Aligning Forces for Quality | Improving Health & Health Care in Communities Across America

Robert Wood Johnson Foundation

EVALUATION

Assessing and Increasing Readiness for Patient-Centered Medical Home Implementation[1]

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Introduction

The current model of primary care in the United States is poorly designed and in need of repair.[2,3,4,5] It is designed to treat acute, episodic illness and limits physicians' ability to provide proactive, preventive and consistent care over time. The Patient-Centered Medical Home (PCMH) model is designed to address these limitations in several ways:

- Enhance outreach and engagement of patients
- Better documentation and coordination of care (e.g., use of electronic medical records)
- Increase use of population-based disease management (e.g., use of disease registries)
- Improve quality of care, increase satisfaction with care, and lower cost of care

PCMH is being implemented in many settings, and the concept even appears in the Patient Protection and Affordable Care Act.[6] However, implementing the PCMH model can be a major challenge, and many primary care practices may not be ready to undertake such a significant change in care delivery. This study evaluates the readiness of primary care practices for implementing PCMH and provides guidelines for assessing and increasing this readiness.

Study Setting and Methods

We collected data for this study from primary care practices participating in both the Blue Cross/Blue Shield of Michigan's (BCBSM) Physician Group Incentive Program (PGIP) and the Robert Wood Johnson Foundation's (RWJF) Aligning Forces for Quality (AF4Q) initiative. The PGIP is a statewide initiative to help primary care practices implement the PCMH model. The AF4Q program is RWJF's signature effort to raise the overall quality of health care, reduce racial and ethnic disparities, and provide models for national reform.

About Aligning Forces for Quality

Aligning Forces for Quality (AF4Q) is the Robert Wood Johnson Foundation's signature effort to lift the overall quality of health care in targeted communities, as well as reduce racial and ethnic disparities and provide real models for national reform. The Foundation's commitment to improve health care in 16 AF4Q communities is the largest effort of its kind ever undertaken by a U.S. philanthropy. AF4Q asks the people who get care, give care and pay for care to work together to improve the quality and value of care delivered locally. The Center for Health Care Quality in the Department of Health Policy at George Washington University School of Public Health and Health Services serves as the national program office. Learn more about AF4Q at www.forces4quality.org. Learn more about RWJF's efforts to improve quality and equality of care at www.rwjf.org/qualityequality/af4q/.

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This report is based on work conducted by researchers at the University of Michigan in collaboration with the Aligning Forces for Quality Evaluation Team. The AF4Q Evaluation Team is studying the AF4Q initiative to gain insights about community-based reform that can guide health care practice and policy. The AF4Q Evaluation Team presents periodic research summaries on key findings and policy lessons gleaned from its ongoing mixed-method evaluation of the AF4Q program. For more information about the AF4Q Evaluation Team, visit http://www.hhdev.psu.edu/CHCPR/alignforce/.

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To identify practices for the study, we categorized 2,214 practices into four groups according to their responses to a BCBSM PCMH implementation self-assessment. We then chose eight practices from the group with the highest implementation scores and eight practices from the group with the lowest scores (four practices in each of the two groups have a hospital affiliation and four do not). From winter 2009 through summer 2010, we conducted 66 half-hour interviews in person at the sixteen practices; the interviewees' practices included key physicians, practice managers, nurses, and medical assistants.

We used existing literature on readiness for change to guide our analysis of the interview data. We measured readiness for PCMH implementation using two separate but related concepts: motivation and capability.[7] **Motivation** is the collective willingness and commitment of the primary care team to implement PCMH. **Capability** is the collective perceived ability of the primary care team to implement PCMH. We also analyzed and categorized the approaches that primary care teams used to prepare their practices for PCMH implementation.

Results

Motivation for PCMH Implementation

Through analysis of the interview data, we identified four themes that influenced the level of motivation of a primary care team for PCMH implementation:

"[The PCMH] is a lot to take in, and I get lost with all of it, sometimes. I have to learn all of this, and then I have to teach the doctor."

–Practice manager, lower-scoring PCMH

(1) Perceived Value of PCMH

An important component in a primary care team's motivation for PCMH implementation was the perceived value of PCMH. Many respondents discussed the potential benefits and costs to themselves, their practice, and their patients. Practices with higher implementation scores were more likely to view PCMH as a valuable next step in improving care, an enhancement of the roles and responsibilities of nurses and staff, and a means to free up time for physicians. Practices with lower implementation scores were more likely to view PCMH implementation as an imposed requirement involving extra work. These practices typically were not convinced that the existing model of primary care was dysfunctional or that PCMH would bring improvements to care delivery.

(2) Understanding PCMH Domains and Tasks

Understanding the PCMH model and steps to implementation was related to a practice's motivation to do so. Practices with higher implementation scores generally had taken active roles in learning about PCMH, such as webinar and "lunch and learn" seminar participation. Practices with lower implementation scores still found such education important, but were more passive in their learning and often considered this education to be a responsibility of external agencies.

