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

Anita Morris
University of Massachusetts Medical School

Joan Johnston
University of Massachusetts Medical School

Sai Cherala
University of Massachusetts Medical School

See next page for additional authors

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

Authors
Anita Morris, Joan Johnston, Sai Cherala, Ruth Aboagye, Pam Senesac, Judith L. Steinberg, and Jaime Vallejos

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Patient-Centered Medical Home, Health Care Reform, Medicaid, practice transformation, care coordination, clinical management, training, Massachusetts, MassHealth

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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.

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)
- To Time 1 (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

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<th>Average Rate</th>
<th>Baseline</th>
<th>Time 10</th>
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Values met the study’s definition of statistical significance p<.05

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

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<td>Practice #8</td>
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Values met the study’s definition of statistical significance p<.05

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