Amazing Grace: A Free Clinic's Transformation to the Patient-Centered Medical Home Model

Jason Alexander, BS, PCMH CCE; Jordon Schagrin, MHCI, PCMH CCE; Scott Langdon, BA; Meghan Hufstader Gabriel, PhD; Kendall Cortelyou-Ward, PhD; Kourtney Nieves, PhD; Lauren Thawley, MSHSA; and Vincent Pereira, MHA, PCMH CCE

A patient-centered medical home (PCMH) is a care delivery model that pursues care delivery improvement through primary care services. The PCMH model was designed to meet patient needs, increase access to care, and enhance overall quality, all while being more cost-efficient. In 2007, multiple primary care associations collaborated to develop the Joint Principles of the Patient-Centered Medical Home, which established a comprehensive primary care model for children and adults.[1] As it relates to medical expenditures, empirical study results show that PCMHs help control costs by optimizing patient access and population health management, which reduces costly hospital and emergency department visits.[2] With recent value-based payment models being implemented, a delivery system that focuses on primary care and prevention is key to helping achieve the goals of the healthcare Triple Aim: improving the patient experience of care (including quality and satisfaction), improving the health of populations, and reducing the per capita cost of healthcare.[3] PCMHs provide continuous, comprehensive care to patients, who build personal relationships with their care providers, including nurse practitioners and physician assistants.[4] Predominantly, PCMHs use a team-based delivery model usually led by a primary care provider.5 However, this model is also attractive to nontraditional methods of healthcare delivery, including free clinics.[6-9] The National Committee for Quality Assurance (NCQA) has a recognition program that is the most widely adopted PCMH evaluation program in the United States. Most PCMH transformations occur following the NCQA standards,[10] because the NCQA closely aligns practice transformation into a PCMH with achieving the Triple Aim and lends itself to high-quality care delivery. This has captured the attention of healthcare stakeholders, including providers, policy makers, and purchasers. The goals of this paper are to highlight activities associated with PCMH transformation, inform readers about how a free clinic mitigated barriers and motivated drivers, and describe lessons learned during this transition.

An Overview of Grace Medical Home

In 2008, Marvin Hardy, MD, founded Grace Medical Home (“Grace”), a nonprofit free clinic located in Orange County, Florida. Soon after, Kirsten Carter, MD, an Orlando internal medicine physician, joined Hardy in his journey to open Grace’s doors. The majority of Grace’s funding comes from private donors. Grace has a small staff of paid employees and many clinical and nonclinical volunteers. The clinic operates under a holistic model of care, providing a host of onsite ancillary services, including nutrition counseling, pharmacy, laboratories, x-rays, and mental health counseling, all of which lend themselves to supporting the PCMH model. The clinic serves more than 3000 patients in central Florida, all of whom do not qualify for Medicaid but cannot afford private insurance. The eligibility criteria include currently living in Orange County, Florida, for at least 2 months; earning less than 200% of the federal poverty line; being uninsured; being 65 years or younger; and being employed (currently or in the last 6 months), a full-time student, or a single parent. The population of

Orange County is 1.2 million residents, 25% of whom are uninsured.[11] The county is approximately 70% white and 23% black, and 30% identify as Hispanic.[10]

Health information technology (IT) and engaged teams of medical professionals help patients become more involved with their own healthcare. The decision for Grace to pursue PCMH transformation and NCQA recognition was driven by the model's positive impact on population health needs.

Starting the PCMH Transition

Regional Extension Centers (RECs) are organizations originally funded under the Health Information Technology for Economic and Clinical Health Act (HITECH) to support specific healthcare providers with the implementation of electronic health record (EHR) systems. Building on this business model, some RECs now promote the progression of innovative health IT and the adoption of best practices throughout the medical community. This expansion of services has extended to assisting with the transformation of healthcare delivery systems.

One of the requirements within HITECH was that RECs should create sustainability plans for continuous operation once the original funding had been exhausted. The REC at the University of Central Florida's College of Medicine chose to implement PCMH transformation and recognition as one of several additional services to continue to assist providers in the central Florida community, with Grace presenting particular challenges due to its status as a free clinic. The REC established a program that focused on PCMH transformation using change concepts, Plan-Do-Study-Act (PDSA) improvement activities, and robust measurement. It also established a core team of NCQA PCMH Certified Content Experts to provide the practice support necessary to making substantive changes in a clinical setting.

In 2013, Grace began its PCMH transformation with the assistance of the REC. Initially, the project experienced a slower-than-anticipated start due to a variety of factors, including staffing resources and other pressing priorities that go with running a free clinic. Eventually, however, Grace leadership worked closely with the REC team and engaged key Grace clinical leaders (3 physicians and 1 nurse practitioner, all specializing in family medicine and pediatrics) to spearhead Grace's PCMH transformation.

