Idaho SHIP Clinic Transformation

Patients + Providers = Better health, Better value

Prepared for
Idaho SHIP PCMH Clinics

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Statewide Healthcare Innovation Plan (SHIP) is supported by Funding Opportunity Number CMS-1G1-14-001 from the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services.

Look What We Accomplished!

Through Idaho's Statewide Healthcare Innovation Plan (SHIP) 163 primary care practices, just like yours, have transformed into Patient-Centered Medical Homes (PCMH). As of January 31, 2019, 88 clinics have achieved national PCMH recognition as well. It has not been easy, but it has been worth it, and we celebrate your success.

Researchers with the State-Level Evaluation Team (SET) sought to capture and tell the story of PCMH transformation in Idaho. This is what we did:

- We interviewed PCMH clinic staff from 126 clinics spanning the three cohorts. We spoke with individuals either in person or by phone.
- We analyzed PCMH Portal Notes of clinics in each of the three cohorts.
- We conducted windshield surveys to get a snapshot of the clinics and surrounding environment.
- We recorded panel discussions among members of the healthcare team. We posted the recordings on the SHIP website in order to share the "lived" experience of transformation.
- We spoke with 1,143 of your patients from 92 clinics. Based on your recommendations, program participation, or random selection, we interviewed individuals either in person, by phone, or completion of a written questionnaire.

As a result of our work, the SET gained valuable insights about how the experience made a difference to you. We also learned about your patients and what they need to achieve better health. The purpose of this report is to share statewide themes and recommend broad strategies to support your continued efforts to advance healthcare in Idaho. We hope this will be valuable to you, your clinic staff and patients! In this report we'll highlight three key topics:

1. What we heard from you
2. What we heard from your patients
3. SET recommendations going forward

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What we heard from you

It's all about patient care, and the PCMH model translates to better patient care

Your clinics strive to provide patient-centered care where the focus is on the best thing for the patient at the time. Your patients appreciate PCMH in the practice and in the care, they receive.

- *"PCMH allows me to provide better care for patients with complex needs."*
- *"When a clinic transforms to PCMH, all the patients in the clinic benefit."*
- *"It's a chance to get back to what we say we want from medicine."*

PCMH is a team sport

Patients are better served by team-based care, and an integrated care team results in more points of contact which lead to improved outcomes. Team members enjoy working in a team; it's more efficient and makes more tools available.

- *"The people on our team want to be more engaged clinically."*
- *"Through the resources we now have we're able to manage a difficult patient's care without me having to see him all the time."*
- *"We're getting better at providing proactive care around specific diagnoses."*

PCMH transformation is a journey, not a destination

Clinics must determine the pros and cons of becoming PCMH accredited. Transformation involves a heavy lift, both financially and organizationally. A lot of it is about learning the systems and tools that work best for the clinic and developing better systems of communication. It's a continual effort.

It requires redefinitions of staff roles and redirection of certain workflows. Restructuring of the work environment occurs for professionals involved in direct patient care and their administrative support teams. The experience and challenges of transformation vary greatly and depend on individuals' roles.

Data and documentation are critical

PCMH requires a greater degree of focus and attention to data.

- *"We have to be able to measure things to improve them, so you have to continually look at the data and you have to react to it."*

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The payment systems haven't caught up with transformation efforts

The payers want to pay for value, and its coming. But many of you repeatedly acknowledged the challenges of heading toward a value-based payment model while still existing in a fee-for-service world.

— *"Sometimes it feels like rafting down a fast-moving river with your legs in two different rafts."*

PCMH has a positive impact on clinics and patients

You are already seeing short-term benefits of PCMH. Your most stated response was greater access and better continuity of care. You also identified pre-visit planning, seeing gaps in care, and addressing environmental factors.

Your journey continues

As your journey of PCMH transformation continues, most of you reported that your first priority for the coming year is continual development in the areas of quality improvement and performance measures. You are also prioritizing care coordination and care transitions, as well as care management and support.

There seems to be a collective need for continued support, specifically in the form of mentoring from other clinics. Our clinics in frontier counties desire help with patient-centered access and continuity of care. Our rural clinics seek help with templates for policies and procedures, and EHR affinity groups.

We also heard you identify a need for assistance with health technology. You told us that you feel there are so many programs to report to, it becomes a balance between providing better care or providing better reports.

— *"We want to be able to provide the most beneficial care to patients, without it being too cumbersome in terms of documentation."*

— *"We seem to be navigating how to implement and document processes while providing efficient services."*

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What we heard from your patients

Most patients accept responsibility for their role in creating better health

Most of the patients we talked to believe they are personally responsible for their own health. Responsibility looks different to different people. For example, some may define their responsibility as following the directions of the healthcare team.

Circumstances matter

We talked to many people who will never get better due to circumstances beyond their control. We talked with others who will only get better when circumstances beyond their control are addressed, such as co-morbidities, homelessness, socioeconomic status, employment, etc. Still others experience barriers that can be overcome with time or effort. All of these circumstances must be recognized when working with the whole person.

Patients we spoke with identified 23 specific barriers to better self-care. The most frequently stated barriers were finances, health issues, and personal motivation.

Patients value the patient-centered care they receive from their healthcare team

Although they may not know the technical terms, patients desire the foundations of PCMH. For the most part, they value the patient-center care they receive.

