

UNDERGOING TRANSFORMATION TO THE PATIENT CENTERED MEDICAL HOME IN SAFETY NET HEALTH CENTERS: PERSPECTIVES FROM THE FRONT LINES

Objectives: Safety net health centers (SNHCs), which include federally qualified health centers (FQHCs) provide primary care for underserved, minority and low income patients. SNHCs across the country are in the process of adopting the patient centered medical home (PCMH) model, based on promising early implementation data from demonstration projects. However, previous demonstration projects have not focused on the safety net and we know little about PCMH transformation in SNHCs.

Design: This qualitative study characterizes early PCMH adoption experiences at SNHCs.

Setting and Participants: We interviewed 98 staff (administrators, providers, and clinical staff) at 20 of 65 SNHCs, from five states, who were participating in the first of a five-year PCMH collaborative, the Safety Net Medical Home Initiative.

Main Measures: We conducted 30–45 minute, semi-structured telephone interviews. Interview questions addressed benefits anticipated, obstacles encountered, and lessons learned in transition to PCMH.

Results: Anticipated benefits for participating in the PCMH included improved staff satisfaction and patient care and outcomes. Obstacles included staff resistance and lack of financial support for PCMH functions. Lessons learned included involving a range of staff, anticipating resistance, and using data as frequent feedback.

Conclusions: SNHCs encounter unique challenges to PCMH implementation, including staff turnover and providing care for patients with complex needs. Staff resistance and

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turnover may be ameliorated through improved health care delivery strategies associated with the PCMH. Creating predictable and continuous funding streams may be more fundamental challenges to PCMH transformation. (*Ethn Dis.* 2013;23[3]:356–362)

Key Words: Patient Centered Medical Home, Safety Net Health Centers, Federally Qualified Health Centers, Qualitative Research

INTRODUCTION

The community health center movement, initiated in 1965, provided a system of federally qualified health centers (FQHC), which were designed to reduce health disparities among racial/ethnic minority groups, the poor, and uninsured by providing affordable, accessible, and high quality primary care services.¹ The FQHC system has grown to provide primary care service to over 20 million patients at over 8,000 sites.² These organizations are collectively referred to as safety net health centers (SNHCs), and include rural and migrant clinics, free clinics, and county health clinics. To enhance capacity to provide affordable, accessible, and quality service, many FQHCs and other SNHCs are embracing the patient centered medical home (PCMH) model.³

The PCMH is a model for comprehensive, continuous, patient-centered, team-based, and accessible primary care delivered in the context of a patient's family and community.⁴ Diverse stakeholders support efforts to implement and evaluate the PCMH, including primary care associations, health systems, health plans, governmental agencies, and private foundations.⁵ Local and regional efforts to implement and test the PCMH, and state and federal demonstration projects have begun.⁶

Adopting the PCMH model can be challenging, even in the most motivated and capable health care settings.⁷ Transformation requires profound changes of roles and responsibilities among medical providers and staff.⁸ While core principles and concepts guide PCMH transformation, ideal methods for transforming current practices have not been specified.⁹ The contexts of individual practices necessitate a variety of approaches.¹⁰

Models for implementing system-wide changes in health care highlight the importance of readiness for change, the extent to which participants are individually and collectively primed, motivated, and capable of bringing about the desired change.¹¹ Evaluations of PCMH demonstration projects suggest organizational and individual readiness for change are often overestimated, that the magnitude and time frame for PCMH changes are often underestimated, and that many are seriously undercapitalized.^{7,12}

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Our study aimed to understand how safety net health centers prepare for medical home adoption, as early anticipated benefits and obstacles are key to understanding sustained transformation efforts.

Anticipating and managing challenges associated with PCMH implementation is especially important among SNHCs. Federally qualified health centers and other safety net health centers are the main source of primary care for underserved patients, who are largely minority and of low income.¹³ These patients are more likely to have a chronic illness.¹⁴ Access to specialty care for these patients is often a challenge.^{15–16} Moreover, personnel turnover is often high, and work environments can be stressful due to insufficient resources, high workload and time pressure.^{17–18} Safety net health centers must provide care to more uninsured and underinsured patients.¹⁹ Recently, the Centers for Medicare and Medicaid Services (CMS), in partnership with the Health Resources and Services Administration (HRSA), launched the Federally Qualified Health Center Advanced Primary Care Practice (FQHC APCP) demonstration project to facilitate the adoption of the PCMH in up to 500 FQHCs.²⁰ This three-year demonstration project aims to show how the PCMH model can improve care, promote better health, and reduce costs among Medicare patients.

