Innovation in community-based settings:

Supporting Federally Qualified Health Centers to implement complex health interventions.

Mónica Pérez Jolles, PhD, M.A.

USC Gehr Family Center for Health Systems Science and Innovation
Keck Medicine of USC

USC Suzanne Dworak-Peck School of Social Work

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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

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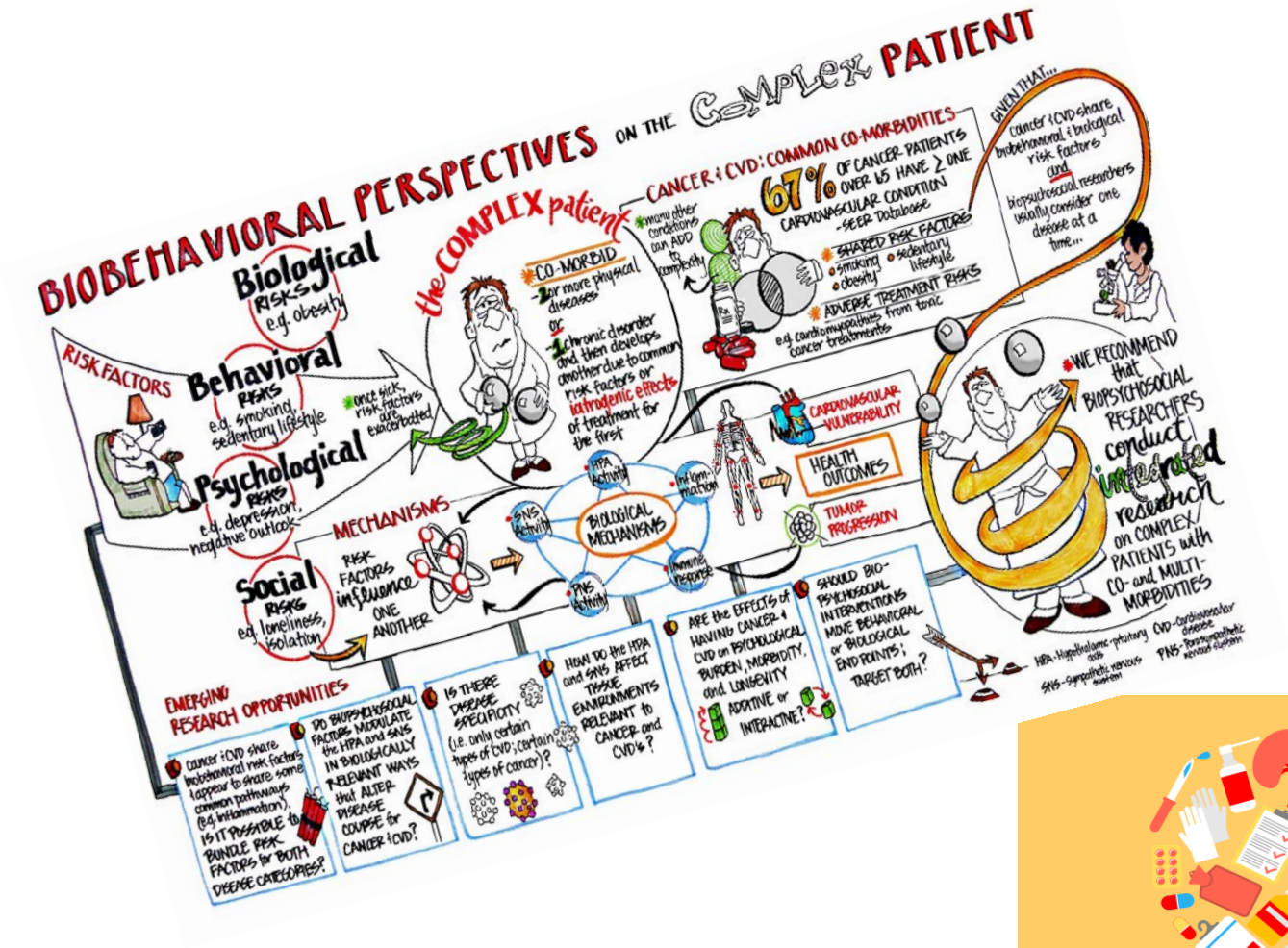
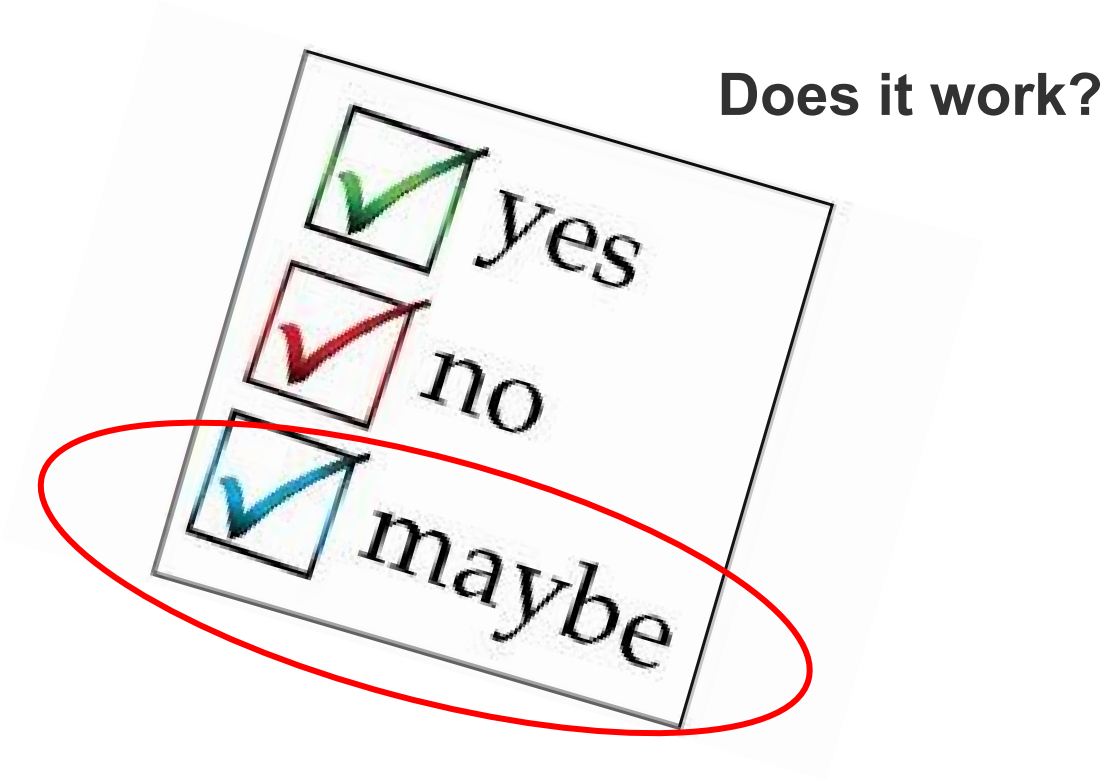
But many challenges faced by FQHCs to implement innovations