Achievements for NCQA Recognition

Grace earned NCQA recognition under the PCMH 2011 version of the standards and guidelines.[12] To achieve this PCMH transformation, a practice must satisfy, at a minimum, the following 6 "must-pass" elements: (1A) access during office hours, (2D) use data for population management, (3C) care management, (4A) support self-care process, (5B) referral tracking and follow-up, and (6C) implement continuous quality improvement.

These 6 elements are the core PCMH activities and the baseline requirements for NCQA recognition, but practices must satisfy many other requirements under the PCMH standards and guidelines. Moreover, Grace's

achievement of PCMH recognition indicates that the practice delivers patient-centered care through these PCMH activities despite the challenges of providing this model of care in the environment of a free clinic.

Grace's approach to satisfy each of the basic elements, although not unique, was based on the realities of its limited resources and staffing model. Grace's small core staff relies on the volunteer providers who donate their time and effort to see patients. These providers typically volunteer several days a month, and Grace has formed relationships with them so that the time donated is consistent and routine. This unique way of providing patient care made satisfying element 1A, access during office hours, challenging, but Grace demonstrated that it monitors patient access through same-day appointment availability and timely responses to patients by phone. Despite its limited resources, Grace invested in and implemented an EHR system within its clinic, which allows it to use evidence-based guidelines to follow up with patients regarding their care needs (eg, element 2D, use data for population management). Grace demonstrated the ability to monitor gaps in patient care needs by service care type and to develop a follow-up reminder process to contact patients and schedule them for appointments. The uninsured patients at Grace often present with complex chronic conditions, likely as a result of not having access to proper medical care for long periods of time. Therefore, it was important for these patients that Grace satisfied element 3C, care management, by collaborating with the patients and their families regarding the development of the care plan for the patient. Satisfying element 4A, support self-care process, implies that Grace equips its patients with resources and education to help patients and their families manage patient conditions. Grace also faced a challenge in providing specialist care for its uninsured patients and had to work to develop a network of community specialists who would evaluate and treat these patients. Grace developed a Care Coordination Department that managed all referrals to these community specialists and made sure that the specialists had all of the information necessary to provide care for the patients, thereby satisfying the PCMH requirements of element 5B, referral tracking and follow-up. Finally, Grace's overall PCMH transformation demonstrates completion of PCMH element 6C, implement continuous quality improvement, in that it established goals based on its performance measures for care delivery and patient experience on an ongoing basis. Grace continues to work to improve performance on these important clinical and patient experience measures.

Grace faced challenges with the must-pass elements and some of the additional requirements that are needed to achieve PCMH recognition due to its clinic model and the patient population it serves. Working in collaboration with the REC, Grace put forth the effort to refine its processes, develop policies, and implement best practices that would demonstrate how its unique model of care could be highlighted to support PCMH recognition.

Lessons Learned

Leadership commitment. To achieve PCMH transformation and earn NCQA recognition, senior leaders must first engage staff by making PCMH transformation a key goal for the practice. Leadership buy-in is essential to the successful adoption of the transition. Like any form of innovation, it is more likely to be successful when influential peers become adopters, encouraging others to buy into the transition.[13] Engaged leaders make the case for the need to improve the current state of disjointed care, articulate a vision for a better future, and set the tone for change. They identify and mentor champions, use data to drive and guide improvement, and ensure

adequate time and resources for the work of transformation.[14]

To drive the transformation, the leaders at Grace created a PCMH taskforce consisting of the executive director, founder/pediatric medical director, adult medical director, clinical manager, a pediatric nurse, and the REC PCMH team. These leaders, working closely with the REC team, formed a strategy for implementation of the PCMH standards that focused on sustainable change. The full engagement among leaders resulted in the adoption of a clinicwide PCMH culture. The staff and leadership devoted more time to the PCMH project weekly meetings, setting the foundation for successful transformation.

Care team and staff engagement. Once the leaders at Grace were fully engaged in the concept of change, they worked closely with the REC team to engage the clinic's staff. This was accomplished through training on PCMH transformation concepts and regular communication about the status of the project at weekly staff meetings. These meetings engaged staff members in the process of transformation and allowed them to provide feedback on the implemented changes. Additionally, leaders set project and staff goals and expectations, allowing for a culture of accountability to be instilled.

True leadership means you have achieved buy-in from those you lead. Demonstrating to the staff how transitioning to a PCMH would positively impact their roles and the lives of their patients was essential for leadership to create that buy-in. The REC PCMH team helped accomplish this by providing staff training on the concepts and benefits of PCMH transformation and a forum for staff to ask questions and voice their concerns regarding the implementation. Resistance to change is to be expected, but providing staff with an external expert resource to express their concerns further validated Grace's commitment to its staff. This engagement was also important, as it had a direct impact on the PCMH requirement to measure the patient and family experience.