The PCMH transformation evaluations have been conducted largely in family practice, academic outpatient, and large organized health system settings.^{7,12,21} We know little about

PCMH transformation in SNHCs. This resource-constrained setting is an area in which we need to understand experiences of frontline staff in order to improve design, implementation, and evaluation of PCMH programs. Our study aimed to understand how safety net health centers prepare for medical home adoption, as early anticipated benefits and obstacles are key to understanding sustained transformation efforts. This article reports on the early PCMH adoption experiences of health center administrators, providers, and staff.

METHODS

We conducted semi-structured telephone interviews with administrators, providers, and staff participating in the first 6 to 12 months of the Safety Net Medical Home Initiative (SNMHI) in 2010. The SNMHI is a five-year Commonwealth Fund-supported PCMH demonstration project in which Qualis Health and the MacColl Center for Health Care Innovation work with 65 clinics to implement the PCMH. This process uses a framework of eight change concepts: engaged leadership, quality improvement strategies, patient empowerment, patient-centered interactions, organized evidenced-based care, continuous and team-based healing relationships, enhanced access, and care coordination.^{22,23} Participating health center staff attend regional collaborative learning sessions, and receive support through a regional coordinating center.²⁴

This study was approved by the University of Chicago Institutional Review Board. A purposive sample of 20 health centers was selected from the 65 participating health centers in Colorado, Idaho, Massachusetts, Oregon, and Pennsylvania. Sites were sampled proportionately across region, urban vs rural location, clinic size, and baseline extent of PCMH capabilities. Baseline PCMH capability was assessed using the

Safety Net Medical Home Scale.²⁵ Due to substantial variability in baseline PCMH capability across regions, within region PCMH capability distributions were used to select two high-performing and two low-performing sites from each region. A sample of five diverse staff was selected from each site, including chief executive officer (CEO), medical director, QI/operations manager, a randomly selected provider, such as a medical doctor (MD), physicians' assistant (PA), or nurse practitioner (NP), and a randomly selected clinical staff member, such as a registered nurse (RN), licensed practical nurse (LPN), medical assistant (MA), or clerk. Research staff randomly selected providers and clinical staff respondents through a list of staff provided by each site.

Main Measures

We conducted 30–45 minute, semi-structured telephone interviews. Interview questions addressed benefits anticipated and obstacles encountered to date in transition to the PCMH model, and early transformation lessons learned. The interview protocol was pilot tested with clinicians to ensure relevance and clarity of questions, usefulness of probes, optimal sequencing of domains, and to enhance reliability among the six experienced interviewers (MTQ, LPC, ESH, JB, DLB, and MHC) and three observers (SEL, RSN, and AMV).

Analysis

The raw data consisted of transcripts completed by an observer during interviews and subsequently reviewed by the interviewer for accuracy and completeness. Data analysis used a modified template approach to text analysis; text coding was guided by an initial codebook that was further developed and amended during data review.²⁶ Three trained reviewers (MTQ, SEL, RSN) independently reviewed the transcripts. To develop internal consistency among reviewers, coding for the first 10% of transcripts was discussed to agreement

among all reviewers. The remaining transcripts were reviewed independently, with reviewers meeting weekly to discuss questions, uncertain code assignments, and proposed codebook additions. Transcripts were uploaded and coded in Atlas.ti 5.2 software (Scientific Software Development, 2003). Chi-square tests were used to test for differences in frequency of responses across respondent roles.

RESULTS

Health Center Respondents

Interviews were completed by 98 respondents from the 20 selected health centers. Sixteen (80%) of the health centers were FQHCs, 3 (15%) were rural health centers and 1 (5%) was an FQHC look-alike. Fifty percent of the health centers were rural, and 50% were relatively large clinics with more than 7,000 patients. Mean number of full-time equivalent (FTE) primary care providers was 7.7 (range=1–24), and mean number of unique patients seen was 7,357 (range=1,322–16,489). Health centers treated a mean of 28.8% Medicaid patients (range=5%–56%), and a mean of 29.4% uninsured patients (range = 5%–66%). Respondents were distributed across Colorado (18%), Idaho (19%), Massachusetts (23%), Oregon (19%), and Pennsylvania (19%). Nineteen percent of respondents were CEOs, 20% were medical directors, 20% were operations managers, 19% were health care providers (physicians, PAs, or NPs), and 20% were clinical staff (RNs, LPNs, MAs, or clerks).