- *"Whenever I have any questions they always can answer it."*
- *"I think that I've been given a lot of needed information from my clinic and everyone has been really helpful."*
- *"They are very engaged in my health. When I have questions, they call me back, and they're very good at making sure that they relay information to me in a way that I can understand."*

Patients want more from their healthcare team

Communication was by far the most frequent aspect that patients want. This ranged from listening to concerns, confirming the patient understands recommendations, and providing further explanation when necessary.

- *"Listen, listen, listen. They really need to listen to what you say, what you are concerned about. If they don't know the answer, look something up and get back in touch with you."*
- *"I think they need to make sure that they're really paying attention to what the patient is saying. I like to be heard."*

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— *"Making sure that I understand and am heard."*

Patients indicated they would benefit by counseling on nutrition.

— *"I think it is the healthcare team's responsibility to be able to educate the patient on how to prevent and take care of their health."*

Patients told us they value care coordination.

Patients want access to care

They want to be able to schedule an appointment with a healthcare team when they need one, at a location that is accessible to them. They want their care to be coordinated in a way that does not require them to repeat their story along their journey to health. They appreciate when their provider and healthcare team know who they are before they enter the exam room. Patients want to be listened to by providers and staff who care about them.

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SET recommendations going forward

Acknowledge the momentum and gains in PCMH transformation

The Goal 1 of the SHIP program was an amazing endeavor to get multiple stakeholders to the discussion table and to create an environment ripe for transformation. I think Goal 1 of SHIP provided a launch pad for PCMH transformation in Idaho. It encouraged clinics to begin the PCMH journey and connected them to resources, technical assistance, and other PCMH clinics.

Ongoing role of RCs and expanding role of medical health neighborhood

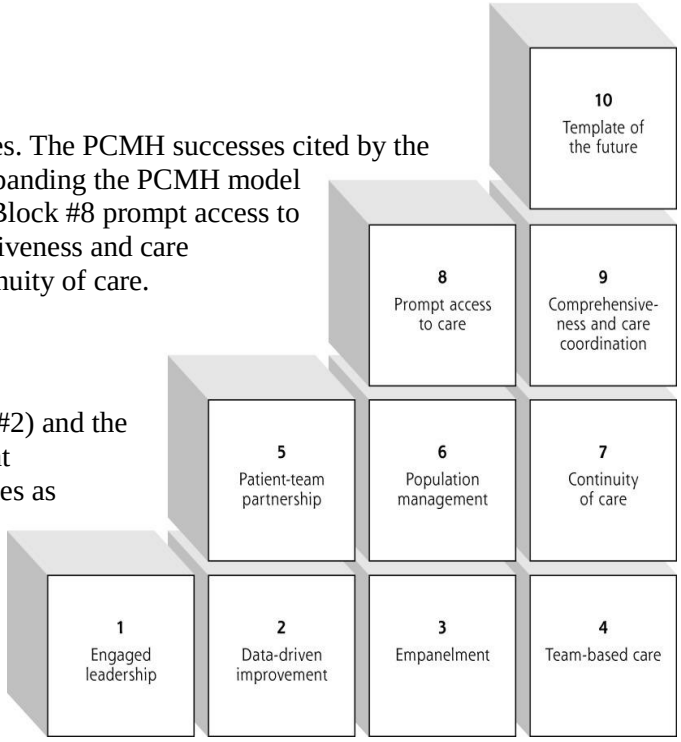
Primary care clinics are not positioned to deal with the barriers alone, they need the partnerships across the community to address the barriers and make sure the PCMH can function. Partnerships provide additional sources of what patients want: listening, etc. CHWs could help here too as could CHEMS staff. Breaking out of the silos.

Expand PCMH services

There is room to expand on PCMH services. The PCMH successes cited by the clinics offer a possible continuation of expanding the PCMH model for clinic functions. These were Building Block #8 prompt access to care and, Building Blocks #9, comprehensiveness and care coordination and Building Block #7, continuity of care.

Data-driven improvement

The Bodenheimer model (Building Block #2) and the related function of Population Management (Building Block #6) appeared multiple times as recognized key PCMH functions and frequently encountered challenges.
Of central concern was a basic capacity to generate timely and accurate clinical data from the Electronic Health Records. Because of problems with data quality, as one example, capacity was limited for the risk stratification analyses necessary for effective population management (Building Block #6).



Building Block #2: Ten Building Blocks for the Patient Centered Medical Home

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Clinic's challenges in data generation, particularly for rural, independent clinics, recommends that training modules be developed for mid-level clinic staff in data capture, data aggregation, data validation and data reporting.

The responses of patients to a question on what prevented them from taking care of themselves as well as what they would like to underscore the necessity of differentiating among the social determinants health that may be feasibly addressed by a clinic, and determinants requiring support from a broader medical health neighborhood. This question reverts to the role of some version of a Regional Collaborative Organization with capacity to identify and connect resources for primary care providers and their patients.

Patients' feedback on their interest in exercise and nutrition offer an example of collaboration at the clinic and community level within the PCMH and medical health neighborhood paradigms. Primary care clinics could build on patients' interest in the patient team partnership using Motivational Interviewing or similar techniques to assess patient's readiness to change for specific health behaviors. Patients in turn could be referred to options for food and for exercise offered through community partnerships with ongoing follow-up from their healthcare team. The Idaho SHIP leaves in place an interconnected, patient-centered system for such initiatives central to improvement of individual health.

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