The Safety Net Medical Home Initiative
Transforming Care for Vulnerable Populations

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Background: Despite findings that medical homes may reduce or eliminate health care disparities among underserved and minority populations, most previous medical home pilot and demonstration projects have focused on health care delivery systems serving commercially insured patients and Medicare beneficiaries.

Objectives: To develop a replicable approach to support medical home transformation among diverse practices serving vulnerable and underserved populations.

Design: Facilitated by a national program team, convening organizations in 5 states provided coaching and learning community support to safety net practices over a 4-year period. To guide transformation, we developed a framework of change concepts aligned with supporting tools including implementation guides, activity checklists, and measurement instruments.

Subjects: Sixty-five health centers, homeless clinics, private practices, residency training centers, and other safety net practices in Colorado, Idaho, Massachusetts, Oregon, and Pennsylvania.

Measures: We evaluated implementation of the change concepts using the Patient-Centered Medical Home-Assessment, and conducted a survey of participating practices to assess perceptions of the impact of the technical assistance.

Results: All practices implemented key features of the medical home model, and nearly half (47.6%) implemented the 33 identified key changes to a substantial degree as evidenced by level A Patient-Centered Medical Home-Assessment scores. Two thirds of practices that achieved substantial implementation did so only after participating in the initiative for >2 years. By the end of the initiative, 83.1% of sites achieved external recognition as medical homes.

Conclusions: Despite resource constraints and high-need populations, safety net clinics made considerable progress toward medical home implementation when provided robust, multimodal support over a 4-year period.

Key Words: medical home, practice transformation, safety net

(Adam 2014;52: S1–S10)

The medical home model of primary care delivery has captured the attention of health care policy makers, purchasers, and providers as a means to improve the quality and efficiency of health care delivery, and to enhance patients’ experience care.1–3 Evidence from early pilots derived primarily from systems serving commercially insured and Medicare populations suggested that successful implementation of medical home concepts can be associated with a variety of favorable clinical, financial, and experiential outcomes.4–10 Based in part on promising evidence from such settings, the Federal government, most states—particularly through Medicaid programs—and many private payors have begun exploring payment and delivery system models that support the medical home.11,12

A number of medical home demonstration projects emerged shortly after the 2007 release of the Joint Principles of the Patient-Centered Medical Home (PCMH) by several primary care medical specialty organizations.13 However, most demonstration projects focused on commercially insured patients or Medicare beneficiaries; few were primarily focused on providers serving vulnerable, underinsured, or uninsured patients.14 Policy makers at that time concluded that some findings from the early pilot and demonstration projects derived from initiatives focused on commercially insured and Medicare populations might be generalizable to practices comprising the health care safety net. However, various delivery system characteristics, financing models, and characteristics of vulnerable and underserved populations served by safety net providers may pose unique challenges in implementation of the medical home model.

A 2007 study conducted by The Commonwealth Fund concluded that medical homes were associated with reduction or elimination of disparities in health care delivery and health status among racial and ethnic minorities.15 The study also found that the certain characteristics of a medical home

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Presented at a number of meetings and professional conferences including the National Medical Home Summit (2013, 2012), National Academy for State Health Policy (2012), the Institute for Healthcare Improvement (2010, 2012), and the National Medicaid Congress (2010). It also includes data from the Patient-Centered Medical Home-Assessment (PCMH-A). An earlier version of Figure 3 was published in: Daniel et al.23

The authors declare no conflict of interest.

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were less likely to be present in settings that predominantly care for uninsured, low-income, and minority patients (such as community health centers and other public clinics) than they were in private doctors’ offices.

In response to the findings from that study, and in the absence of other large, national demonstration projects that focused on medical homes for vulnerable populations, The Commonwealth Fund launched an effort in 2008 to develop and implement an approach for accelerating medical home transformation among safety net practices. Thus, the Fund established the Safety Net Medical Home Initiative (SNMHI or Initiative) to support improvements in quality of care, patient experience, and efficiency in 65 safety net practices in 5 states.

In this article, we describe the context, structure, and design of the SNMHI. We also summarize, a series of lessons learned from the initiative to inform local, regional, and national efforts to support safety net practices in implementing the medical home model of primary care.

