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

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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

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

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

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

SYSTEMS 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...

CONCLUSION
- Primary care practice transformation takes time
- Care transitions including ER or post discharge follow-up require the development of new clinical workflows
- Processes of care are more likely to improve before outcomes are impacted
- In the context of national efforts to increase the value of health care delivery, the lessons learned from this model can be valuable to provider organizations who take on clinical and financial risk:
  - 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