Anticipated Benefits

Anticipated benefits associated with participating in the PCMH initiative were reported by 93 of 98 respondents (95%) a total of 317 times (Table 1). Thirty-seven percent of the 317 anticipated benefits reported would accrue to staff, while another 34% would accrue

Table 1. Frequency of reported anticipated benefits, obstacles encountered, and lessons learned, and percent of respondents reporting

	<i>n</i> Times Mentioned	% of Respondents, <i>N</i> =98
Anticipated benefits	317	95
to staff	116	80
to patients	107	80
to health center	76	55
to community	10	9
Obstacles encountered	337	92
staff resistance	159	83
lack of financial support	101	64
inadequate electronic medical record capability	37	19
insufficient time	20	20
Lessons learned	233	86
involve staff early	57	45
ensure support of leadership & staff	49	46
set realistic goals	48	42
anticipate staff resistance	45	38
provide feedback to staff	27	24
learn from other health centers	7	6

to patients. Other reported benefits included benefits that would accrue to the health center, such as professional recognition and status (24%), and benefits that would accrue to the community, such as improved community well-being (3%). Anticipated benefits to staff were more frequently reported by medical directors than by non-provider clinical staff (85% vs 55%, respectively; $P=.038$). Patient-related benefits were mentioned with equal frequency by administrators and clinical staff (74% vs 70%; $P=.798$).

Improved job satisfaction and a supportive team environment were benefits anticipated accruing to staff reported by 73 of the 98 respondents (74%). Specifically, respondents expected that staff would find greater work satisfaction as their performance and the performance of the health center improve. For example: “Nurses are excited about the opportunity to work at the top of their license, getting to work at their fullest potential, which makes them happy (medical director).” “Now, even reception is buying into the idea that they’re part of an organization, not just here for a job. People don’t mind staying late as much – they know the patient needs it (provider).”

Twenty-three respondents (23%), especially those in leadership positions, expected that this improved level of satisfaction would translate into reduced turnover, a chronic problem in safety net settings where staff encounter challenges caring for patients with significant needs: “We’re interested in staff outcomes – provider satisfaction. We have more turnover than we’d like, mostly related to burnout (medical director).” “Ideally, we’d like higher (staff) retention because we want staff to feel like they are making a significant difference for their patients because they are providing good care (provider).” “A core question being raised by the staff is that the type of work we do has a significant emotional, physical toll, and how can we address that so that our medical staff sees an opportunity here as a long term career option rather than just a shift (medical director).”

Anticipated benefits to patients, as reported by respondents, included improvements in access to care (65%), health outcomes (63%), and patient satisfaction (32%). Examples of improved access included: “In the past, we had 30% of our first-trimester obstetrics patients enrolled in our prenatal care programs, but now, with

more access, we have about 80% come in (medical director).” “Patients will get their needs met with one phone call, rather than repeatedly being told to call back (provider).”

Improved patient outcomes were also commonly reported anticipated benefits. Respondents noted that the value of the PCMH was not only in improving patient care, but ensuring that those improvements were measured and documented: “Our A1c’s are getting much better. We’re close to getting NCQA recognition for diabetes (medical director).” “Number one is improving outcomes. We had a very subjective environment. You used to think - you’re taking care of the poor, so that’s good enough. And that’s just not the case anymore. You need to show those outcomes. You need to show the good you’re doing (medical director).” “I think providers want to get some continuity of care that will ultimately create better quality of care for our patients (provider).”

Improved patient satisfaction was also a commonly reported anticipated benefit: “We hope to improve patient satisfaction...the biggest thing with community health centers is (patients) go to anyone who’s open, so you lose a lot of continuity (medical director).”

Obstacles Encountered

Across 90 of 98 respondents (92%), obstacles to the implementation of the PCMH model were reported a total of 337 times. Forty-seven percent of 337 reported obstacles were staff-related, including staff skepticism and resistance to changing established roles. Skepticism expressed appeared to be rooted in a history of similar past attempts at change. Example comments reflecting staff skepticism and resistance included: “People are concerned that this is just a fad. It’s just the latest thing we’ll do for two years, and nobody else will care about it, and we’ll stop doing it (CEO).” “Our staff morale is at an all-time low. Providers feel overwor-

ked...not enough time...they’re expected to do too much (clinical staff).” “As a CHC it seems like we get asked to do a lot of projects, research whatever. And, we can’t see how it’s going to benefit anything. People ask ‘Why do we report that?’ I don’t know. The feds want it. But it doesn’t help patient care. It’s just tedious work (medical director).”