**BACKGROUND**

In April 2008, The Commonwealth Fund selected Qualis Health, a not-for-profit Seattle-based health care consulting and management firm and its partner, the MacColl Center for Health Care Innovation at the Group Health Research Institute, to lead the SNMHI (national program team). The intent of the SNMHI was to develop and demonstrate a replicable and sustainable implementation model to transform primary care safety net practices into PCMH with benchmark performance in quality, efficiency, and patient experience. In addition to helping practices redesign their clinical and administrative systems, the Initiative aimed to build regional capacity for primary care improvement by training local practice coaches, and to improve both reimbursement and coordination among community resources.

**METHODS**

**Structure/Design**

The first year of the 5-year initiative was devoted to planning, development of a framework to guide technical assistance, and selection of safety net practices to participate in the initiative.

To translate the aspirational goals of the Joint Principles into actionable steps to guide medical home transformation, we developed a series of 8 change concepts—general high-level ideas to guide process change—and identified a series of 3–5 more specific key changes in each of the 8 domains. The Change Concepts for Practice Transformation were developed based upon a synthesis of several conceptual models including the Joint Principles and the Chronic Care Model, and an analysis of approaches described in the health services literature and used in other primary care redesign initiatives. The Change Concepts were subsequently refined based on input from a national expert panel. A detailed description of the development process and evidence base for the Change Concepts can be found elsewhere.16

We reorganized the Change Concepts in May 2012 and again in March 2013 to reflect our learning from guiding change at the practice level. The key observation that led to the reorganization was that sites were by and large more successful in adopting and sustaining the PCMH Model of Care, when they implemented the Change Concepts in a specific particular sequence (Fig. 1).

**Participants**

We sought to identify entities in 5 states, each of which would serve as a convening organization for 10–15 safety net practices within a defined geographic region. We required that each organization, referred to as a Regional Coordinating Center (RCC), name an Executive Sponsor charged responsible for activities with regional stakeholders (including a state Medicaid representative), and identify one or more “medical home facilitators” (MHFs) who would serve as practice coaches responsible for organizing and providing technical assistance to participating practices. Practice coaches were expected to have a firm grounding in quality-improvement methodologies and change management, and to have familiarity with medical home principles. More information on the Initiative’s MHFs is provided elsewhere.17 We elected to provide technical assistance through regional entities for 2 reasons. First, we reasoned that local technical assistance provided by a trusted entity with existing relationships with participating practices and intimate knowledge of the local policy environment would be more preferable to assistance solely from a national program team. Second, we hoped to develop local capacity that would remain after conclusion of the Initiative to support dissemination and spread of the work.18 Figure 2 identifies the structural relationship of participants in the Initiative.

In response to a widely circulated request for proposals seeking candidate RCCs, we received 42 applications from organizations located in 31 states. To assess the readiness of practices to participate in the initiative, we required each practice site named as a partner by an applicant RCC to complete a Medical Home Self-Assessment tool adapted from NCQA’s Physician Practice Connections—PCMH recognition tool (RS version, 2006).19 We analyzed the data from 554 applicant sites to better understand the capabilities and needs of safety net clinics across the country. The results of the analysis of all applicant sites are published elsewhere.20

RCCs were selected based on their history with large-scale quality-improvement efforts, the experience and credentials of the proposed MHF(s), and the presence evidence that medical home transformation was already underway in the majority of practices named in the application. Geographic diversity was considered, as was the level of support from the applicant’s State Medicaid agency, identified stakeholders, and community foundations. Each applicant was scored on a scale of 0–125 by at least 2 members of a 11-member review panel comprised of funders, staff, and a member of the Technical Expert Panel. High-scoring applications were advanced through 2 additional rounds of review. Site visits were made to finalist organizations.

We selected 5 RCCs—4 statewide centers in Colorado, Idaho, Massachusetts, Oregon, and 1 city-wide center in Pittsburgh, Pennsylvania—each partnered with an average of
13 practice sites (range, 10–15, total of 65 practice sites). Eight regional foundations offered additional funding to support the SNMHI. The RCCs included state primary care associations, a Medicaid health plan, an agency of state government, and a regional health improvement organization. The participating practices, which included a mix of rural and urban Federally Qualified Healthcare Centers, homeless clinics, residency training programs, private practices, and other settings, cared for over half a million patients, with nearly 2 million annual visits in 2007. Selected characteristics of the practices are shown in Table 1.

