



Equal access. It's within reach.

Medical Home Initiative

Dawn Downes, Program Officer

REACH Healthcare Foundation

Our Mission:

Inform and educate the public and facilitate access to quality healthcare for poor and underserved people.

Our Vision:

All poor and underserved people in our community will have quality healthcare.

Our Funding Areas:

Allen, Johnson and Wyandotte counties in Kansas, and Cass, Jackson and Lafayette counties in Missouri, and Kansas City, Missouri



Why did REACH undertake this effort?

- Systematic approach to change
- Alignment with REACH's Theory of Change and long-term outcomes





Initiative Goal

... to guide transformation
of Kansas City area safety net clinics
toward adoption of
the Medical Home model of care

Project Design

- **Individual Clinic Technical Support**
(face to face and telephonic)

- readiness assessments
- gap analysis
- on-site observation of work flow
- clinic work plans

- **Group Workshops**

- **Supplemental activities:** forums, institutes, scholarships

*Grants awarded to consultants, not individual clinics



The Paradigm Shift

FROM:	TO:
Acute reactive care	Proactive planned care
Solo provider mindset	Team-based care
Volume-driven	Value-based
Chaos	Control
Fragmented services	Full service integration

What has REACH brought to the effort?

- Over \$1.1 million in support
- Experienced TA provider, Qualis Health



Participating Clinics



REACH
Medical
Home
Initiative



Timeline and Initiative Overview

2008-Phase I (Identification of Needs)

KU HealthPartners, Inc. provided consulting services for four clinics. Need for **core infrastructure support** for clinics was identified before engaging in medical home transformation process. Operational support included medical records management, human resources and office management systems. When lead consultant left the region, REACH engaged a national technical assistance organization, Qualis Health (www.qualishealth.org).

2009-Phase II (Transformation Support)

Qualis consultants initiated the project with eight clinics. Activities included on-site clinic evaluations, individualized TA plans, and monitoring & reporting of transformation activities. Group workshops included: access scheduling, quality improvement and health information technology (HIT).

Timeline and Initiative Overview, cont.

2010

Individual clinic TA focused on anchoring NCQA standards in each clinic and addressing clinics' work plans. **Group workshops** conducted on: institutionalizing NCQA standards, team-based care and care management, health information technology, supply & demand/access, and process improvement/quality improvement. **Nurse-Leader Institute** focused on: quality improvement & population management for nurse leaders, team building, supply & demand, process improvement/quality improvement follow-up.

2011

Continuation of individual TA and clinic work plan efforts. **Group workshops** were conducted, and one 4 hour session on primary care/behavioral health integration. **Medical Assistants Institute** reinforced their knowledge base, clinical skills and prepared them for expanded roles on clinical care teams. The **Patient Centered Medical Home Effectiveness Reporting Collaborative (PERC)** was created, capturing administrative and clinical data to demonstrate effectiveness.

Timeline and Initiative Overview, cont.

2012

Continued **individualized TA** for all clinics (NCQA recognized and those in process). Continuation of **PERC** data collection and reporting. **Provider Engagement Forums** focused on continued engagement of medical providers in the PCMH transformation process and creating a culture of quality in their respective clinics were conducted. Topics included provider challenges with implementation and sustainability, team-based care roles, supporting culture of quality, population management, registries and reporting.

Scholarships for medical interpreter certification offered.

2013

Continued **individualized TA** for all clinics (NCQA recognized and those in process). Continuation of **PERC** data collection and reporting. **Individual Clinic Retreats** will be conducted on building and maintaining effective care teams. One 6 hour **Primary Care and Oral Health Integration Forum** will be conducted. **Scholarships** for leadership training and national/regional PCMH conferences will be offered.

Are We There Yet?



How do we measure success?