Lack of financial support was reported as an obstacle to PCMH transformation by 63 of 98 respondents (64%), with continuity of funding being a particular challenge. Respondents described funding obstacles: “We’re getting cut by the state. We have to cut 2 million dollars in the budget for next year. What can we cut? First thing would be expanded hours (CEO).” “Our state says now they’re not reimbursing for Medicaid. How do you handle cash flow? How do you make sure patient care is getting done despite all of this (CEO)?” “We occasionally have grants that have supported outreach. We recently got another grant to help patients with self-management. It kind of exists and doesn’t exist depending on funding streams (medical director).” “I’m fed up with needing grants to provide good primary care. Specialists don’t need grants to provide good care...We need a payment structure that will help (medical director).”

Other obstacles included inadequate electronic medical record technology for registry and tracking functions (reported by 19% of respondents), and insufficient time to implement changes (reported by 20% of respondents).

Early Lessons Learned

Across 84 of 98 respondents (86%), early lessons learned were reported a total of 233 times. A frequently cited lesson learned had to do with setting realistic goals, which was mentioned by 42% of respondents. One respondent noted: “Be realistic about the amount of time it actually takes. It’s the right thing to do, but it takes a lot of time, energy, and conviction (medical director).”

Ensuring the support of leadership and staff was a frequently (46%) reported lesson learned: “One of the problems was not having all the right people at the table for that change...I think with big changes you need to have the right people in support and who can make those changes (medical director).”

Interview respondents (38%) reported the importance of anticipating staff resistance. “Expect you’re going to have three different responses from people – 1/3 on board, 1/3 who will wait and see, and 1/3 who are resistant. You’ll need to anticipate that. You need to encourage the people who are excited and make sure you hang and wait until you see benefits. And, try to engage the people who are resistant to move a little bit (CEO).” “We anticipate that there will be a lot of turnover...change is hard and a lot of people can’t adapt to this model (operations manager).”

Respondents emphasized the importance of involving staff early in the change process to reduce resistance (45% of respondents): “Inform everyone. Involve the staff from the bottom up. No directives from above...that’s been the best thing we ever learned. Getting buy-in from the bottom up and getting people to understand why we’re doing things (CEO).” “When we jumped on the bandwagon, they should have done much more to educate staff. They just sent out memos and said we were going to participate...people didn’t know what it was (clinical staff).”

The value of providing staff with frequent data-driven feedback (24% of respondents) and of visiting other sites undergoing transformation (6% of respondents) were also cited as lessons learned. Example comments included: “Would have made a point to take more staff to see a clinic that’s doing it right earlier – we did a few weeks ago and it changed attitudes of staff and increased buy-in (CEO).” “Visit other centers... you don’t have to invent everything yourself. Take advantage of other centers who have been doing it (operations

Our findings reflect the unique context of SNHC settings as our respondents mentioned challenges associated with high staff turnover, which they attributed to the difficulties of providing care for patient populations with significant needs, with insufficient resources to adequately address those needs.

manager).” “Look at real data to show how you’re affecting things. Make sure they get that rapid feedback to keep everything going, and make sure you involve your entire staff and not just have closed-door meetings with providers and management (provider).”

DISCUSSION

This study offers early insight into PCMH transformation in SNHCs, an emerging setting for medical home adoption. The SNHCs are important areas for medical home expansion, given their history and experience meeting the needs of the Medicaid population, and the way in which their services align with aspects of the PCMH model.¹³ Our findings reflect the unique context of SNHC settings as our respondents mentioned challenges associated with high staff turnover, which they attributed to the difficulties of providing care for patient populations with significant needs, with insufficient resources to adequately address those needs. Staff turnover was reported as resulting in chronic staffing shortages and ineffi-

ciencies. Notably, staff turnover had not been highlighted as an obstacle by respondents in past studies of PCMH transformation.

Respondents cited the uncertainty regarding funding stream continuity as a significant challenge. To bolster their funding, many SNHCs reported reliance upon grant-funded quality improvement initiatives. Despite pursuing these initiatives to improve care delivery, the temporary and cyclical nature of grant-based funding has led to a discontinuity in services and limitations on health centers’ ability to plan. While respondents noted that participation in these quality improvement initiatives was worthwhile, they also noted that their short-term nature may lead to change fatigue among staff, which may contribute to staff resistance to the PCMH initiative.