(3) Financial Incentives

Several insurers in Michigan offered financial incentives for parts of PCMH implementation. Practices with higher implementation scores viewed financial incentives as necessary for PCMH startup, but were also motivated by PCMH benefits, such as better patient care and improved workflow. They were also more likely to use these incentives to hire additional personnel for implementation. Practices with lower implementation scores were skeptical that incentives would outweigh the costs of PCMH implementation.

(4) Commitment to Change

A primary care team's culture of embracing or rejecting change was an important factor in its motivation. Practices with higher implementation scores often described themselves as "early adopters" of new approaches. These practices had a strong "team" mentality, appreciated constructive criticism, and often had someone who championed practice improvement. Practices with lower implementation scores were less likely to be "team-oriented." They often cited particular individuals as resistant to change (especially to advances in information technology) due to generational differences.

PCMH Implementation Capability

Through analysis of the interview data, we were also able to identify four themes that influenced the perceived capability of a primary care team to implement PCMH.

> "We all know that [PCMH is] going to help the patient. It's making it easier on the doctor, and eventually it's making it easier on us."
>
> –Medical assistant, higher-scoring PCMH

(1) Time Demands of PCMH Implementation

All practices viewed the time required to implement PCMH as a major challenge, especially documenting progress toward official PCMH designation, learning to use new Health Information Technology (HIT) systems, and educating patients. However, practices with higher implementation scores did not view the substantial time investment as a reason for not pursuing PCMH implementation. Instead, they recognized that the current practice system was overburdened and needed to be changed. Practices with lower implementation scores indicated that the time needed to implement PCMH would cut into patient volume and, thus, PCMHs were not financially feasible to implement. This was perhaps because many of these practices assumed that implementation was an individual provider responsibility, instead of a shared personnel responsibility.

(2) Prospect of Changing Patient Behavior

For patients to benefit from PCMH, practice teams must be responsible for all aspects of their health (e.g., coordinating care through their primary care office). Practices with higher implementation scores saw this as an opportunity to engage patients in their own health and looked forward to defining their practice as the patients' home. Practices with lower implementation scores worried that patients would be non-compliant or unenthusiastic about this responsibility and that this would hinder their practice from implementing PCMH.

(3) Health Information Technology (HIT)

Obtaining and implementing HIT is crucial to the PCMH model and may require significant time and money. Practices with higher implementation scores were able to move quickly through initial HIT implementation tasks (e.g., entering historical information) and began to observe benefits (e.g., more efficient workflow). Though practices with lower implementation scores believed they needed HIT, the time and costs were seen as too great to fully engage them in its implementation. Regardless of implementation score, practices believed two factors enhanced HIT capability and use: (1) younger team members, who generally have more HIT experience, and (2) a team "champion" of HIT. From a less-positive perspective, a common concern among all practices was that HIT would not be compatible among different practices or provider organizations.

(4) Setting Implementation Expectations

The expectations that primary care teams had about the process of implementing PCMH influenced their views about implementation capability. Practices with higher implementation scores recognized that implementing PCMH would be hard work and may take years. They accepted the possibility that implementation would be filled with both successes *and* failures and viewed this as part of the process. Practices with lower implementation scores thought the time and effort to implement PCMH would be burdensome, and that the probability of failure would be high. They frequently desired a standardized implementation plan that would only take one or two months.

Approaches

We also asked primary care teams about the approaches they used to prepare their practices for PCMH implementation. We identified several themes from their responses:

(1) Leadership

The most successful PCMH implementation occurred in practices that had both a practice manager and a physician act as champions. Practice manager champions acted as "implementation leaders" who encouraged a team orientation in the implementation process and could sometimes secure additional financial support to offset any potential lost clinical revenue. Physician champions acted as "thought leaders" who could promote the values of PCMH to the rest of the practice. Celebrating even small successes was important. Practices without both leaders had more difficulty.

(2) Translating the Value of PCMH

Practices had greater success implementing PCMH if they had physicians talk about its value to skeptical team members. This was accomplished in different ways, such as creating a financially-compensated advocacy team of physician champions knowledgeable about the PCMH model. Consistently holding regular meetings to discuss implementation successes and failures and having physician champions participate in these meetings helped other team members engage in and develop an appreciation of the overall purpose of PCMH.

(3) Understanding PCMH Domains and Tasks

Some physician organizations and health systems designated individuals to become "PCMH experts" by attending PCMH education sessions and meeting with insurers to discuss aspects of implementation, designation, and financing; the experts then advised their respective practices.

(4) Incrementalism

Nearly all practices identified the need to implement PCMH incrementally. Though not all practices agreed on where to begin, all agreed it was crucial to review PCMH components/requirements with the entire practice to collectively decide where to start.

(5) Using Data

All practice teams found data helpful in implementing PCMH, particularly in regard to evidence-based quality outcomes, pharmacy use, and patient satisfaction. Practices that were further along in implementing PCMH were active in obtaining and reviewing data from internal and external sources (such as insurers). Review of this data helped practices identify gaps in care, which motivated them to work toward improvements. Practices that were lagging in PCMH implementation were interested in more data, but did little to obtain and/or collect data on their own.