What other challenges?

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



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

Moving Target

Bauman, Stein & Ireys, 1991

How can we better prepare FQHCs' inner context to successfully innovate?

Understanding sources of variation

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

Authors | Authors and affiliations

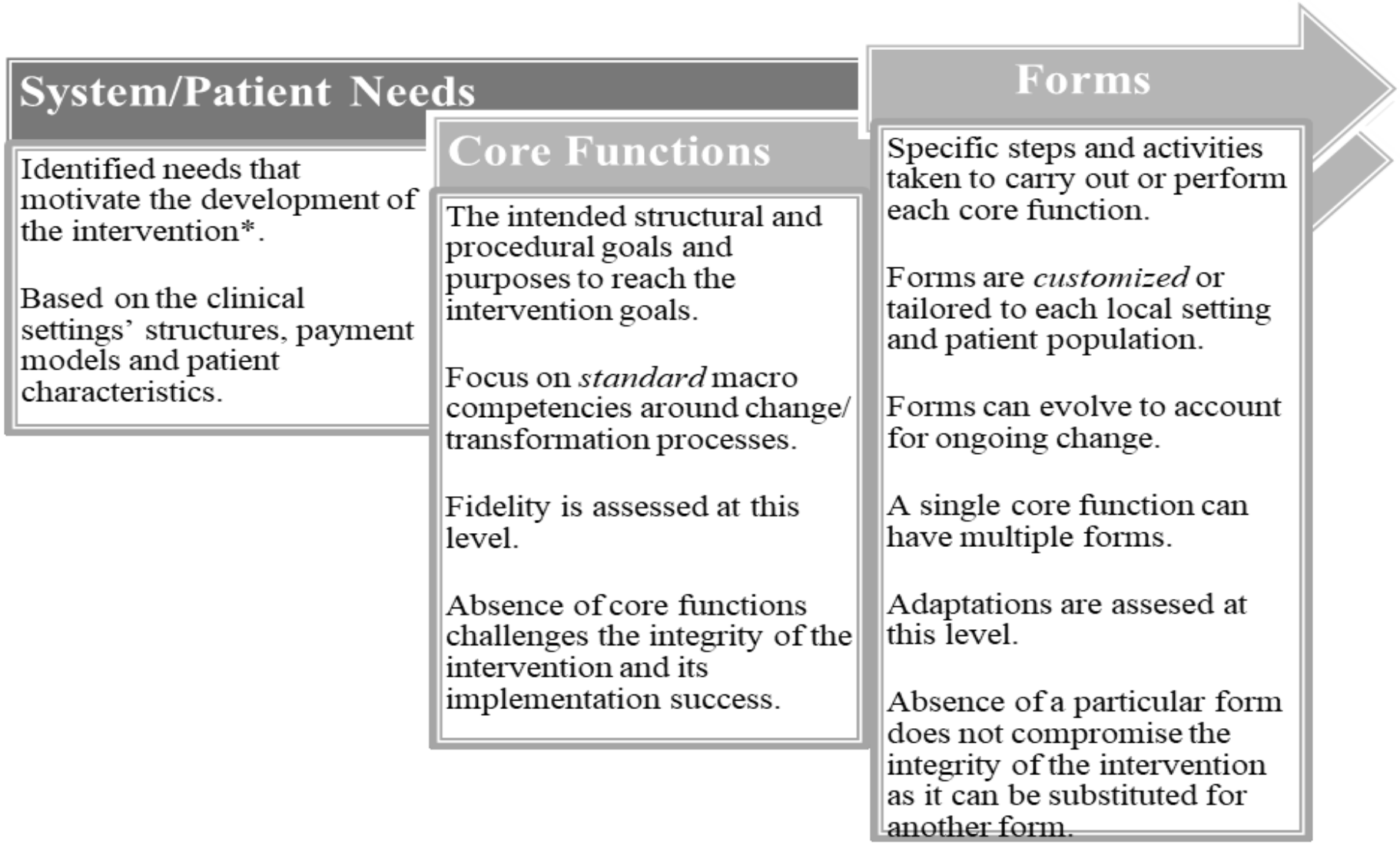
Mónica Perez Jolles, Rebecca Lengnick-Hall, Brian S. Mittman

Perspective
First Online: 08 January 2019

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

Key Concepts



Jolles, M. P., Lengnick-Hall, R., & Mittman, B. S. (2019). Core Functions and Forms of Complex Health Interventions: A Patient-Centered Medical Home Illustration. Journal of general internal medicine, 1-7.