Each RCC convened a Stakeholder Advisory Group to provide guidance on the design and delivery of regional activities and to advocate for improved reimbursement and coordination of community resources. Stakeholder Advisory Groups typically included representatives from public and private payors and government and community agencies that could support or advocate for primary care transformation (eg, Rural Health Council, medical societies).

### Technical Assistance Approach

We convened representatives from the 5 selected RCCs for an orientation meeting in month 12. In the second year of the Initiative, we launched a robust, multimodal technical assistance program to support MHFs, Executive Sponsors, and sites. The components of the technical assistance program are briefly summarized in Table 2.

Throughout the Initiative, the national program team identified, adapted, and created materials to help sites translate the Change Concepts into action. Materials included a series of implementation guides, interactive tools, and a catalogue of webinars and videos on a broad array of medical home and policy topics.

Implementation guides provided strategies and examples of successful efforts to actualize each of the change concepts and key changes. Many of the implementation guides drew upon the experience of SNMHI practices, and some were coauthored by Initiative participants. Supporting
TABLE 1. Characteristics of Participating Sites (N = 65)

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<thead>
<tr>
<th>Characteristic</th>
<th>Mean (%)</th>
<th>Range</th>
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<tbody>
<tr>
<td>Percent Medicaid</td>
<td>43</td>
<td>4–93</td>
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<tr>
<td>Percent Medicare</td>
<td>12</td>
<td>0–45</td>
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<tr>
<td>Percent uninsured/self-pay</td>
<td>24</td>
<td>2–88</td>
</tr>
<tr>
<td>Percent commercial</td>
<td>18</td>
<td>0–60</td>
</tr>
<tr>
<td>Serves rural or frontier community</td>
<td>20</td>
<td>20 (31)</td>
</tr>
<tr>
<td>Serves predominantly migrant population</td>
<td>11</td>
<td>11 (17)</td>
</tr>
<tr>
<td>Serves predominantly homeless population</td>
<td>7</td>
<td>7 (11)</td>
</tr>
<tr>
<td>Located in inner city area</td>
<td>23</td>
<td>23 (35)</td>
</tr>
<tr>
<td>Non-FQHC</td>
<td>13</td>
<td>13 (20)</td>
</tr>
<tr>
<td>Faith-based organization</td>
<td>6</td>
<td>6 (9)</td>
</tr>
<tr>
<td>Residency program</td>
<td>7</td>
<td>7 (11)</td>
</tr>
<tr>
<td>Critical access hospital or other hospital</td>
<td>8</td>
<td>8 (12)</td>
</tr>
<tr>
<td>Designation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>EHR capability</td>
<td>52</td>
<td>52 (80)</td>
</tr>
</tbody>
</table>

EHR indicates electronic health record; FQHC, federally qualified health center.

tools were created by participating practices or other best-practice primary care sites, or were created specifically for the Initiative based upon site request and need. Webinars featured SNMHI sites, patients, other best-practice primary care sites, and national experts were held approximately monthly over the course of the Initiative (n = 38). The number of individuals participating was not tracked. The number of lines connected to webinars ranged from as few as 20 to >100, and participants often noted that several team members used the same call-in line. To support access to “just-in-time” learning resources, all webinars were recorded and posted on the Initiative Web site for later viewing.

The first edition of the implementation guide series was published piecemeal between March 2010 and June 2012. In the final year of the Initiative, we enhanced and published a revised series to reflect learning and experience of SNMHI sites, address critical gaps, update content, and, more generally, improve the usability and navigability of the resources (The SNMHI resource library is available at: http://www.safetynetmedicalhome.org). Webinars and other media were produced and released in real time. Table 3 identifies the components of the resulting public domain SNMHI re-source library.