(6) Defining Roles and Responsibilities

Practice teams found that clearly defining the roles and responsibilities of team members helped in clarifying duties, engaging all members, and standardizing PCMH work. Practice teams further along in PCMH efforts used such techniques, while emphasizing that defined roles could change; they made adjustments throughout the process, with the stated goal of having all team members working at the highest level of their training and experiences. They often shared information about these roles, responsibilities, and experiences with other practices.

(7) Desire to Learn More from Peers

All practices noted a desire for more peer learning opportunities. While some practices participated in local PCMH learning collaboratives, approaches to these collaboratives still were under development and participation was limited.

Summary of Key Findings

The factors that we identified as influential to practice team perception of motivation and capability to implement PCMH, as well as approaches to PCMH implementation that improved these perceptions, are summarized below:

	Higher Implementation Scores	Lower Implementation Scores
Motivation	• Viewed PCMH as valuable to practice and patient care	• Viewed PCMH as an imposed external requirement
	• Regarded PCMH financial incentives as offsetting costs	• Regarded PCMH financial incentives as insufficient reward
	• Took active role in learning about PCMH concepts and functions	• Felt a need for external teaching of PCMH concepts and functions
	• Took the initiative to promote change to PCMH	• Felt a need for external direction in promoting change to PCMH
	• All or most team members invested in PCMH change	• Tended to place responsibility on one person; had influential resistors
Capability	*Viewed barriers as challenges to overcome:*	*Viewed barriers as imposed obstacles:*
	• Time demands necessary to produce desired change	• Time demands are unfeasible and cut into patient volume
	• Opportunity to engage patients in their health; create medical home	• Thought lack of patient enthusiasm and noncompliance would be high
	• Quickly implemented/benefited from Health Information Technology (HIT)	• HIT too costly and time-consuming; older team; lack of HIT "champion"
	• Expected it to be hard work and take years, but accepted successes and failures	• Expected quick change, thought process was too much time and effort

Approaches that improve motivation and capability for PCMH implementation:

- Have a physician and a practice manager as “champions”
- Facilitate conversations between physician champions and skeptical team members
- Develop trained PCMH experts to advise practice teams
- Create a team-wide implementation plan with incremental action items
- Use data to identify opportunities and assess progress
- Clearly define standardized roles and responsibilities to fully engage all team members
- Learn from other practices

Conclusions and Policy Implications

To enable true health care reform as outlined in the Patient Protection and Affordable Care Act,[8] the current processes of care delivery must be redesigned and implemented by practices nationwide. The PCMH model, the components of

which are supported in the PPACA and demonstrated in multiple regional projects, can accomplish this change. Primary care practice teams need to be motivated to accept that, while it will be difficult, adopting PCMH will result in improved patient flow, better teamwork within the practice, more time with patients, higher job satisfaction, and higher patient satisfaction. Practice teams also must believe that they have the capability to undertake and accomplish the desired changes.

While factors and approaches that improve a practice team's ability to implement PCMH have been identified, economically and logistically feasible ways of helping practices improve their readiness for such implementation must be developed. Information is needed about the effectiveness of such approaches and the impact on cost and quality of health care.

Implementing the PCMH model nationwide would be a transformational change in a variety of increasingly complex health care settings. The potential of PCMH for quality of care improvement and cost reduction is influenced by a range of human, socio-cultural, and organizational factors within each practice. Policymakers and national health care leaders must therefore recognize that not all practices are equally good candidates for such a change. For policy makers, understanding a practice's readiness for change and knowledge of successful strategies is crucial to its success of implementing PCMH.

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[1] The full article describing this study and its findings can be found in Wise CG, Alexander JA, Green LA, Cohen GR and Koster CR. "Journey toward a Patient-Centered Medical Home: Readiness for Change in Primary Care Practices." *Milbank Q* 89(3):399-424, 2011.

[2] Grol R and Grimshaw J. "From Best Evidence to Best Practice: Effective Implementation of Change in Patients' Care." *The Lancet*, 363:1225–1230, 2003.

[3] Institute of Medicine Committee on Quality of Health Care in America. "Crossing the Quality Chasm: A New Health System for the 21st Century." Washington, DC: National Academic Press, 2001.

[4] McGlynn EA, Asch SM, Adams J, et al. "The Quality of Health Care Delivered to Adults in the United States." *New England Journal of Medicine*, 348:2635–45, 2003.

[5] Rosenthal TC. "The Medical Home: Growing Evidence to Support a New Approach to Primary Care." *Journal of the American Board of Family Medicine*, 21:427–40, 2008.

[6] *Patient Protection and Affordable Care Act of 2010*, Public Law 111–148, *U.S. Statues at Large* 124 573 (2010).

[7] Weiner BJ, Amick H and Lee SD. "Review: Conceptualization and Measurement of Organizational Readiness for Change: A Review of the Literature in Health Services Research and Other Fields." *Medical Care Research and Review* 65(August):379-436, 2008.

[8] *Patient Protection and Affordable Care Act of 2010*, Public Law 111–148, *U.S. Statues at Large* 124 573 (2010).