Research Partner

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

Patient-Centered Primary Care COLLABORATIVE

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

Source: www.ahrq.gov

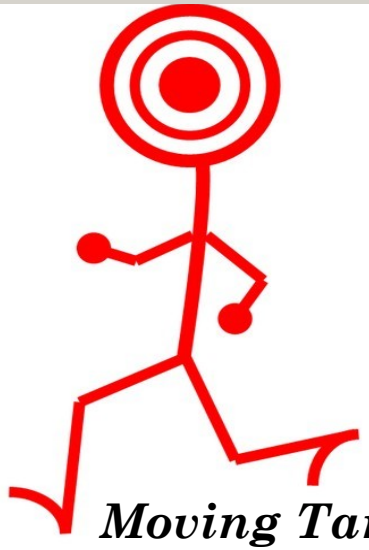
PCMH as a Complex Health Intervention

- ✓ 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

Organizational level

Workforce level

Patient level



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

Patient Centered Medical Home (PCMH) Principles 1-5		
1. ACCESSIBLE CARE Health system makes primary care accessible through minimizing wait times, enhanced office hours, and after-hours access to providers through alternative methods such as telephone or email[1]		
Motivating problems/needs	**PCMH Core Functions (Standardized)**	**PCMH Tailored Group of Activities (Form)**
Patients unable to reliably access care when needed[1]	A. Offer enhanced options for increased access to in-person care	I. Strategies for expanding access to in-person care/appointments. (examples) ○ Provide care for patients in non-traditional ways (e.g., telephone, email) ○ After hours' clinic/open scheduling
	B. Facilitate and document remote access to health consultation / clinical advice	II. Resources that enable remote access to medical information or virtual consultation. (examples) ○ 24/7 access to clinical advice
	C. Create written processes and defined standards to facilitate patient's access to EHR	III. Resources that enable remote access to medical information. (examples) ○ Patient web portal

achieves its effects. It can also address heterogeneity by

Motivating need/ problem	Core functions (standardized)	Forms (tailored)
Unreliable patient access to health care when needed	Offer enhanced options for access to in-person care	• In person care outside of traditional hours • Schedule same day appointments

MEDICAL HOME CARE AS A COMPLEX INTERVENTION 2018-2019

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

MEDICAL HOME CARE AS A COMPLEX INTERVENTION 2018-2019

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

MEDICAL HOME CARE AS A COMPLEX INTERVENTION 2018-2019

Ethnographic Methods

Walking interviews/ Observations

Sit-in interviews

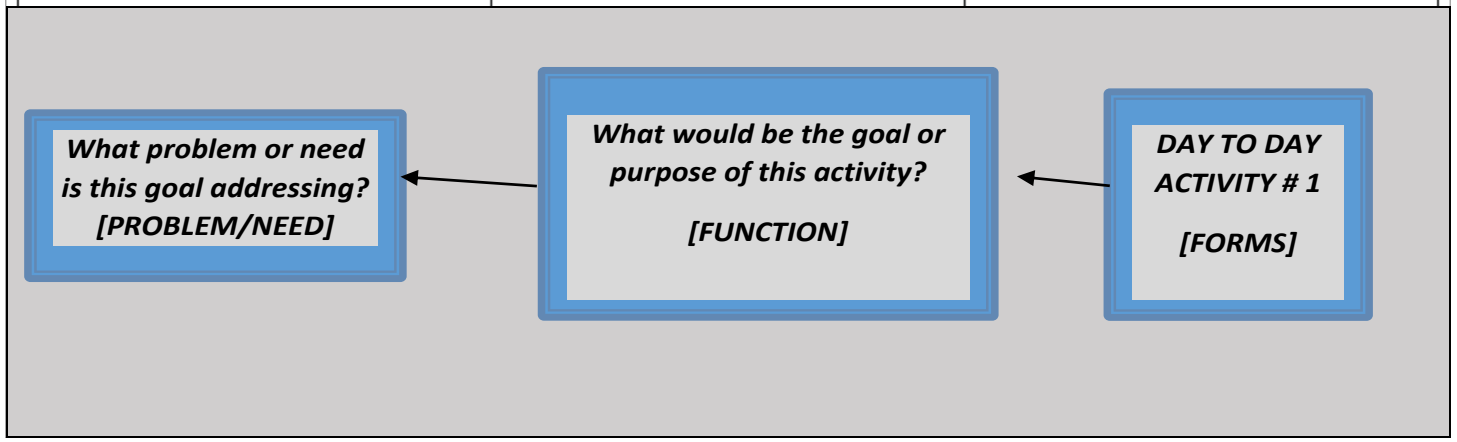
Quarterly Leadership Meetings

Document review

SEGMENT 1 – F&F MATRIX TOOL FOR DATA COLLECTION

Participant ID: _____

Step 3. Need or problem	Step 2. Function / goal	Step 1. Form / activities
		1.
		2.
		3.
		4.



