Innovation in community-based settings:

Supporting Federally Qualified Health Centers to implement complex health interventions.

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Acknowledgements

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Some of the ideas presented are informed by mentors and faculty at the Implementation Research Institute.
Why FQHC contexts serving families?

What works?

How service delivery innovations operate?

Applicable solutions that promote equity and inclusion
But many challenges faced by FQHCs to implement innovations
What other challenges?

- Implementation of interventions that **work sometimes, in certain settings and for certain patient populations/communities**

Does it work?

- Yes
- No
- Maybe
Complex Health Interventions

- Their execution requires precision (potential for error/deviations)
- Their implementation requires high coordination
- Often, they involve a difficult concept to ‘grasp’ in the field
- Difficult to successfully implement
  - The intervention must be highly integrated into the local context
  - It requires dynamic and multi-level changes

Bauman, Stein & Ireys, 1991
How can we better prepare FQHCs’ inner context to successfully innovate?
Understanding sources of variation

Core Functions and Forms of Complex Health Interventions: a Patient-Centered Medical Home Illustration

Authors
Mónica Perez Jolles, Rebecca Lengnick-Hall, Brian S. Mittman

Abstract

Despite policy and practice support to develop and test interventions designed to increase access to quality care among high-need patients, many of these interventions fail to meet expectations once deployed in real-life clinical settings. One example is the Patient-Centered Medical Home (PCMH) model, designed to deliver coordinated care. A meta-analysis of PCMH initiatives found mixed evidence of impacts on service access, quality, and costs. Conceptualizing PCMH as a complex health intervention can generate insights into the
<table>
<thead>
<tr>
<th>System/Patient Needs</th>
<th>Core Functions</th>
<th>Forms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identified needs that motivate the development of the intervention.*</td>
<td>The intended structural and procedural goals and purposes to reach the intervention goals.</td>
<td>Specific steps and activities taken to carry out or perform each core function.</td>
</tr>
<tr>
<td>Based on the clinical settings’ structures, payment models and patient characteristics.</td>
<td>Focus on standard macro competencies around change/ transformation processes.</td>
<td>Forms are customized or tailored to each local setting and patient population.</td>
</tr>
<tr>
<td></td>
<td>Fidelity is assessed at this level.</td>
<td>Forms can evolve to account for ongoing change.</td>
</tr>
<tr>
<td></td>
<td>Absence of core functions challenges the integrity of the intervention and its implementation success.</td>
<td>A single core function can have multiple forms.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Adaptations are assessed at this level.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Absence of a particular form does not compromise the integrity of the intervention as it can be substituted for another form.</td>
</tr>
</tbody>
</table>

Research Partner

Federally Qualified Health Center (FQHC) with a network of 26 community-based clinics located in Southern California
Defining the Medical Home

The medical home is an *approach* to primary care that is:

- **Person-Centered**
  Supports patients and families in managing decisions and care plans

- **Comprehensive**
  Whole-person care provided by a team

- **Coordinated**
  Care is organized across the 'medical neighborhood'

- **Committed to Quality and Safety**
  Maximizes use of health IT, decision support and other tools

- **Accessible**
  Care is delivered with short waiting times, 24/7 access and extended in-person hours
PCMH as a Complex Health Intervention

- Its execution requires precision
- Its implementation requires high coordination
- Difficult concept to ‘grasp’ in the field
- Difficult to successfully implement across clinical settings
  - The intervention must be highly integrated into the local context
  - It requires changes at the organizational, workforce and patient levels

Bauman, Stein & Ireys, 1991
Applying the concepts of Functions and Forms in the field
# PCMH Functions & Forms Matrix

## Table 1. Patient-Centered Medical Home Care Function & Form Matrix Table

<table>
<thead>
<tr>
<th>Motivating problems/needs</th>
<th>PCMH Core Functions (Standardized)</th>
<th>PCMH Tailored Group of Activities (Form)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients unable to reliably access care when needed</td>
<td>A. Offer enhanced options for increased access to in-person care</td>
<td>I. Strategies for expanding access to in-person care/appointments. (examples)</td>
</tr>
<tr>
<td></td>
<td>B. Facilitate and document remote access to health consultation/clinical advice</td>
<td></td>
</tr>
<tr>
<td></td>
<td>C. Create written processes and defined standards to facilitate patient’s access to EHR</td>
<td>II. Resources that enable remote access to medical information or virtual consultation. (examples)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Motivating need/problem