We created additional tools specifically for practice coaches. These materials were incorporated into Coach Medical Home, a free online curriculum designed to equip practice facilitators with knowledge and tools to support PCMH transformation based specifically on the SNMHI Change Concept framework.21 These supporting tools are described elsewhere.17,22

Because a goal of the Initiative was to improve reimbursement for primary care practices that adopted the PCMH Model of Care, the SNMHI provided both learning and financial resources on policy topics. Learning resources included research support, webinars, and policy briefs on topics such as health reform and evolving payment models. Financial resources were provided to support regional policy activities, which included Key Stakeholder Group meetings.

TABLE 2. Technical Assistance Program Components

<table>
<thead>
<tr>
<th>Type of Technical Assistance</th>
<th>Activities</th>
</tr>
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<tbody>
<tr>
<td>Medical Home Facilitator (MHF) training and support</td>
<td>Training and support for MHFs on PCMH transformation, as well as techniques for working with teams through challenging situations (eg, managing transformational change).</td>
</tr>
<tr>
<td>Direct practice coaching and consultation</td>
<td>Virtual and in-person group interactive learning, materials and tools (eg, implementation guides, assessment tools), and 1:1 consultation (eg, site visits).</td>
</tr>
<tr>
<td>Facilitation of learning communities</td>
<td>Peer-to-peer learning and support. Connected sites with similar populations, needs, or challenges. This included a national learning community, region-specific learning communities, and an electronic sharing site called Basecamp that allowed registrants to share and edit documents, ask and answer questions, post videos, and develop shared calendars.</td>
</tr>
<tr>
<td>Data collection and feedback</td>
<td>Regular data feedback reports and specific coaching on using data for improvement.</td>
</tr>
<tr>
<td>Financial support for sites</td>
<td>Stipends for field trips, special projects, and training/development.</td>
</tr>
<tr>
<td>NCQA PCMH Recognition support</td>
<td>Education on the NCQA PCMH Recognition Standards and application process, project management support, application preparation support, documentation review, and mock scoring.</td>
</tr>
<tr>
<td>Policy support for Executive Sponsors</td>
<td>Policy briefs on key topics, research support, funding for regional policy efforts.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Roles</th>
<th>Medical Home Facilitators/Regional Coordinating Centers</th>
<th>National Program Team (Qualis Health and MacColl Center)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participation in cross-regional learning activities</td>
<td>Primary responsibility for 1:1 consultation</td>
<td>Development of materials and tools.</td>
</tr>
<tr>
<td>Designed and administration of MHF learning community</td>
<td>Led regional activities including learning sessions</td>
<td>Direct practice consultation, as needed for specific topics</td>
</tr>
<tr>
<td>Provided guidance, support, and funding for regional activities</td>
<td>Identified mentor sites</td>
<td>Led cross-regional learning activities, including field trips and the national meeting</td>
</tr>
<tr>
<td>Collected and analyzed data. Developed data feedback reports and analyses for distribution to MHFs Provided</td>
<td>Identified site needs</td>
<td>Provided</td>
</tr>
<tr>
<td>Provided</td>
<td>Convened Regional Stakeholder Advisory Groups identified needs and topics</td>
<td>Provided or arranged from technical experts</td>
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<table>
<thead>
<tr>
<th>Resource</th>
<th>Number</th>
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<tbody>
<tr>
<td>Change Concept executive summaries provide a concise description of the Change Concept, its role in PCMH transformation, and key implementation activities and actions</td>
<td>8</td>
</tr>
<tr>
<td>Implementation guides provide a detailed introduction to the Change Concept, list the relevant key changes, describe implementation strategies, and present case studies</td>
<td>9</td>
</tr>
<tr>
<td>Implementation guide supplements further discuss specific PCMH issues and considerations (eg, health center board support, expanding the role of the medical assistant, care management)</td>
<td>3</td>
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<tr>
<td>Tools practices can use to test or apply the key changes</td>
<td>23</td>
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<tr>
<td>Webinars on PCMH topics</td>
<td>38</td>
</tr>
<tr>
<td>Policy briefs</td>
<td>3</td>
</tr>
<tr>
<td>PCMH-A and other practice assessment, tracking, and recognition tools</td>
<td>3</td>
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PCMH indicates Patient-Centered Medical Home; PCMH-A, PCMH-Assessment.

