Developing an Organizational Culture that Sustains the **Patient-Centered Medical Home:**

Lessons Learned

Prepared by Capital Link | 2016

CAPITAL LINK

INTRODUCTION

The shift to a patient-centered medical home (PCMH) model of care in the U.S. is driven by the need to provide high-quality, coordinated, accessible, and affordable care to an expanding patient base. It is supported not only by the health care community, but also by policymakers, employers, and third-party payers. Health centers that have made the decision to obtain certification as a PCMH seek to improve quality, outcomes, patient and staff satisfaction, and to prepare for new reimbursement methodologies. However, this endeavor comes with challenges. It requires significant investments in time, resources, technology, operations, and community relations. Additionally, the transition to a PCMH often involves a shift in work culture within an organization. Moving to a team-based approach to primary care requires total commitment on the part of all staff; roles often need to be redefined and work processes redesigned.

The goal of this resource is to address the challenges health centers face in creating a culture that will sustain a PCMH and to provide strategies for success. It includes valuable lessons learned from health center leaders who have navigated this transformation and insight from Capital Link's own work with health centers across the country.

What is a PCMH?

The Agency for Healthcare Research and Quality (AHRQ) defines a PCMH as "a model of the organization of primary care that delivers the core functions of primary health care" with the following five functions and attributes:

1. Comprehensive Care - The primary care medical home is accountable for meeting the large majority of each patient's physical and mental healthcare needs, including prevention and wellness, acute care, and chronic care. Providing comprehensive care requires a team of care providers.

2. Patient-Centered - The primary care medical home provides care that is relationship-based with an orientation toward the whole person. Partnering with patients and their families requires understanding and respecting each patient's unique needs, culture, values, and preferences.

3. Coordinated Care - The primary care medical home coordinates care across all elements of the broader healthcare system, including specialty care, hospitals, home health care, and community services and supports.

4. Accessible Services - The primary care medical home delivers accessible services with shorter waiting times for urgent needs, enhanced in-person hours, around-the-clock telephone or electronic access to a member of the care team, and alternative methods of communication such as email and telephone care.

5. Quality and Safety - The primary care medical home demonstrates a commitment to quality and quality improvement by ongoing engagement in activities such as using evidence-based medicine and clinical decision-support tools to guide shared decision making with patients and families, engaging in performance measurement and improvement, measuring and responding to patient experiences and patient satisfaction, and practicing population health management. Sharing robust quality and safety data and improvement activities publicly is also an important marker of a system-level commitment to quality.

Source: Agency for Healthcare Research and Quality, https://pcmh.ahrq.gov/page/defining-pcmh

THE CHALLENGES OF TRANSFORMATION

The following is a collection of insights and trends from the field on the organizational culture challenges of becoming a PCMH. The information has been summarized from interviews with leadership, providers, and staff from more than 60 health centers that Capital Link assisted in their transition to the PCMH model of care.

Why Pursue Certification?

Health center leaders report that their motivation for pursuing PCMH certification is due to one or more of the following three reasons — a quick response to a directive, the desire to be ready for new reimbursement methodologies under payment reform, and the desire to remain competitive in the marketplace. The challenge is making the needed changes without damaging processes and relationships that are working well.

Does PCMH Lead to Better Outcomes?

If outcomes are defined as completing tasks and providing services according to new PCMH models of care, then the answer is "yes". If outcomes are defined as enabling patients and communities to achieve a higher level of health, then the answer is "maybe". Since health centers are currently focused on incorporating new structures and processes, we cannot yet determine if significant progress towards better health outcomes has been made.

Have You Successfully Incorporated New Tools and Technology?

In many cases, health centers simultaneously undergo the transition to an electronic health record, the expansion of clinical technology, and the movement toward team care. While the three initiatives support each other, the cumulative effect of change can produce negative consequences in productivity, retention, and performance improvement. Successfully traversing the path from tool acquisition through orientation to proficiency is, in many cases, still a work in progress.

Are You Receiving Adequate Reimbursement?

Whether driven by the loss in billable productivity or the expansion of staff positions, even in centers receiving PCMH certification incentives, revenue does not yet align with expense. Health centers report that the transition to a PCMH culture will only happen when the traditional face-to-face encounter with a billable provider is no longer the sustainability driver.

How Can You Sustain Change?

Most of the health centers interviewed concurred that the transition to a PCMH environment has been task driven rather than reflective of a shift in their organizational culture. While the concept of relational, patient-centric, and interdisciplinary team-based care is generally understood, focus to date has been on the mechanics of monitoring, coordinating, and documenting care. For some, the barrier to cultural change is lack of consensus. Others follow a calculated strategy to minimize perceived clinical, operational, and financial risk while slowly moving forward to meet certification requirements. However, to be both sustainable and effective, task activity must be supported by changes in both the structure and culture of the care environment.

