improvement Teams: Rationale and Value

Direct quotes from Practices about the value of Family Partners:

- Our 2 parents are integral and key members of our MH Team. They literally have contributed on every level. They often offer their own experiences within the practice that more times than one have lead us to a positive change or have given us insight as to whether or not a change is being implemented across all care teams appropriately.

- The clarity around what their needs are has been extremely helpful because it allowed us to realize that our priorities were off.

- Our FP’s contributions have far exceeded our expectations. They have proven to be very invested in our practice and their perspective as parents has been respected within our medical home team meetings.
Family Partner Group Exercise

Objectives:
- Understand fundamental improvement science principles
- In pairs, develop one PDSA to engage families in medical home transformation efforts

Model for Improvement

Aim
Measures
Ideas

Source: Associates in Process Improvement
Repeated Use of the PDSA Cycle

**Model for Improvement**

- What are we trying to accomplish?
- How will we know that a change is an improvement?
- What change can we make that will result in improvement?

**Hunches**
- Theories
- Ideas

**Changes That Result in Improvement**

- Very Small Scale Test
- Follow-up Tests
- Wide-Scale Tests of Change
- Implementation of Change

**DATA**

**Revised Initiative for Children's Health Care**

12/2/2013

14
Repeated Use of the PDSA Cycle

**Model for Improvement**
- What are we trying to accomplish?
- How will we know that a change is an improvement?
- What change can we make that will result in improvement?

**Changes That Result in Improvement**

**Very Small Scale Test**

**Follow-up Tests**

**Wide-Scale Tests of Change**

**Implementation of Change**

**DATA**

**Plan Do Study Act (PDSA) Cycle**

**Developing a PLAN**
- Is this cycle used to develop, test, or implement a change?
- What question(s) do we want to answer on this PDSA cycle?
- Based on this question, what are my predictions?
- Plan to answer questions: Who, What, When, Where
- Plan for data collection: Who, What, When, Where
Plan Do Study Act (PDSA) Cycle

Do:
- Execute the plan as developed
- Report the completed change or tests
- Report on data collected
- Begin analysis

Study:
- Complete analysis of data
- Compare data to predictions
- Summarize learnings
Plan Do Study Act (PDSA) Cycle

Act:
- Are we ready to make a change?
- Should we adopt, adapt, or abandon the change?
- Plan for the next cycle

PDSA Cycle Example

Question:
Will a pre-visit questionnaire support families to identify current family concerns and priorities?

Prediction:
- Some families will complete the pre-visit questionnaire and it will help the practice focus on those concerns during the visit more directly
- Medical procedures / tests will take precedence and the pre-visit questionnaire will be underutilized
- .....
Improvement team including family voice
Ideas from experts and other practices
Discuss with patient advisory group

Test of Change
Pre-visit questionnaire to identify family concerns and priorities

ACT: Train all staff and address questions; test again with next vaginal birth

STUDY: Was able to get baby S2S in 6 minutes. Team aiming for 5 or less. Changes needed to shorten time to mom. Need some additional work with team to educate on importance of immediate S2S

PLAN: Develop sample questionnaire with improvement team and family input; plan to test with Dr. Jones and 1 family

DO: Dr. Jones and team tests S2S with one patient; S2S tested as planned; Test prompted dialogue
Test of Change
Pre-visit questionnaire to identify family concerns and priorities

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STUDY: Was the family’s concerns and priorities identified and information used to guide the visit? Visit time allowed for one concern to be addressed. Need additional work on usability of questionnaire & operationalize collection during check-in

ACT: Train all staff and address questions; test again with next vaginal birth
Test of Change
Pre-visit questionnaire to identify family concerns and priorities

**PLAN:** Develop sample questionnaire with improvement team and family input; plan to test with Dr. Jones and 1 family

**ACT:** Adapt form and test with another family with protocol for front desk to collect at check-in

**STUDY:** Was the family’s concerns and priorities identified and information used to guide the visit? Visit time allowed for one concern to be addressed. Need additional work on usability of questionnaire & operationalize collection during check-in

**DO:** Dr. Jones and family tests pre-visit questionnaire as planned

PDSA Ramp: Identifying Family Concerns

**Pre-visit questionnaire**

**Very Small Scale Test:** one provider, one family

Evidence & Data → Breakthrough Results

Learning and improvement
Follow up Tests: More providers, More families, involve support staff

Wide-Scale Test: Standardize process, clarify roles and responsibilities, workflows
PDSA Ramp: Identifying Family Concerns

Implement Change:
New procedure, training, job descriptions (spread)

Your Turn!