Unreliable patient access to health care when needed

### Core functions (standardized)

Offer enhanced options for access to in-person care

### Forms (tailored)

- In person care outside of traditional hours
- Schedule same day appointments
Goals of this case study:

1. **Identify the core functions and forms** of Patient-Centered Medical Home (PCMH) care within Federally Qualified Health Center clinics

2. **Explore the applicability** of these concepts with clinical partners
Goal 1. Identify the core functions and forms of Patient-Centered Medical Home (PCMH) care within Federally Qualified Health Center clinics.
Ethnographic Methods
Walking interviews/ Observations
Sit-in interviews
Quarterly Leadership Meetings
Document review
The *Function and Form Matrix* was used to capture participants’ day-to-day routine activities to deliver the intervention (PCMH), its perceived goals and needs.
What we found from this process

1. Lack of PCMH implementation flexibility to account for differences at each clinic (customizations)

2. Difficult concept to ‘grasp’ in the field

3. Need to integrate and align functions and forms
Goal 2. Explore the applicability of these concepts with clinical partners
# Tailored Functions & Forms Matrix

## MAPPING THE PCMH CARE MODEL AT

<table>
<thead>
<tr>
<th>Source: AHRQ</th>
<th>Motivating Need - Source: Published Literature</th>
<th>Source: USC Team Analysis based on the PCMH literature</th>
<th>=&gt; AHRQ-NCQA STANDARDS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NCQA SIX STANDARDS OF CARE /CORPORATE CATEGORY</strong></td>
<td><strong>PCMH PRINCIPLES</strong></td>
<td><strong>GOAL</strong></td>
<td><strong>ACTIVITY</strong></td>
</tr>
<tr>
<td>Knowing &amp; Managing Your Patients (KM)</td>
<td>Quality and Safety</td>
<td>Care is not consistently driven by scientific evidence and supported by clinical information systems</td>
<td>Function A. Identify needs and services in health continuum, including social and behavioral needs</td>
</tr>
<tr>
<td>Knowing &amp; Managing Your Patients (KM)</td>
<td>Comprehensive Care</td>
<td>Care is episodic. Lack of innovative models of team work to support team-based care</td>
<td>Function A. Create an infrastructure to exchange information via shared records</td>
</tr>
<tr>
<td>Care Coordination &amp; Care Transitions (CC)</td>
<td>Coordinated Care</td>
<td>Lack of communication and coordination across health care providers and institutions</td>
<td>Monitors the timeliness and quality of the referral response. Documented process AND report</td>
</tr>
<tr>
<td>Patient-Centered Access &amp; Continuity (AC)</td>
<td>Accessible Care</td>
<td>Patients need to reliably access care when needed</td>
<td>Function A. Offer enhanced options for access to in-person care</td>
</tr>
<tr>
<td>Patient-Centered Access &amp; Continuity (AC)</td>
<td>Quality and Safety</td>
<td>Care is not consistently driven by scientific evidence and supported by clinical information systems</td>
<td>Documents clinical advice in patient records and confirms clinical advice and care provided after-hours does not conflict with patient medical record. Documented process AND evidence of implementation--Audit process with non Superbill for after hours care</td>
</tr>
<tr>
<td>Patient-Centered Access &amp; Continuity (AC)</td>
<td>Accessible Care</td>
<td>Patients need to reliably access care when needed</td>
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**PCMH Forms Source: Borrego Health**

**DESCRIPTION/Additional Information**

This column could be seen as referring to **PCMH FORMS**

- Comprehensive health assessment includes all items required. Documented process and evidence of implementation--Ongoing comprehensive health assessment (see above). Screen shots of all assessments used in ENG.
- Has regular “case conferences” involving parties outside the practice team (e.g., community supports, specialists). Only within Borrego: PCP, Psychologist, Psychiatrist, RN. Care coordinator, Community Health worker.
- Provides same-day appointments for routine and urgent care to meet identified patient needs. Documented process AND evidence of implementation—same day included in Basic. Some sites leave openings for same day. Address with NCP group.
- Provides scheduled routine or urgent appointments by telephone or other technology-supported mechanisms. Documented process AND report—Telemedicine.
# PCMH: Accessible Care