Payers

To help offset the cost of practice transformation and participation in technical assistance activities, SNMHI practices were eligible to receive a variety of financial supports. These included stipends for field trips, data infrastructure, staff training, and small grant awards to support special projects. In total, 167 activities were supported. Most sites received multiple awards over the course of the 4-year project period. The SNMHI also paid directly for all NCQA PCMH Recognition fees and reimbursed travel costs for the national learning session and most regional learning sessions. In addition, 3 of the 5 RCCs provided general stipends to support participation in the SNMHI. About half (55%, n = 36) of SNMHI sites received at least 1 stipend payment from their RCC over the course of the 4-year project period. The total mean stipend amount provided by an RCC was $7,593 ($1,898 per year; range $661–$14,212 per site).

Evaluation and Project Monitoring

The Commonwealth Fund commissioned an independent evaluation of the SNMHI conducted by the University of Chicago. The evaluation will assess the impact of the SNMHI on measures of clinical quality, patient and provider experience, and costs. Thus, the data collection and measurement activities of the SNMHI itself were focused on supporting quality-improvement efforts, and helping target technical assistance support for participating practices.

We reviewed several medical home assessment instruments, and determined that none mapped closely enough to the 8 SNMHI Change Concepts to effectively assist teams in monitoring the progress of practice redesign activities required for medical home transformation. To remedy this, we developed a new instrument, the Patient-Centered Medical Home-Assessment (PCMH-A) as a means to highlight progress and identify opportunities for improvement over the course of the SNMHI. The development and validation of the instrument have been described in detail elsewhere. Briefly, we modified the Assessment of Chronic Illness Care instrument, an existing and validated tool developed by the MacColl Center for Health Care Innovation to measure quality improvement related to implementation of the Chronic Care Model, to incorporate elements of the SNMHI Change Concepts not measured by the Assessment of Chronic Illness Care.

The PCMH-A includes 8 subscales (1 for each Change Concept) and 33 individual items scored on a 1- to 12-point scale. PCMH-A scores consist of 8 Change Concept subscale scores and an overall average score. PCMH-A scores are also divided into 4 levels, A through D. Mean total summary score, scores for each Change Concept, and for all 33 individual items on the PCMH-A can be categorized as level D through A. Level D scores reflect absent or minimal implementation of the key change addressed by the item (represented by a score of 1–3). Scores in level C suggest that the first stage of implementing a key change may be in place, but that the site has not yet made important fundamental changes (scores of 4–6). Level B scores are typically seen when a site has implemented basic elements of the key change, but still has significant opportunities to make progress with regard to one or more important aspects of the key change (scores of 7–9). Level A scores are present when most or all of the critical aspect of the key change addressed by the item are well established in the practice (scores of 10–12). Mean scores for each Change Concept, and for all 33 items on the PCMH-A, can also be categorized as level D through A, with similar interpretations.

We recommended that front-line practice team members (rather than a single-staff person or leader) complete the assessment individually and then meet together to discuss the results and produce a consensus version to better develop action plans. Each of the participating sites completed the PCMH-A every 6 months beginning in March 2010 and ending in March 2013. In this report, we update the previously reported PCMH-A data by including the results of the seventh and final administration of the survey to demonstrate the evolution of the findings throughout the entire course of the SNMHI.

In the final year of the Initiative, the PCMH-A was slightly revised based on experience and user feedback. Two items were added and the domains were reorganized to reflect the sequencing of the Change Concepts presented earlier. The current version is available online as a public domain resource.

Site Survey

To assess the perceptions of participating practices about the relative contributions of various components of the technical assistance offerings, we conducted a survey of participating sites between March and June of 2013. Surveys were emailed to a primary contact at each practice. The surveys sought feedback on the impact of the practice coaching, regional and national learning community activities, data collection and feedback, tools such as the
implementation guides, and support for NCQA PCMH Recognition.

**Site Narratives and Interviews With MHFs**

Shortly before the conclusion of the SNMHI, sites and RCCs were asked to complete a final report that identified successes and challenges encountered during the Initiative. We reviewed the reports to identify common themes raised by the practices and MHFs. We also convened the MHFs from each region and sought their perspectives regarding barriers to practice transformation at the site level.