In pairs:
Develop 1 PLAN (PDSA) to engage families in medical home transformation efforts

1. Develop question and prediction
2. Develop PLAN to address this question

Handouts
- Family, Youth, and Child Centered Care Drivers and Changes
- PDSA Worksheet
Report Out

- What surprised you the most about using this approach to engage families?
- What questions did this raise for your team?
- How do you see yourselves taking this information back to your practices?

LINKAGE TO AND MOBILIZATION OF COMMUNITY RESOURCES

SHIKHA ANAND, MD, MPH
Benefits of Community Partnering

• Families look to their physicians *(and care teams)* for guidance and support through collaborative problem solving and resource management

• It is important to be aware of, refer, and even partner with community organizations that offer ancillary services of benefit to patients and families

National Center for Medical Home Implementation
http://www.medicalhomeinfo.org/how/care_delivery/#partnering

Identify Community Assets

• Discover the programs and services in the community that provide positive, strength based assistance to families

• Established organizations with experience effectively supporting families can be productive partners in improving outcomes for patients and families
Identify Community Assets

Where to start making connections:

• Survey families in practice
• Network with other medical professionals
• Connect with Early Childhood programs (Head-start, Early Intervention, etc.)
• Establish contacts in school districts (elementary and secondary school level)
• Learn of resources available through faith-based organizations
• Check Community Education, Town Recreation, YMCA and Boys & Girls clubs
• Look for family support organizations
• Check local Department of Public Health
• Review services of State Maternal and Child Health Title V programs
• Maternal and Child Health Library’s Community Services Locator
  http://www.mchlibrary.info/KnowledgePaths/kp_community.html
• Use internet searches and phone books

Building Knowledge within the Practice

• Create practice resource book
• Bulletin boards
• Invite community partners to staff meetings
• Host resource fairs
• Include community groups contact information on practice web-page
• Devote time during staff meeting for success stories of community linkages
• Local list of possible community resources for pediatric practices
• Create local list of possible community resources for pediatric practices

Use sample form to gather contact information on local referral sources and family groups
Family Support Organizations

- Peer support can provide valuable opportunities for families to learn the systems and services needed to help their children and youth thrive
- By sharing a common lived experience, families develop a trust which can lead to deeper identification of needs
- These relationships allow families to develop community connections while gaining practical knowledge

COMMUNITY RESOURCES SPIDER WEB EXERCISE
Mapping Your Community Connections

Spider Web Instructions:

- Write your practice name in the middle of a large post-it sheet
- Write the names of key community organizations you are already connected with on the left. Draw a solid line to connect the organization with your practice name
- Write the names of organizations you would like to connect with on the right. Draw a dotted line to connect the organization with your practice name

<table>
<thead>
<tr>
<th>Current Connections</th>
<th>Future Connections</th>
</tr>
</thead>
<tbody>
<tr>
<td>PPAL</td>
<td>MSNO</td>
</tr>
<tr>
<td>Community Catalyst</td>
<td>MCPAP</td>
</tr>
<tr>
<td>Family TIES</td>
<td>WIC</td>
</tr>
<tr>
<td>EI</td>
<td>Boys &amp; Girls Club</td>
</tr>
</tbody>
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Practice Name
Community Resource Spider Web Report Out

- Identify key areas your team identified as strengths and gaps in your community connections

- How can you engage community resources within those areas?

- By next Tuesday, what is the first step you’d like to take in connecting with or strengthening one community partnership?

Thank You!

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