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

MEDICAL HOME CARE AS A COMPLEX INTERVENTION 2018-2019

Goal 2. Explore the applicability of these concepts with clinical partners

Tailored Functions & Forms Matrix

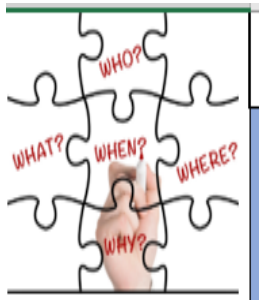
	MAPPING THE PCMH CARE MODEL AT		=> AHRQ-NCQA STANDARDS		
	Source: AHRQ	Motivating Need - Source: Published Literature	Source: USC Team Analysis based on the PCMH literature	PCMH Forms Source: Borrego Health	FLAG: (e.g., mi between NCQA & A implemented
NCQA SIX STANDARDS OF CARE /CORPORATE CATEGORY	PCMH PRINCIPLES	 *MOTIVATING PROBLEM*	 FUNCTION(S)	 DESCRIPTION/Additional Information This column could be seen as referring to *PCMH FORMS*	
Knowing & Managing Your Patients (KM)	Quality and Safety	*Care is not consistently driven by scientific evidence and supported by clinical information systems*	**Function D.** Monitor and measure care as delivered to assure adherence to evidence-based standards	Comprehensive health assessment includes (all items required)...Documented process and evidence of implementation-CORE-Comprehensive health assessment –see above. Screen shots of all assessments used in EHS	
Knowing & Managing Your Patients (KM)	Comprehensive Care	*Care is episodic. Lack of innovative models of team work to support team-based care*	**Function A.** Identify needs and services in health continuum, including social and behavioral needs	**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**	 *mis-alignment id*
Care Coordination & Care Transitions (CC)	Coordinated Care	*Lack of communication and coordination across health care providers and institutions.*	**Function A.** Create an infrastructure to exchange information via shared records	Monitors the timeliness and quality of the referral response...Documented process AND •report	
Patient-Centered Access & Continuity (AC)	Accessible Care	*Patients need to reliably access care when needed*	**Function A.** Offer enhanced options for access to in-person care	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 HCP group	
Patient-Centered Access & Continuity (AC)	Quality and Safety	*Care is not consistently driven by scientific evidence and supported by clinical information systems*	**Function D.** Monitor and measure care as delivered to assure adherence to evidence-based standards	**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**	 *mis-alignment id*
Patient-Centered Access & Continuity (AC)	Accessible Care	*Patients need to reliably access care when needed*	**Function A.** Offer enhanced options for access to in-person care	Provides scheduled routine or urgent appointments by telephone or other technology-supported mechanisms...Documented process AND • Report- Telemedicine	

PCMH: Accessible Care

MENU OF FORMS

FQHC Partners: 17 forms	National Review Matrix: 12 forms
Provides scheduled routine or urgent appointments by telephone or other technology-supported mechanisms…Documented process AND • Report- **Telemedicine**	System in place that ensures patients have same day access to their healthcare provider e.g. open access scheduling for **same day appointment**[32]
Confirms **clinical advice and care provided after-hours** does not conflict with patient medical record	
	The health home provider ensures **24 hrs / 7 days a week availability to a care manager** to provide information and emergency consultation services[38]