THE EXPERIENCE OF CARE

Move your culture toward patient-centeredness by understanding the patient and family experience within five stages of care through the eyes of the patient.

How Can You Improve Access?

Whether by phone, email, text, or face-to-face, the optimal time to interact with a patient is…whenever they would like to! Creating an access plan is more than designing a visit template to maximize slots. The patient-centric goal is to maximize utilization and enhance interactions by changing your schedule to accommodate the patient, not the other way around. Health centers must align the lifestyle preferences and culture of their communities with processes in order to break down the barriers to access. Within a PCMH culture, each team needs to develop a different encounter template to align their availability and processes to maximize access for their unique population. For example, keeping appointment slots open in the mornings for new moms, scheduling early morning appointments for diabetics, or scheduling well-child visits during after-school hours.

How Can You Provide Sustained Engagement?

Relational care is the door to optimizing clinical outcomes, providing the opportunity to not simply address acute needs, but to influence the future health status of patients and communities. Developing those relationships must be intentional as both the staff and the organization build bridges to sustain patient engagement.

Effective strategies include:

- Communicate a welcome inclusion by creating entry spaces that reflect and celebrate your communities' cultures and history.
- Evaluate the role of making eye contact within the culture and organize staff workspaces to either encourage or minimize as appropriate.
- Establish peer relationships, rather than dominant ones, between patients, families, and staff by allowing independent, intuitive movement through the facility, accommodating personal care needs without requiring permission, and providing multiple opportunities for patient-initiated conversations with staff.
- Invest in systems that ensure inter-visit contact between staff and patients.

How Can You Work with Patients to Develop the Plan of Care?

Provider and patient roles change within a patient-centric team culture. Historically, the patient requests a plan, the provider creates one, and then the patient decides if they will or will not follow the plan. Those who follow are "compliant"; those who do not are "noncompliant."

Now, the provider relinquishes authority, within the team as well as with the patient, as he or she takes on the role of informed advisor. The provider develops, rather than dictates, the plan of care with input from the team and in agreement with the patient. Thus, if the plan falters, all three parties will determine if the plan is unrealistic, unattainable, or ineffective and create a new plan accordingly. Within this culture, the patient encounter may be longer, the tone and content of dialogue changes, and the number of persons involved grows. Visit process flow must develop flexibility to accommodate this new way of interacting.

How Can You Help Facilitate the Care Plan?

Facilitation is the process by which the team accompanies the patient as they carry out the plan of care to encourage action, remove barriers, and monitor progress. It is the core function of the team designed to sustain the process and maximize the outcomes of care.

The team is able to quickly identify untoward events and challenges, and assure patient access. Its relationship with the patient develops as contact, either direct or indirect, is maintained. The team is also able to evaluate the effectiveness of the plan as data is collected and measured. Health centers that invest, financially and operationally, in active facilitation ensure that patients experience a circle of care rather than an open arc.

How Can You Provide Care in Context with Your Community?

The Context that Exists: Patients are not always forthcoming about barriers they face in moving toward optimal health. It is a vital function of the team to be alert to common and unique barriers patients face and advocate for their elimination within the community.

The Context we Create: Our relationships with our community significantly impact the patient experience. Whether it's the treatment they receive from staff at a referral site or pharmacy, or the responses from friends and neighbors when they tell them where they get care, or their ability to negotiate healthy lifestyle resources, our reputation can either pave the way or create a barrier to a patient's optimal health. It is imperative to not only build but also monitor those relationships on behalf of our patients.

Understanding Context: Referral coordinators, outreach staff, social workers, peer counselors, and patients alike are a rich resource, serving as leadership's eyes and ears in the community.

THE DELIVERY OF CARE

What are key elements of the optimal staff experience within an integrated care team model?

Team Composition

A team that is too small lacks the capacity and resources to effectually manage the patient population. For instance, small teams cannot meet the access commitments to accommodate same-day service and extended hours for all of their patients. If a team is too large, it starts to splinter off creating outliers and "teamlets", which challenges effective communication and negatively affects team function. An industry recommendation is five to nine team members; however, successful primary care teams are often 10 to 13. Under the current payment system, at least three team members should function as billable providers. Other members include both process facilitators, such as medical assistants and referral clerks, and care facilitators, such as registered nurses and dieticians.

Integration

The charge of the team is to do more together than they could separately; working with each patient to develop, monitor, and facilitate a plan of care tailored to their unique strengths and challenges. Thus, the more varied the skill set of the team, the greater the opportunity to provide quality care. Health centers traditionally have incorporated behavioral health and oral health as core services within their systems. Integrating and co-locating these services within the primary care team consistently increases both staff and patient satisfaction and supports comprehensive and holistic approaches to health. The decision to incorporate alternative and/or specialty providers should be reflective of the needs and culture of the patient population and may vary from team to team within a health center system.