Culture change for quality improvement. To prepare for PCMH transformation, medical practices must establish a culture of change that embraces continuous quality improvement (QI). Effective implementation strategies must be established so the staff may carry out a successful transition. Additionally, it is crucial that staff members are educated on the benefits that continuous QI will have on patient outcomes and the clinic's performance. This QI culture is built using a defined scope, leadership support, proven QI methods, shared ideas, and lessons learned.[15]

QI efforts are proven drivers for improving care delivery and associated outcomes.[16] They are methodical actions that lead to measurable improvement.[17] In order for the PCMH model of care to be implemented, engaged leaders must lay the foundation and organize a QI strategy. At Grace, this strategy built trust among the staff, mentored them, and aligned them with the vision and purpose of the transition. Grace developed a QI team whose responsibilities included setting quality measure goals, reporting QI performance measures to senior leadership, and implementing activities to increase performance. All of Grace's QI work was guided by the PDSA QI methodology, which was developed and supported by the REC PCMH team through structured training on the PDSA model and ongoing QI support.

Patient engagement. To increase stakeholder engagement during the PCMH transition, Grace used patient information and communication tools for engaging patients, their families, and community organizations. Grace achieved this goal through brochures, the Grace website, and structured face-to-face discussions. This transparency encouraged support from community organizations and educated stakeholders on how PCMH transformation benefits both the patient and community. Ensuring that Grace has an effective learning community through a cooperative and respectful culture will determine its success.

The next step to patient engagement is integrating patients into advisory councils to get them more involved. This aligns with the PCMH requirement to incorporate patients into the quality improvement efforts. This includes patients in the decision-making process and creates an overall better experience. Patients who are more engaged have better outcomes.[18] Gaining support from all stakeholders, including patients, was critical for Grace to have a successful PCMH implementation, and a key benefit of PCMH adoption is its value to healthcare stakeholders.[19-21]

Community support and investment. The goal of a PCMH is to deliver care and coordinate services that focus on the patient's needs and preferences. In practice, it has been documented that patients receive better care and experience better outcomes in a PCMH delivery model compared with traditional fee-for-service clinics.[22-24] The community also receives better value for its healthcare dollars because, in most cases, payers achieve savings when using the PCMH model of care. In addition, educational information on how PCMHs improve quality of care, provide a better all-around healthcare experience, and save money helps increase engagement.

Value Proposition

Grace has made a substantial and lasting impact on the central Florida community. In the 4 years since transitioning to a PCMH, Grace has had 11,193 patient encounters and enrolled 3073 patients from the community. The practice has avoided more than $1.1 million in hospital expenses, reducing costs for both the hospitals and patients. Grace operates with 19 paid staff members and 393 volunteers, who have given approximately 15,385 volunteer hours. The total value of prescription medications dispensed to patients is $2,564,742.[25]

Policy Implications

Grace's transformation to the PCMH model suggests that: (1) leadership commitment is essential for successful culture change, (2) transformation may be achieved with limited staff, and (3) community organizations may have a role in transformation process. The priority setting from Grace's leadership demonstrates that PCMH adoption must have support from senior leaders throughout the entire transformation process for sustainable culture change. The volunteer-based staff of Grace demonstrates that the care team may be supported through innovative staffing strategies. Also, educating community stakeholders on issues that may be addressed through PCMH investment may yield higher returns for practice support.

Conclusions

Despite the resource constraints and initial lack of staff engagement, transitioning a nontraditional clinic into a PCMH is possible. For a seamless transition, the leadership team must lay the foundation by being completely engaged with the process.[26,27] Practice leaders must articulate the vision and establish an atmosphere for change to engage the care team and practice staff. Securing staff buy-in is vital to the success of the transition. Efforts to involve other stakeholders in the transformation through engagement and education outlets will provide the necessary support. Patient-centered interactions assisted Grace in demonstrating its improved care delivery.[28] Due to these efforts, as of August 2017, Grace received 2014 PCMH recognition, was able to go up a level to level 3, and received 93 of 100 possible points. Grace's staff and volunteers are enthusiastic to see the outcomes associated with this achievement.

Postscript

Grace Medical Home's PCMH designation distinguished the center as one of the first low-cost clinics nationally to achieve such recognition. "Patient care at Grace has always been our first priority," said founder Hardy. "We are humbled and honored to receive recognition that reaffirms that. We believe that the low-income and underserved [population] deserve nothing less than the highest level of medical care."[29] Today, Grace continues to function as a recognized medical home and achieved PCMH 2014 level 3 recognition in August 2017. The organization fills a key healthcare services gap in a community with a 20% uninsurance rate, which is slightly higher than the state average of 18%.[30]