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Medical Home: The Bridge Across the Quality Chasm

JEFFERY LOBAS: Good Morning. What I'm going to do is take a lot of the theory that Charlie's talked about and what they've tried to do theoretically and talk about the journey we've had in Iowa to try to introduce that and spread that within our state. And I do think the state is a good unit to really try to spread this kind of thing. So I'm going to go through our journey and hopefully point out some of the lessons learned so you don't have to make the same mistakes that we did.

I'll first say one of the lessons that I learned is that it's a messy process and it has been a character building experience for me. You know my training is pediatric critical care and for almost 20 years I did pediatric intensive care and one of the beauties of the ICU is you monitor everything and you turn the drip up and you watch the heart rate and the blood pressure goes up. And you do this and you get a change, you turn the ventilator the oxygen saturation goes up. Well I really had to learn the way that happens in Medical Home and so I had to accept the new turn that not everything is clean and easy for sure. So I titled this Building from Practice to Policy and you'll see why. We really approach it as while it's okay to work with practices but if we don't introduce it into the state's

policy where we get some infrastructure and funding we really haven't done our job.

So I'm going to talk—we call it the Iowa Medical Initiative and my social work colleagues call it I'm high so I don't especially like that so—It started off in 2002 and it will be difficult to put essentially five years of a lot of effort into a few slides but I will try it. We've moved from a promise to the state and we've have several phases and I'll go thru each of those and what our next steps are. The promise to the state was a bunch of us, a number of us from the Special Needs program and from the AP went to Arizona. We were funded by MCHB to spend some time and Bob Anderson, one of the most conservative pediatricians in the state came back with a new belt and cowboy boots. I was thrilled so he did a good job. But the most important thing here is we really committed ourselves to establishing Medical Home as a standard of practice. That's a big deal and we had a core group that really were serious about how are we going to do this over the next ten years.

So we came back and met a few times and said we're going to meet this promise to the state. We wrote it out, we gave it to the academy and to the special needs program and we said let's do this. So the over arching vision was a comprehensive project that was going to aim not just at practices but at policy. We were going to look at improving all care practices using the PDSA cycle and the Wagner model and hopefully we were going to improve satisfaction in

families and in practitioners. And we really did have a very strong evaluation component in much of what I'm going to talk about in terms of lessons learned and any data is really part of our—we work with the College of Public Health at the University of Iowa. And they've done a great job doing an evaluation on both formative and summative.

So we did approach it as a multi-level project where we were trying to improve the life of that family, make it better for the practices but integrate it into the state. And it was very interesting, it has been incorporated into a lot of governor's language and a lot of legislative language. I don't know that they what they're actually saying when they say every child will have a Medical Home and a Dental Home because there's not a lot of money that follows it but at least we're talking about it. And in fact we've been one of the state for the Office of Performance Review to work with and they've come in and our whole state has accepted that this is our major goal. That every child shall have a Medical Home and Dental Home. You know now what does that mean is the big issue but at least it's on the radar screen at a lot of different levels. So we've already done a good job there.

Our Phase One was to recruit just five practices and work with them and kind of figure this out. Phase Two was to increase that and do ten to fifteen practices each year and then Phase Three was going to be working with multiple practices at a time. So we first started with recruitment of practices and that was we used our parent network as a way to identify them initially. They were selected by the

ones we thought would be most likely to succeed because we wanted a success. Susie Kell is the Executive Director of the American Academy of Family Physicians and she actually became our project coordinator. So there was a partnership between the special needs program and the AAFP and the AAP and I think that really helped. So we had a number of practices that signed up and there were a lot of barriers. One of the first calls I made to talk to a head of a big multi-specialty practice, I was all excited and this was my first effort at selling this and he goes well Dr. Lobas I appreciate your warm fuzzy altruism but if this doesn't increase our reimbursement or decrease the time we spend in the office I'm really not much interested. And that kind of sums up a lot of the barriers that we saw within this. Limited resources, no real interest or understanding of the concept, payment issues. They didn't like outsiders coming in and telling us what they had to do. So there were barriers for sure.