Work Process

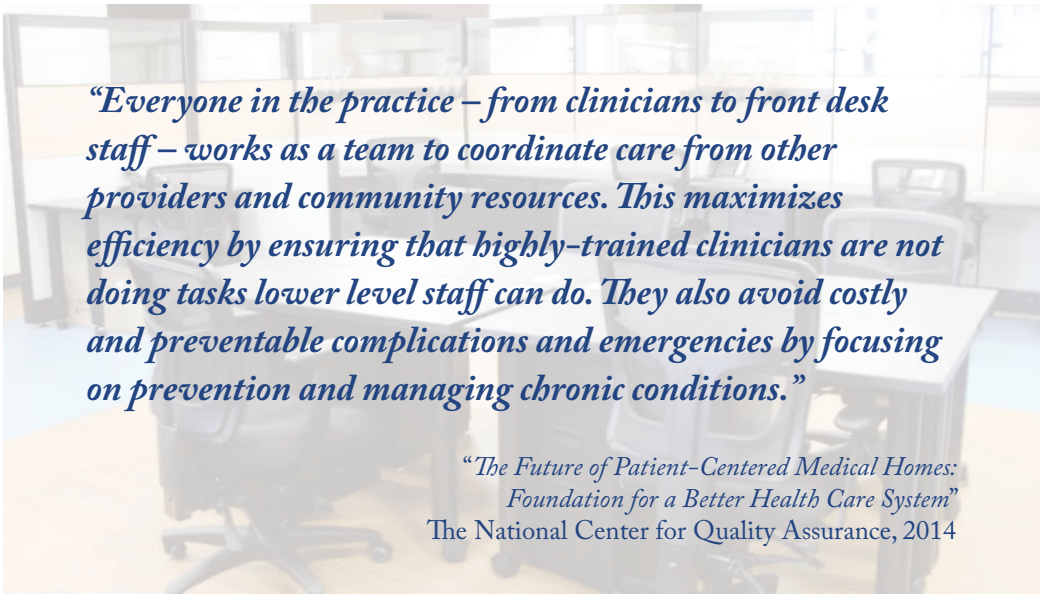
The team work process is designed to maximize each member's skills and experiences while supporting the overall function of the team. A guiding principle is that over the course of a week, each team member spends 80 percent of their time contributing to the process of care using the unique skill set they bring to the team, leaving 20 percent of their time to facilitate the function of the team. For instance, the phone rings and a physician is the only one in the zone. Within a team process, the physician answers the phone and responds fully to the caller, thus supporting the function of the team. However, this does not mean that the physician is now expected to answer every call that comes to that unit, as this process would not maximize the skill set he or she was hired to bring to the team. The primary functions remain clear, but lines between roles can blur as teams work together rather than sequentially. It is critical to have job descriptions and contracts that not only allow but also encourage this blurring which supports team function.

Measuring Performance

As an organization transforms from a group of individuals working side-by-side to a set of teams working collectively to achieve more than they could individually, the measure of successful performance likewise moves from individuals benchmarked against each other to teams benchmarked against other teams. Although team members are responsible for contributing significantly to the team effort, successful performance is measured by the team accomplishing more together than the sum of their efforts individually. Health centers that continue to evaluate each individual without evaluating the function and outcomes of the team fail to support the cultural change to team-based care.

Transforming Space

As health centers work to squeeze team offices into existing spaces, there is often a tendency to move from working "always apart" to "always together", which is well intentioned but ineffective. It is important that members of the team have workspaces that foster real-time communication during the patient care process. There is also a need for spaces that allow for quiet work either alone, with another team member, or with a patient. The team also benefits from spaces located away from the clinical flow to complete case reviews, evaluate care processes, and plan strategically. Work zones developed to support focused work, collaborative work, and group work maximize the function of the interdisciplinary team.



"Everyone in the practice – from clinicians to front desk staff – works as a team to coordinate care from other providers and community resources. This maximizes efficiency by ensuring that highly-trained clinicians are not doing tasks lower level staff can do. They also avoid costly and preventable complications and emergencies by focusing on prevention and managing chronic conditions."

"*The Future of Patient-Centered Medical Homes: Foundation for a Better Health Care System*"
The National Center for Quality Assurance, 2014

THE CONTEXT OF CARE

The environment within which the experience and delivery of care occurs is key to the effectiveness and sustainability of that care. A supportive, sustainable, and flexible structure best supports the cultural transition to a patient-centered, team-based model of primary care delivery.

Internal Structure

Support Teams

Depending on the size, number, and location of the patient care teams, an organization may find it more cost and logistically effective to centralize some of the functions of the team. For small to mid-sized organizations, entry systems, such as telephones, reception, and financial screening, may be conducted by one team that supports all clinical teams. Likewise, the decision to distribute or consolidate staff with specialized skills supports both team function and patient access.