## MENU OF FORMS

<table>
<thead>
<tr>
<th>FQHC Partners: 17 forms</th>
<th>National Review Matrix: 12 forms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provides scheduled routine or urgent appointments by telephone or other technology-supported mechanisms...Documented process AND • Report- Telemedicine</td>
<td>System in place that ensures patients have same day access to their healthcare provider e.g. open access scheduling for <strong>same day appointment</strong>&lt;sup&gt;32&lt;/sup&gt;</td>
</tr>
<tr>
<td>Confirms <strong>clinical advice and care provided after-hours</strong> does not conflict with patient medical record</td>
<td>The health home provider ensures <strong>24 hrs / 7 days a week availability to a care manager</strong> to provide information and emergency consultation services&lt;sup&gt;38&lt;/sup&gt;</td>
</tr>
</tbody>
</table>
# Tailored Functions & Forms Matrix - ALIGNMENT

## MAPPING THE PCMH CARE MODEL AT BORREGO => AHRQ-NCQA STANDARDS

| Source: AHRQ | Motivating Need - Source: Published Literature | Source: USC Team Analysis based on the PCMH literature | PCMH Forms  
Source: Borrego Health |
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<tr>
<td><strong>NCQA SIX STANDARDS OF CARE /CORPORATE CATEGORY</strong></td>
<td><strong>PCMH PRINCIPLES</strong></td>
<td><strong>MOTIVATING PROBLEM</strong></td>
<td><strong>FUNCTION(S)</strong></td>
</tr>
<tr>
<td>Knowing &amp; Managing Your Patients (KM)</td>
<td>Quality and Safety</td>
<td>Care is not consistently driven by scientific evidence and supported by clinical information systems</td>
<td>Function B. Monitor and measure care as delivered to assure adherence to evidence-based standards</td>
</tr>
<tr>
<td>Knowing &amp; Managing Your Patients (KM)</td>
<td>Comprehensive Care</td>
<td>Care is episodic. Lack of innovative models of team work to support team-based care</td>
<td>Function A. Identify needs and services in health continuum, including social and behavioral needs</td>
</tr>
</tbody>
</table>

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**Flag:** (e.g., mis-alignment between NCQA & AHRQ, form not implemented yet, Other)
How are these concepts relevant to adaptation efforts?
Current guidance on adaptations
Identify core components, preserve them and...adapt everything else
Yes, but, how do we systematically and consistently identify those boundaries?
How can we better prepare FQHCs’ *inner context* to successfully innovate?
What about

Defining the Medical Home
The medical home is an approach to primary care that is:

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Source: www.ahrq.gov

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Primary Care Medical Home Certification Program

Transform your primary care services to improve the continuity, quality and efficiency.

Patient-Centered Medical Home (PCMH)

NCQA’s Patient-Centered Medical Home (PCMH) Recognition program is the most widely adopted PCMH evaluation program in the country. Approximately 13,000 practices (with 67,000 clinicians) are recognized by NCQA. More than 95 organizations support NCQA Recognition through providing financial incentives, transformation support, care management, learning collaboratives or MOC credit.
This is one **problem** PCMH is designed to address

Care is often inconsistent with, and not planned or carried out in consideration of, patient preferences and values.
This is a **goal/purpose** we all agree to achieve with PCMH to address that problem.

Assess patient values, needs and preferences.
And here is a **menu of activities/strategies**
to **customize** and carry out that goal

*Written materials published in primary language(s) of the community*

*Providers or telephonic trained interpreters speak a patient and family's language of choice*
Summary Points

• Gaining in-depth understanding of how real-life settings define and manage complex interventions can inform research efforts seeking to test these intervention’s effectiveness and successful customizations

• Operationalizing a complex intervention’s forms and functions could improve FQHCs’ capacity to define it, map it and successfully implement it
Interdisciplinary Collaborators

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Director of Quality / Department
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Christina Reaves, MPH
Director Community Research
FQHC located in Southern California.
“Order is not enough. You can’t just be stable, and secure, and unchanging, because there are still vital and important new things to be learned.”

(Jordan Peterson)

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