What made it work is this core advisory group of the academies and public health and Medicaid to really talk about this and market it. And it was the Initiative's relationship with the special needs director and the fact that I as the director of the special needs program was really committed to this. I am a trustee of the AP. I'm a medical director of the Health Department and boy that's been a key to have that confluence of roles. The Academy of Family Physicians was important. Connection to family practice. We did address reimbursement issues. Most doc's want to do a better job and the fact that physician practices saw that we were

trying to make a policy change helped them say yes to the process because it did take a lot of work.

Our primary goal was in Phase One was to really use a facilitation model. We were involving Children with Special Needs. We talked about lots of things. Sustainable payment methods, optimizing quality, it was a very labor intensive model where we had a team that went into each practice. We did create an organization you know which included a core group, a planning team and a practice group and I think it was important to have a pretty solid structure to go at this as we approached it.

We started with a memorandum of agreement which we clarified what we expected from the practice and what they could expect from us. It wasn't a legal document but it sure did help us. We would go back to that over time to talk with that team. You committed to this because there is a lot of drift in these practices. Our facilitation team included a nurse who was trained at facilitation and these principles, a physician advisor and a parent who worked then with a clinic team which required a physician, an office manager, a nurse and a parent from families in this group. We started with the Medical Home Index. We developed aim statements. We had monthly meetings. Sometimes weekly calls, sometimes daily calls about their project. What we found as we ended that first year those practices didn't want to let us go. You know we became their in house quality consultants which really isn't very good for sustainability but it brings up well what

is the role after that year for technical assistance and that's one of the things we're struggling with at this point.

Our evaluation showed that our strengths, we had a lot of good information. We had requests so there was a lot of interest. We were making headway in these practices with integrating data collection and a lot of relationships and common ground were being built within the initiative. Some of the weaknesses we found is a very inconsistent terminology. When you talk Medical Home in Genesis it might be real different then when you're with a community health center which might be really different at the health department. And that lack of a common understanding even within our own advisors was a real problem. We found that the facilitation process, we heard it could be objective and less directive and that clinics really should direct their own path and too much focus on the meeting rather than that between time pieces.

One of the weaknesses was I think they had difficulty working in multiple goals. It tended to distract them. They wanted to be more focused on one goal. And there was a disconnect between the clinic staff and the facilitator. Often there wasn't good communication so communication was a problem throughout the processes. What we did in Phase Two is we tried to cut out a lot of the face to face meetings and do more by the phone so we tried to streamline it. So the facilitation team was less involved. We put more of the locust of responsibility on the practice but generally used the same approach. What we found is most

practices took kind of boiler plate things that had been done that we could offer them and tried to implement that. So we tried to build on some lessons.

What we found was by doing it this way, as we compressed things we increased the frustration level and everybody was a little more upset a lot of the time. But we worked thru that. The more our staff was experienced, the better it seemed to go but it was still a very slow change process. What seemed to make it work was our core advisory group and those connections. That's a repeat slide. Sorry about that. We have repeated—there must be a—it's looping back so. Okay. There we go. So I'm going to go thru this summary of our formal evaluation in these phases. One of staff, one of our wise staff said we've not yet obtained the culture of Medical Home but we keep trying. And we do keep trying with this. And if we didn't establish it we asked ourselves well why? And one of the big things we saw was that we don't have a common language. We don't have a common definition. It really varies. I don't know if we can get to that. And as we've gone statewide dealing with all the community health centers and the health department it's real clear. People don't know if we're talking about just care coordination or what we're talking about. And that common language it seems to be one of the big problems for us.

The acceptance that change takes a long time was another one. People I think sometime expected oh in six months we'll have changed our whole practice and it just doesn't happen. I think our staff struggled with the slowness of change. We

found that recruitment took a lot of selling. I gave you that quote and that wasn't uncommon so you really had to become a sales person for this. And that creates for many people a pretty high frustration level.