Spaces

Doing things differently or adding non-traditional services often requires a different place to do them! Alternative patient visits including group visits, family meetings, and non-provider visits all require spaces that differ from our traditional "box with a sink and exam table."

Technology

Infrastructure that gives teams tools to interact with patients, peers, and the community while keeping their focus on the interaction rather than the tool boosts both efficiency and effectiveness, supporting improved outcomes and retention of patients and staff.

Decision Making

The optimal PCMH organizational structure facilitates ready response to opportunities and challenges that occur during each day as well as pilots solutions to problematic trends and changing patient needs. Capital Link's health center interviews revealed that staff appeared to believe they had less decision-making freedom than what is reflected in their center's actual policy. Training in team dynamics, decision-making strategies, and root cause analysis will allow teams to more effectively manage their assigned patient population.

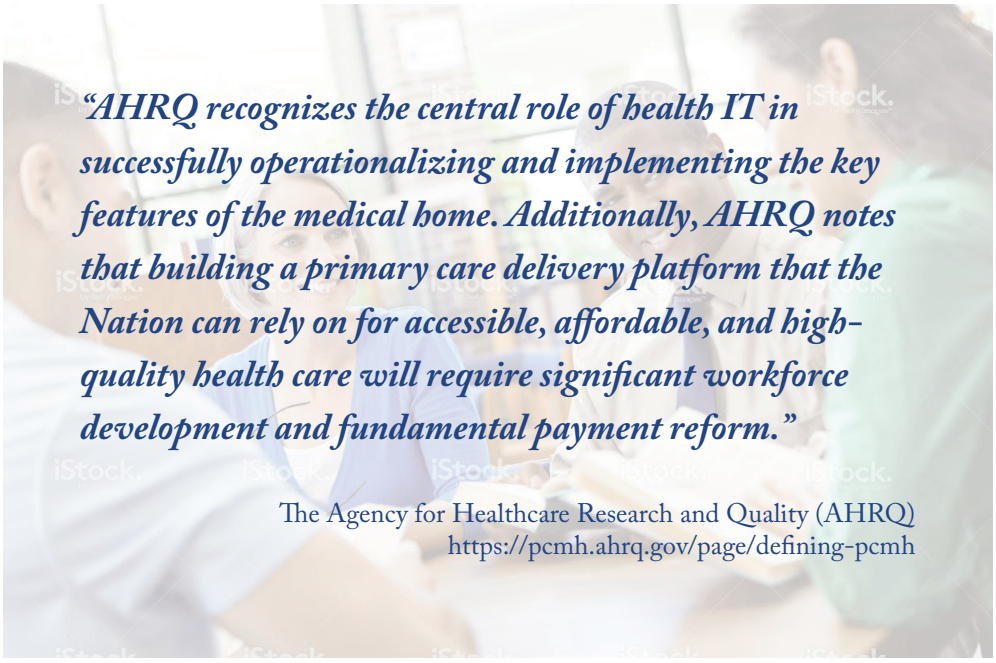
External Structure

The Warm Hand-off

Inevitably, a patient will require an assessment or intervention beyond the clinical scope of the team. The organization that takes responsibility to develop and maintain a strong referral structure will enable the team to work with providers outside of their organization as peers rather than petitioners. Referral sources working as collegial extensions of the team improve outcomes by maximizing communication and minimizing duplication within an agreed upon, cost-effective plan of care.

Community Responsiveness

Responsiveness is key to effectiveness. An organization that is not knowledgeable about the changing needs of their patients, families, and community is unable to effect the continuous alignment necessary to minimize resource waste and service inefficiencies. Patient and caregiver advisory groups as well as the more traditional participation in community development initiatives are effective ways to gather responses to health center services and track emerging community needs.



RESOURCES

Websites

Patient-Centered Medical Home Recognition
National Committee for Quality Assurance (NCQA)
http://www.ncqa.org/Programs/Recognition/Practices/PatientCenteredMedicalHomePCMH.aspx

Patient Centered Medical Home Resource Center
Agency for Healthcare Research and Quality
https://pcmh.ahrq.gov/

Clinic Examples: Transforming Primary Care Environments Through Evidence-Based Design
The Center for Health Design
http://ambulatory.healthdesign.org/clinic-design/clinic-examples

Publications

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http://content.healthaffairs.org/content/27/5/1219.full

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Capital Link is a national, non-profit organization that has worked with hundreds of health centers and Primary Care Associations for over 15 years to plan capital projects, finance growth, and identify ways to improve performance. We provide innovative consulting services and extensive technical assistance with the goal of supporting and expanding community-based health care. For more information, visit www.caplink.org.