AHRQ Transforming Primary Care Grants

A Study of the Patient-Centered Medical Home: Lessons From a New York State Community Health Center

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Overview of Transformation Efforts

Fourteen Federally-Qualified Health Centers (FQHCs) in the Institute for Family Health network implemented key patient-centered medical home (PCMH) elements over 9 years, beginning in 2003. Network leaders championed the transformation by providing oversight and leadership, supporting networkwide information technology (IT) enhancements, and securing grant funds to support new PCMH resources (e.g., diabetes educators and care managers).

PCMH transformation began shortly after the network implemented a systemwide integrated electronic health record (EHR) and practice management system. Key elements of the transformation included developing patient registries and reports using the EHR to support outreach, monitoring, and management of patient populations (with a focus on patients at highest risk for poor outcomes); implementing workflow changes, such as shifting some screening and educational responsibilities to nurses to promote efficiency and teamwork; and introducing online tools, such as clinical decision supports, a visit summary for patients, and a patient portal.

Other changes focused on improving the management of patients with diabetes and depression. Changes affecting diabetes care included the development of a diabetes registry and quality reporting tool to support population-level assessment; outreach to patients in need of enhanced diabetes management; onsite hemoglobin A1c (HbA1c) testing; and the addition of diabetes educators, care managers, and group visits in English and Spanish for patient education and support. To improve depression care, the health centers implemented an integrated mental health care model that included universal depression screening, expanded access to mental health providers for primary care patients, and an "open access" system in which patients could see behavioral health providers on a walk-in basis in addition to scheduled appointments. Multiple alerts were incorporated into the EHR to facilitate timely patient management and screening for depression and other conditions.

Number and Type of Practices

This project included 14 FQHCs belonging to the Institute for Family Health network. The majority of the practices had four to eight primary care clinicians, though some two-provider practices and large training sites were also included.

Location

Medically underserved communities in New York State, including locations in the Bronx, Manhattan, and the Hudson Valley.

Transformational Elements

- Accessible Services
- Comprehensive Care
- Coordinated Care
- Health IT
- Patient-Centered Care
- Quality & Safety

Results of Transformation Efforts

Some PCMH elements, including decision supports, the patient portal, and the diabetes registry, were uniformly implemented across all the health centers. Other elements, such as diabetes educators, were introduced gradually.

All the community health centers achieved Level 3 National Committee for Quality Assurance PCMH certification in 2009.

Key Impacts of Transformation

Utilization:

- Among patients with diabetes and an HbA1c level greater than 9 percent, the average number of encounters with primary care providers decreased, while encounters with outreach, diabetes education, and psychosocial care providers increased. In contrast, encounters with primary care providers among patients with an HbA1c level of 9 percent or less remained relatively steady. These findings are consistent with the health centers' efforts to target high-risk patients with enhanced services and greater diabetes control.

Health Outcomes:

- Overall, HbA1c levels among patients with diabetes improved by an average of 0.5 percent; however, results varied according to baseline HbA1c levels. Among patients whose level was 9 percent or greater at baseline, mean annual HbA1c levels decreased by 2.38 percent. Among patients whose level was less than 9 percent at baseline, HbA1c levels showed a slight upward trend of 0.34 percent. These findings are also consistent with the health centers' efforts to target high-risk patients with enhanced services and greater diabetes control.

Quality of Care:

- Providers reported that the integrated mental health model allowed for greater efficiency because each staff member provided the services most appropriate to his or her training. The model was especially important for patients with complex conditions and multiple psychosocial stressors because it facilitated communication among providers and helped ensure a consistent approach to managing medical and behavioral health issues.

Patient Satisfaction:

- Patients reported being generally comfortable discussing behavioral health issues with their primary care providers and high levels of comfort and positive interactions with behavioral health providers.
- Patients who used the patient portal said they liked being able to easily and rapidly communicate with providers and the ability to make appointments and access test results online.

Challenges to Transformation

- Integrating depression services into primary care posed multiple challenges because it involved a culture shift for the practices. Universal screening for depression identified many new patients who needed further assessment and followup; expanding mental health services entailed bureaucratic complexities (such as provider licenses) and required providers to address behavioral health care (from crisis management to long-term mental health care) in a more comprehensive manner then they had previously. Factors that aided integration included the

support of network champions, workflow changes and redistribution of responsibilities, and the addition of more behavioral health staff.

- Physicians and nurses sometimes felt overwhelmed by the number of online alerts, and physicians reported that some were less beneficial than others. However, providers generally viewed the alerts as helpful in monitoring depression and other complex or uncommon conditions.

Lessons Learned and Implications for Others

- Leadership and support by network leaders was crucial to PCMH transformation. In addition to helping with process redesign and facilitating IT changes, network leaders created a culture that encouraged innovation and early adoption of new policies, practice methods, and recognition standards. Leaders also secured new financial resources to support additional services through grants and reimbursement appeals to the government.
- The EHR, implemented in 2002, was integral to PCMH transformation, as it allowed the network to more easily develop and implement patient registries, a patient portal, visit summaries, care guidelines, screening reminders, and other elements used in patient management. While developing these elements required significant time and workflow changes, providers and staff appreciated the improvements in patient tracking, patient screening, and communication that resulted from EHR enhancements. Because of the benefits of the diabetes patient registry, providers requested that additional registries be developed for other chronic conditions.

Improving patient care was the primary motivator for PCMH transformation among these FQHCs. Similarities between the PCMH model and the network's established family-centered approach to patient care helped providers and staff accept and embrace practice changes.

For additional information about this grant, please visit:
http://www.ahrq.gov/professionals/systems/primary-care/tpc/tpcbib.html#nyschc.

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