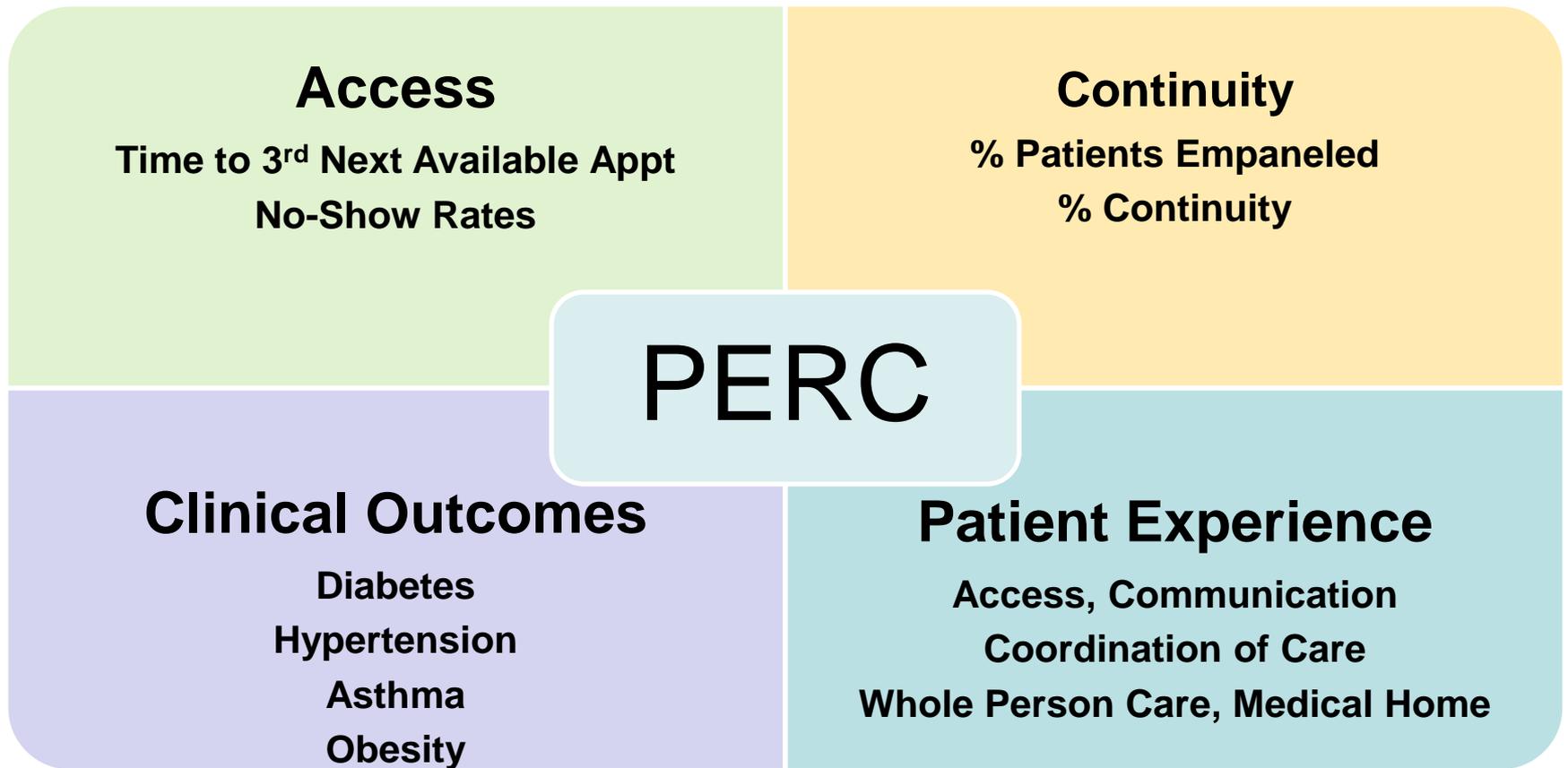
- NCQA Medical Home recognition
- Improvements in PERC elements



Pathway to NCQA PCMH Recognition

Clinic	Date	Version	Level
Silver City Health Center	Mar 2011	2008	3
Cabot Westside	Dec 2011	2008	3
Health Partnership Clinic	Jan 2012	2008	3/1
Children's Mercy West	Feb 2012	2008	3
Turner House Children's Clinic	Sep 2012	2011	3
Samuel U. Rodgers	Goal Apr 2012		
Duchesne Clinic	Goal 2014		

PCMH Effectiveness Reporting Collaborative



PERC Specifics

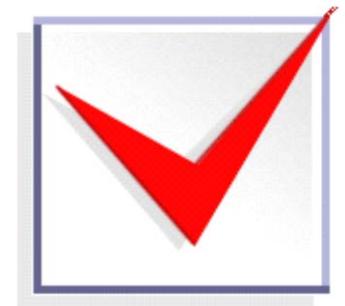
MEASUREMENT DOMAINS	METRICS	FREQUENCY
Access Measures	Continuity of Care report	Monthly
	No Show Rates	
	Time to Third Next Available Appointment	
Clinical Process and Outcome Measures	Clinics to report on one clinically important condition and metrics as developed in Year 3	Monthly
Patient Experience Measures	Questions selected by clinic; at least one question from 3 of the 4 categories <ul style="list-style-type: none"> •Access •Communication with Provider •Coordination of Care •Whole Person Care •Medical Home 	Quarterly