**RESULTS**

During the course of the SNMHI, several of the originally selected practices (n = 8) withdrew from the Initiative. In the first 6 months of the Initiative, 5 sites from 1 region were asked to withdraw due to limited engagement and participation; they were replaced by 4 sites, all of which remained in the Initiative for its duration. Also in the first year, 1 site in another region withdrew due to financial hardship, and was not replaced. In the final year of the Initiative, 1 site in a third region withdrew from the Initiative due to leadership turnover, continuing challenges with staff support for the PCMH Model (specifically, empanelment) and financial hardship. In addition, in the final year of the Initiative 2 sites in a fourth region combined primary care delivery operations and began submitting single PCMH-Assessments and quality data sets.

**Practice Transformation**

At the final PCMH-A administration (March 2013), all sites (100%) had achieved some level of implementation of the key design features of the PCMH Model of Care. Nearly half (47.6%) had implemented the 33 identified PCMH “key changes” to a substantial degree (as evidenced by a level A overall PCMH-A score). Of note, only one third (10) of the 30 sites that ultimately achieved level A (substantial implementation of the medical home change concepts) did so in the first half of the initiative (reflected in scores from March 2010 through September 2011), whereas the remaining 20 sites only reached level A after the midpoint of the project (Table 4).

In addition to steady increases in overall mean scores, sites also improved in each of the eight Change Concept subscale scores (range +1.7 points to +3.2 points on a 12-point scale compared with baseline) (Fig. 3). Improvement varied by subscale (range +1.2 points to +3.4 points). With 2 exceptions in March 2011 (Engaged Leadership and Quality Improvement Strategy), PCMH-A scores increased for each of the Change Concept subscales with each successive administration. The largest absolute increases were in the subscales of Empanelment (+3.2), Organized Evidence-Based Care (+2.3), and Patient-Centered Interactions (+2.3). The highest-scoring Change Concept at final administration (March 2013) was Continuous and Team-Based Healing Relationships (10.0), followed by Enhanced Access (9.7), and Engaged Leadership (9.6). Increases in PCMH-A scores from March 2010 to March 2013 were statistically significant (P < 0.05) for 7 of the 8 Change Concepts for Practice

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<td>Level A (score of 10–12)</td>
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<td>Level B (score of 7–9)</td>
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<td>Level C (score of 4–6)</td>
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<td>Level D (score of 1–3)</td>
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*Scores of ≥ 9.5 were rounded to level A, ≥ 6.5 to level B, ≥ 3.5 to level C.

PCMH indicates Patient-Centered Medical Home.
Transformation. For the Engaged Leadership change concept, the significance of the differences in scores was lower ($P < 0.10$).

**Recognition**

Achievement of external medical home recognition for SNMHI practices was encouraged, but not required. For some practices, the main purpose for seeking recognition was to serve as an external validation of achievement. As the SNMHI evolved, recognition qualified some sites for enhanced payment. At the close of the project in September 2013, 83.1% of sites had achieved NCQA PCMH Recognition or Oregon’s state-based Person-Centered Primary Care Home (PCPCH) recognition (Table 5). Among the sites that achieved NCQA PCMH Recognition, 82% achieved the highest level possible (level 3) and among the sites that achieved PCPCH recognition, 100% achieved the highest level possible (tier 3).

**Survey Data**

Site surveys were completed by 78% (49 of the 63) sites still participating at the end of the Initiative. Most surveys (63%) were completed by a sole member of the site’s PCMH Team. The remaining surveys were completed by a multidisciplinary team who collaborated to submit a single response. Front-line (nonexecutive) staff were represented in

![FIGURE 3. Mean Patient-Centered Medical Home-Assessment (PCMH-A) change concept scores across all sites, March 2010–March 2013.](image)

| Table 5. External Patient-Centered Medical Home (PCMH) Recognition, Percentage of Sites Achieved |
|-------------------------------------------------|---------------|---------------|---------------|---------------|
| Achieved NCQA PCMH Recognition                  | September 2011 | March 2012    | September 2012 | September 2013 |
| Achieved Oregon state-based recognition          | 23.1% (15/65 sites) | 32.3% (21/65 sites) | 43.1% (28/65 sites) | 60% (39/65 sites) |
| Total sites that have achieved NCQA or state-based recognition | 23.1% (15/65 sites) | 52.3% (34/65 sites) | 66.2% (43/65 sites) | 83.1% (54/65 sites) |

