Stories from the Frontline: Patient-Centered Medical Home Care Transitions

INTRODUCTION
• The Patient-Centered Medical Home (PCMH) offers an innovative model of care: comprehensive primary care, quality improvement, care management, and enhanced access in a patient-centered environment.

AIMS
• Objective 1: Identify hospital discharge follow-up as a core clinical process in patient-centered medical home transformation.
• Objective 2: Anticipate common barriers to the implementation of hospital discharge follow-up workflows and processes.
• Objective 3: Develop specific strategies and tools to address anticipated barriers to the implementation of hospital discharge follow-up processes in your setting, to ensure consistent coordination of care across multiple care sites.

BACKGROUND
Massachusetts Patient-Centered Medical Home Initiative
• Multi-payer, statewide initiative
• Sponsored by Massachusetts Health and Human Services; legislatively mandated

System for Identifying Highest-Risk Patients
• Registry Reports
  – Practice Registry Reports
  – Health Plans Monthly List
• Frequent ED Visits
• The Care Team’s List

Domains of Care Management Activities and Services
• Transitions of Care
• Management of Chronic Conditions
• Medication Reconciliation

Care Coordination and Clinical Care Management:
Overlap and Differences...

METHODS: Quantitative Analysis
• Design: Quality improvement study using practices’ self-reported monthly data on clinical care coordination measures from June 2011 through February 2014
• Method: Linear Mixed Model
• Analysis:
  – Data were divided into three-month periods:
    – Baseline (September 2011 – November, 2011)
    – Time 10 (December, 2013 – February, 2014)
  – Analysis of Change over Time: Baseline vs. Time 10

RESULTS: Quantitative
Care Coordination/Care Management Measures: Change over Time

Methods: Qualitative Analysis
• Design: Qualitative study using practices’ self-reported data on key concepts of the medical home model and on practices’ monthly transformation activities including barriers and successes
• Method: Document studies using narratives from PCMH transformation reporting tool
• Analysis:
  – Focused on topics related to care coordination activities
  – Emphasized common themes across practices on issues in hospital discharge follow-up

RESULTS: Qualitative
Success:
• Prioritizing high volume hospital systems for information sharing
• Streamlining documentation of the workflow in the electronic health record
• Focusing on highest-risk patients as evidenced by utilization
• Clearly identifying the role and function of each care team member in the new process

Barriers:
• Inconsistent staffing
• The challenges of information-sharing across various sites of care

METHODS: Qualitative Analysis
• Design: Qualitative study using practices’ self-reported data on key concepts of the medical home model and on practices’ monthly transformation activities including barriers and successes
• Method: Document studies using narratives from PCMH transformation reporting tool
• Analysis:
  – Focused on topics related to care coordination activities
  – Emphasized common themes across practices on issues in hospital discharge follow-up

RESULTS: Qualitative
Success:
• Prioritizing high volume hospital systems for information sharing
• Streamlining documentation of the workflow in the electronic health record
• Focusing on highest-risk patients as evidenced by utilization
• Clearly identifying the role and function of each care team member in the new process

Barriers:
• Inconsistent staffing
• The challenges of information-sharing across various sites of care

SUMMARY
• At the close of the MA PCMH Initiative (3 years), clinical measures related to follow-up after hospital discharge showed improvement
• Eight individual practices showed significant improvement across time
• The average number of hospital follow-up encounters per measurement period more than doubled over the span of the Initiative, dramatically increasing the opportunity for coordination of care for patients during this important transition
• Improvement in:
  – Communication infrastructure between practices and hospitals
  – Ability of practices to track and report on their clinical processes

CONCLUSION
• The qualitative narratives from the practices reveal aspects of the common experience shared by many practices in their efforts to establish this new workflow
  – Focusing on highest-risk patients
  – Prioritizing high volume hospital systems for information-sharing
  – Streamlining documentation of the workflow in the electronic health record
  – Clearly identifying the role and function of each care team member in the new process

• Challenges include:
  – Inconsistent staffing
  – Information sharing

METHODS: Quantitative Analysis
• Design: Quality improvement study using practices’ self-reported monthly data on clinical care coordination measures from June 2011 through February 2014
• Method: Linear Mixed Model
• Analysis:
  – Data were divided into three-month periods:
    – Baseline (September 2011 – November, 2011)
    – Time 10 (December, 2013 – February, 2014)
  – Analysis of Change over Time: Baseline vs. Time 10

RESULTS: Quantitative
Care Coordination/Care Management Measures: Change over Time

Follow-up After Hospital Discharges Change Over Time for 8 Practices

Aggregate Average Number of Hospitalizations Identified by Practices During Each Time Period