Was Phase Two improvement or a Phase One? Well it was streamlined. We worked with more practices. I don't know that our data showed that those practices had changed as much as the Phase One. The barriers were as you might guess, limited time, constraints on the busy practice, lack of structure. When we were dealing with the big health system unless we got and I'll talk about this in Phase Three, unless we got the whole system to buy in it made it hard for that practice to be an outlier when it came to data and things. So we thought a lot about going to systems, health systems in the state rather than individual practices. And just understanding the concept of Medical Home continued to be a barrier. Time, time, time, time. We kept hearing that a lot. You know we paid stipends. We tried coming early in the morning, we'd come at noon, come after. We tried to make it as flexible as possible but that's what we heard a lot of.

Limitations of the software to do registries was a problem. A lot of things were hand generated. I think electronic medical records; if we had it widely spread and they could talk to each other it would make a huge difference. I'm not understanding, the flowness of change. Bureaucracy, trying to involve families, how to do that were issues. We had a number of practices that were team

leaders but they really weren't champions and there is a real distinction. They might have said okay, you're the office manager, you're in charge but unless they in their heart bought this things didn't work well. When we had a champion leave, that practice uniformly left or didn't do well. So a committed, passionate champion about this is really very, very important. The variation in educational experience with clinic staff really made a difference too.

We looked at what is our focus in our evaluation. Is it system wide change or practice change and it really was both. We did a lot of efforts. The planning group was very involved in trying to make policy changes and work with Medicaid and health department and the governor's office on this. And that was really important to get those right stakeholders. Insurers were another one we aimed at. It was hard to hold that group together.

We found a very explicit planning process with a strategic plan, a periodic review, the planning team meeting regularly was an important piece to move us forward. Without that and we say here, June of 2004 when we have a two day retreat inviting all the stakeholders for a planning retreat it really was a watershed moment about where are we going to go with this statewide. And that's when we started seeing it coming up in a lot of languages and legislation.

We found there was a lack of clarity about roles and responsibilities. There was a defuse organizational structure. What's the role of the planning team? What was

the role of the facilitation team? What was the role of the practice and the more that could be clarified we found the better things went. We did find though that there was a real sense of commitment in the practices we worked with. One practice staff member said that the progress they saw in their practice was just awesome. And we found generally that the practices were really eager to learn and change and our evaluation showed it was a very positive experience for the practices. Even though we may have felt we didn't get the results we wanted, the practices felt there was a change in their culture.

So some of the lessons in Phase One and Two is this whole definition. The more we can clarify and set that the better the common understanding. A focus on—we learned that we have to focus on recruitment and it's difficult hard work and it takes a strategy. It takes an explicit strategy. We learned how to facilitate. We learned the importance of comprehensive long term planning. We learned the importance of family participation in both the practices and at the system level. We learned that evaluation is key to guide us in both formative and summative way and obviously efficiency and use of resources was an important piece too.

So this just depicts that lack of definition and a clear understanding of Medical Home. We can look at the attributes, the culturally competent and comprehensive and care coordinated and those are all well and good. But when you start saying well what does that really mean for my practice that's where we really got pretty fuzzy. When we can't define that it affects the ability to recruit the

practices, our use of resources and our ability to organize any work groups. So that was really an important lesson.

And trying to do a system wide change at the macro level and micro level is tough. I think you have to really get a lot of clarity and have champions for both of those pieces. Other lessons learned, I think strategic approach to recruit, the use of a MOU we found was really important. It helped us a lot in putting that together so that we had mutual expectations.

Champions. I've already mentioned that but if we didn't have a true champion as the leader of teams things just didn't work. And we really found you had to when you look at change theory if you got practices who really after your assessment weren't ready to change, you wasted a lot of time and created a lot of frustration. So we've gotten to the point where we really do try to assess that practice's readiness to change before we invest in them or ask them to invest in us. We found education about the theory is helpful for the practice and trying to involve the entire clinic rather than just a group of two or three was really important and the use of family. Many of our practices resisted bringing families in. We didn't require it because I think we would have had a harder time recruiting. We encouraged and what we found after a few months of the families being involved in the practices it was just a no brainer. They were thankful and got so much out of it.