Tailored Functions & Forms Matrix- ALIGNMENT



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

NCQA SIX STANDARDS OF CARE /CORPORATE CATEGORY	PCMH PRINCIPLES (Source: AHRQ)	 MOTIVATING PROBLEM (Motivating Need - Source: Published Literature)	 FUNCTION(S) (Source: USC Team Analysis based on the PCMH literature)	 DESCRIPTION/Additional Information This column could be seen as referring to *PCMH FORMS* (PCMH Forms Source: Borrego Health)	FLAG: (e.g., mis-alignment between NCQA & AHRQ, form not implemented yet,Other)
Knowing & Managing Your Patients (KM)	Quality and Safety	*Care is not consistently driven by scientific evidence and supported by clinical information systems*	**Function D.** Monitor and measure care as delivered to assure adherence to evidence-based standards	Comprehensive health assessment includes (all items required)...Documented process and evidence of implementation-CORE-Comprehensive health assessment –see above. Screen shots of all assessments used in EHS	
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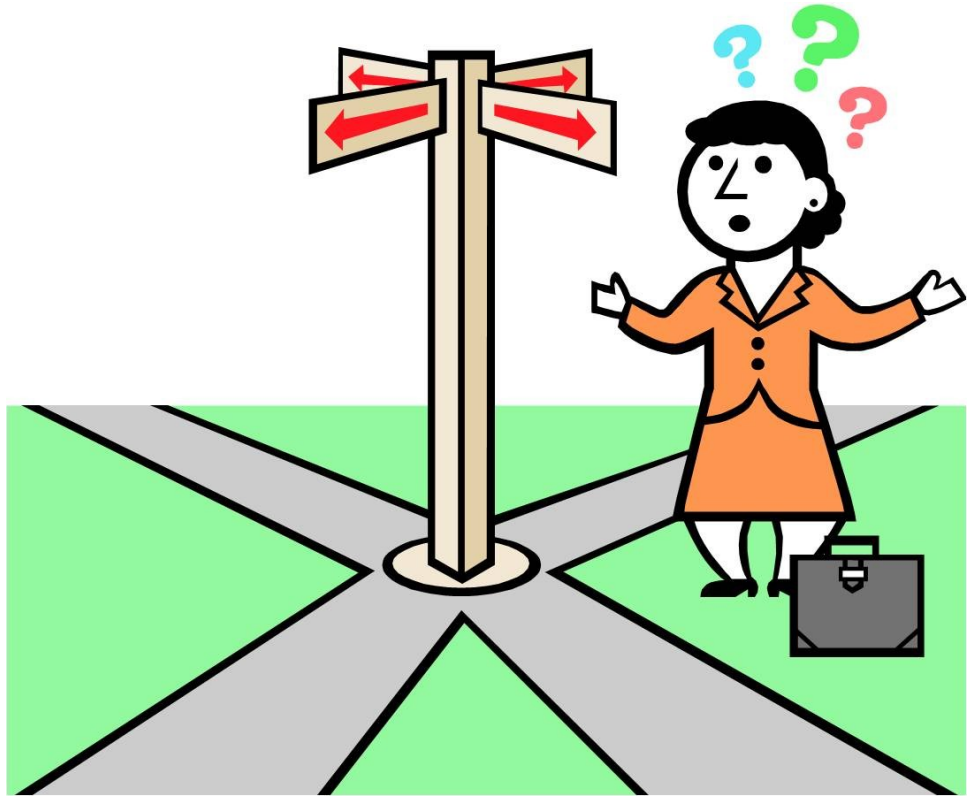
How are these concepts relevant to adaptation efforts?