Our findings share some similarities to results reported in other PCMH demonstration projects not located within safety net clinics. For example, in interviews with primary care practices in a PCMH transformation initiative, reported challenges included the time demands of implementation, the difficulty of facilitating behavior change among patients, and the challenges of adopting health information technology.²⁷ Reported barriers to implementing care management processes included lack of resources, inadequate reimbursement, inadequate information technology, physician resistance, and insufficient staff time.²⁸ Setting appropriate and attainable goals, ensuring support by involving all team members, and using frequent feedback to maintain motivation were also reported in PCMH demonstration projects in family practice and primary care settings.^{7,27}

Our study represents the first effort to characterize perceptions of SNHC staff in the early process of PCMH transformation. The findings have implications for PCMH transformations of other SNHCs. The reported lessons learned suggest strategies for preventing

or managing obstacles – such as highlighting tangible benefits to providers’ work life, and opportunities to improve quality of patient care– all of which might help motivate staff and reduce resistance to PCMH transformation. Early involvement of all staff in the planning and transformation process may reduce some resistance while developing supportive team relationships. And, frequent data-driven feedback may alleviate staff skepticism while highlighting accrued benefits to patients.

Study Limitations

This study has several limitations. First, interviews were conducted during the first year of a five-year intervention; we did not sample staff views retrospectively, after the five-year intervention. However, our aim was to better understand the early anticipated benefits and obstacles as these may be key to understanding sustained transformation efforts. Second, respondent clinics comprised a purposive sample, and were not randomly selected. This selection method may limit generalizability. Efforts were made to select broadly and representatively across the 65 health centers. Third, this study did not involve patients as respondents. A separate study is being conducted to assess the experience of patients in these health centers that are adopting the PCMH model. Fourth, because this study examined staff experience early in the PCMH transformation process, PCMH-related benefits were largely anticipated rather than actually accrued, while obstacles were those actually encountered. It is possible that the obstacles encountered may have influenced anticipation of benefits. A follow-up study to further explore later-stage experiences with both obstacles and benefits is in preparation.

Policy Implications

The findings of this study have policy-relevant implications for other PCMH initiatives with SNHCs, which

are important in light of recent initiatives for PCMH expansion (ie, CMS, HRSA). Our study participants reported challenges associated with the tenuous funding of SNHCs, citing lack of continuity in funding streams, as well as variability of state Medicaid funding. Participation in various quality initiatives (eg, HRSA's Health Disparities Collaboratives) was reported as helping to build quality improvement infrastructure within health centers. However, these health centers reportedly encounter multiple challenges to sustaining systems changes associated with these short-term, grant-funded projects. The adequacy of ongoing support will likely be a critical aspect of success for health centers that are adopting and attempting to sustain the PCMH.²⁹

Identifying reimbursement options for medical home models was reported by many respondents as a priority. Restructured payment systems that support PCMH development while covering the cost of services not reimbursable under the current payment structure (eg, information technology, patient reminder systems) are important for comprehensive and continuous patient-centered care. An approach recommended by multiple stakeholders (eg, Patient Centered Primary Care Collaborative; American Academy of Family Practitioners, American Academy of Pediatrics) merges fee-for-service for office visits with monthly medical home payments that reward practices that demonstrate PCMH capabilities. Another option is to shift payments to a shared savings, incentive-pay approach, to compensate health centers for improving care and reducing costs.³⁰ The health center's role in continuous care may help reduce unnecessary emergency department visits and hospital admissions. Funding for ongoing PCMH support could be linked to documented maintenance of PCMH function and linkage to downstream savings. Examples of other funding mechanisms include higher fee-for-service payment

rates to PCMH practices, fee-for-service payment for PCMH activities, fee-for-service plus a per member per month payment to support PCMH activities, and capitated payment.²⁹

As health care reform is implemented, safety net providers will continue to play a crucial role in delivering care.³¹ However, the costs associated with sustaining high functioning PCMHs are unknown, and little is known about the cost implications of functioning as a PCMH from the clinic perspective.³² Initiatives to advance the PCMH capability of health centers must carefully weigh potential benefits with accurate estimates of potential costs. Additional costs must be accounted for in efforts to promote PCMH adoption. The true costs associated with medical home transformation will need to be quantified in longitudinal studies with a focus on costs associated with sustaining high performing medical homes.

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