On-Going Challenges



Lessons Learned

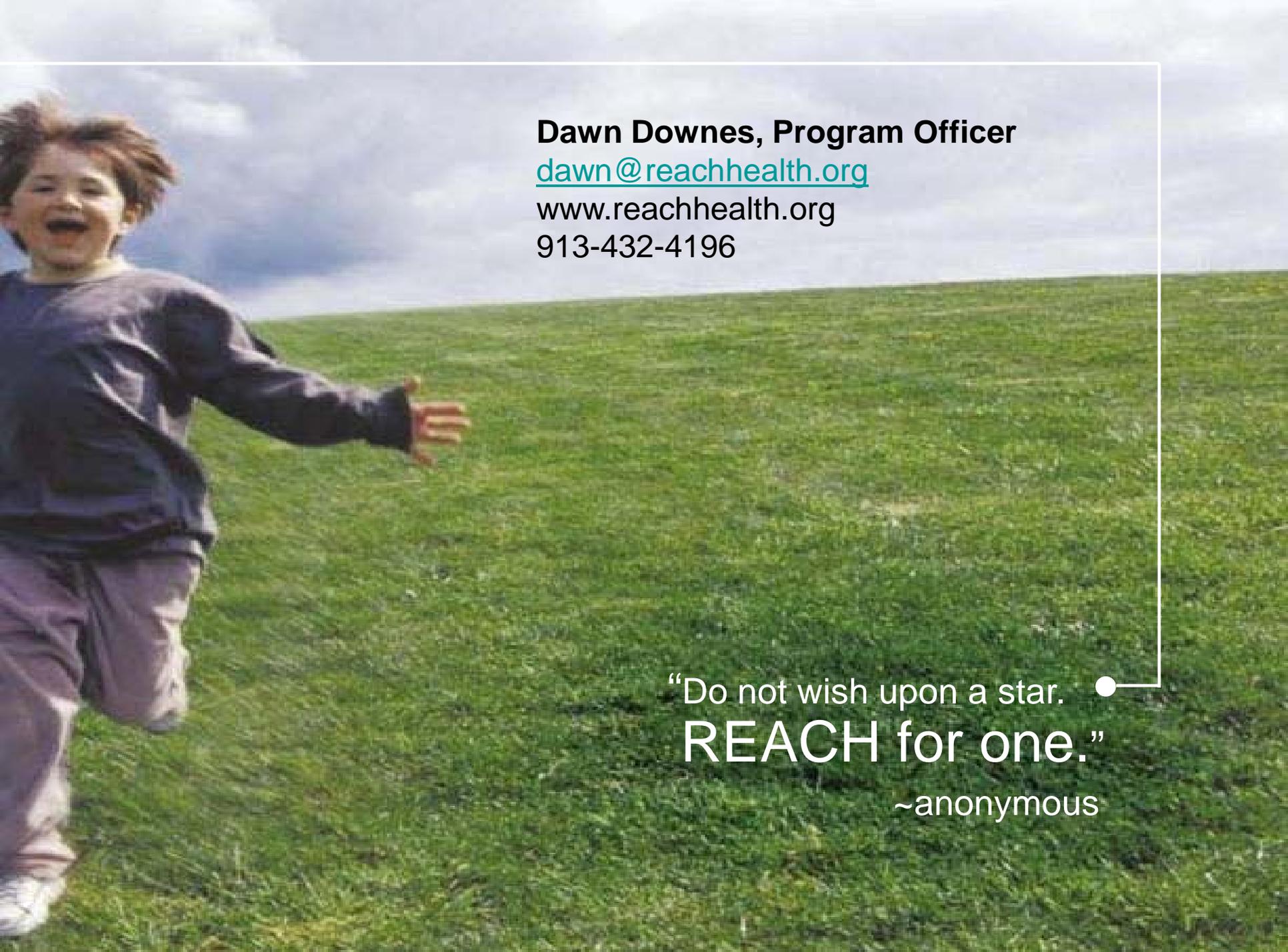
- Key role of leadership
- Burden and benefits of measurement
- The crush of competing priorities
- Transformation is a developmental process
- Providers must re-invent themselves
- Change fatigue is not just a cliché
- PCMH anchors a culture of quality
- Technology will not magically transform a practice
- Commitment, Curiosity, Courage, Action = Progress!



What's Next?

- Support for transformation efforts
- Oral health integration
- Mental health integration





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“Do not wish upon a star. ●

REACH for one.”

~anonymous