Current guidance on adaptations

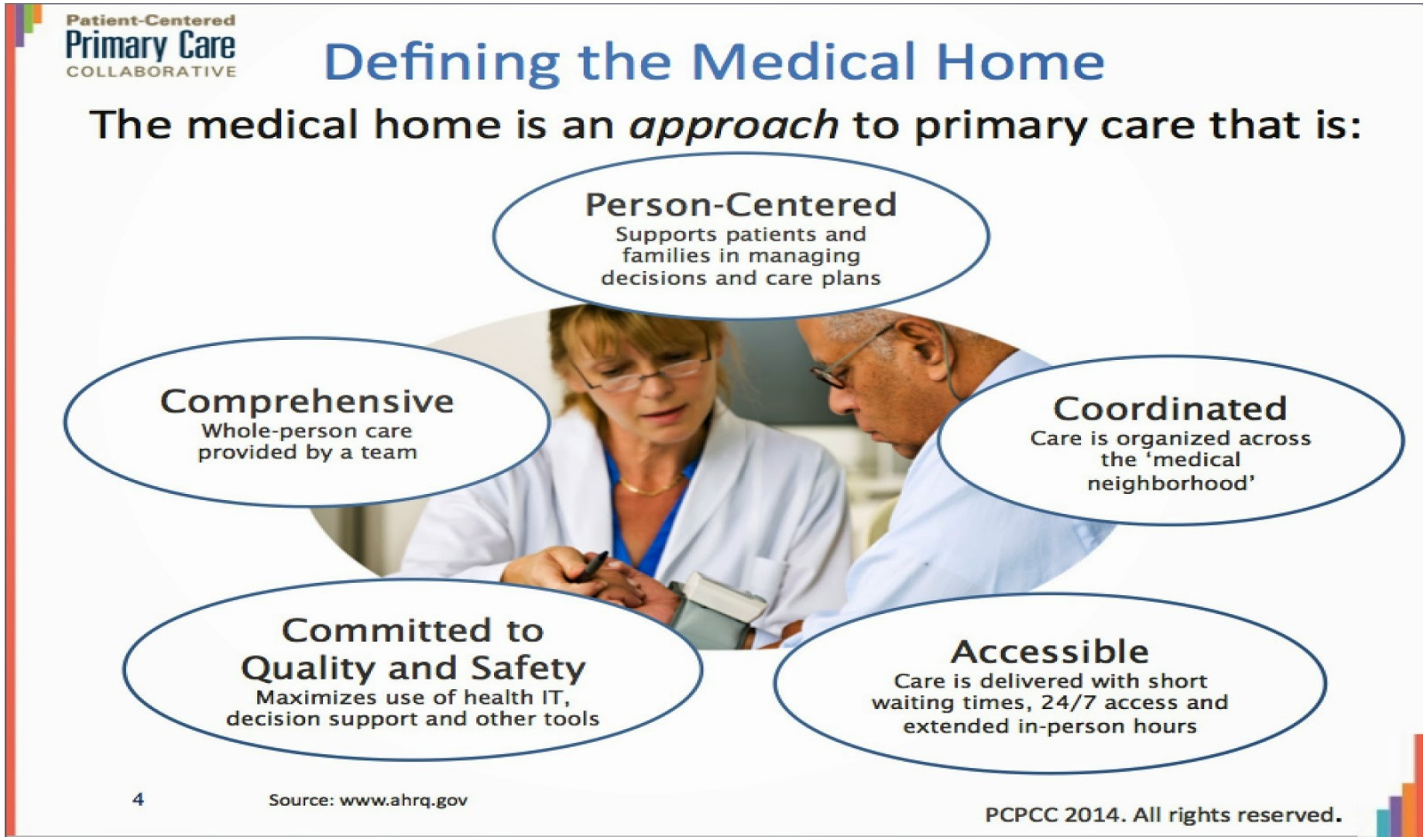
Identify core components, preserve them and…adapt everything else



Yes, but, how do we **systematically and consistently** identify those boundaries?

How can we better prepare FQHCs' inner context to successfully innovate?

What about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Source: www.ahrq.gov
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The Joint Commission

Our Websites:

Accreditation & Certification | Standards | M

Home > Accreditation & Certification > Certification > C

Primary Care Medical Home Certification Program

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

NCQA
Measuring quality. Improving health care.

PCMH | Overview

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

Rebecca Lengnick-Hall, *PhD*
Washington University
St. Louis, MO.

Brian Mittman, PhD
Kaiser Permanente
Pasadena, CA.

Haomiao Jin, *PhD*
USC, Los Angeles, CA.

Leslie Myrick, MSOD
Director of Quality / Department
FQHC located in Southern California.

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)

Mónica Pérez Jolles, PhD
Email: mjolles@usc.edu

Research Affiliate, USC Gehr Family Center for Health Systems Science
Fellow, Cecil G. Sheps Center for Health Services Research, UNC-Chapel Hill
Assistant Professor, USC Suzanne Dworak-Peck School of Social Work
University of Southern California
Profile: https://expertfile.com/experts/monica.jolles