PCMH indicates Patient-Centered Medical Home.
90% of survey responses. The vast majority (91.8%) of respondents agreed or strongly agreed that the SNMHI materials helped the practice learn about the changes necessary for becoming a medical home, and 87.8% of responding sites reported that the SNMHI was helpful or very helpful in supporting their practice’s medical home transformation efforts.

Respondents cited the implementation guides (87.5%), field trips or site visits (91.2%), regional meetings (89.4%), and the national summit (95.0%) as being among the most helpful components of the initiative. Regional MHFs were reported as being helpful or very helpful by 71.4% of respondents. More information on site evaluation of the technical assistance components is provided elsewhere.17

The national program team reviewed the final narrative reports and observations from MHFs, and identified 5 themes by group consensus. The 5 themes were (1) the impact of turnover, especially leadership turnover; (2) challenges in engaging staff support for PCMH implementation; (3) financial resource constraints; (4) competing priorities, especially electronic health record (EHR) implementation and involvement in other initiatives; and (5) limited capacity to collect and report data.

Half of the sites cited staff or leadership turnover as a challenge during the Initiative. Sites reported that when senior leaders left, PCMH work lost momentum and sometimes led to lower staff morale. Remaining staff were often distracted by additional work and new responsibilities (eg, search committees, job sharing). Recognition goals were often put on hold as resources were directed toward leadership recruitment and training.

Similar problems were experienced with high provider and staff turnover, especially when the staff leaving the practice had played the role of PCMH champion. According to 1 participant, “It takes a long time for any MA, RN, or provider to understand the role of medical home and the new model of care that we are embracing and be proficient. With high turnover, we are bringing new staff up to speed, and not having the time to move on to the next project.” Sites noted that provider turnover led to access barriers for patients, complicated empanelment, and made it more difficult to build cohesiveness within care teams.

Practices often reported challenges in fully and rapidly engaging staff support for PCMH implementation, at least early in the Initiative. Some sites described a “cultural resistance” to change. Others struggled with lack of hard evidence that the PCMH Model of Care would lead to improved patient health outcomes. Empanelment was especially difficult, as many providers pushed back against the idea of closing their panels to new patients or viewed empanelment as an attempt to drive physician productivity. Pushback came in many forms—passive or active vocal resistance; rejection of patient assignment calculations; and, in a very few cases, resignation when administrators and providers were unable to agree on the staffing ratios or provider schedules necessary to provide enhanced access for a panel. Still others struggled with change fatigue (exhaustion from the process of continuous change) and found maintaining momentum and engagement was especially difficult given the complexity and pace of change. As described by one site, “PCMH transformation is a complex and far-reaching process—no part of the organization is untouched.”

Financial constraints were noted as a significant barrier to PCMH implementation and sustainability by many sites. Several regions made progress toward reimbursement approaches that supported medical home implementation by, for instance, providing payments for care management that was not associated with face-to-face visits. However, only a minority of SNMHI sites [approximately 30 (46%)] received enhanced payment from a PCMH payment pilot or demonstration at some point during the course of the Initiative. Additional sites became eligible for enhanced payment or incentives in the year following the Initiative.

Not unexpectedly, competing priorities were reported to be a challenge by a number of participating practices. Many sites faced distractions from capital campaigns, EHR implementation, and the daily demands of providing patient care. EHR implementation was an especially time-consuming process that took resources away from other PCMH transformation activities.

Despite an effort to select practices with quality-improvement experience, many sites did not have in place the infrastructure to accurately and consistently gather data at the inception of the Initiative. Lack of a robust measurement program limited the ability of some sites to understand the impact of their changes, fully engage their practice teams, and prepare documentation for NCQA PCMH Recognition. Sites and MHFs identified a number of challenges to routine data collection and reporting. These included issues such as difficulty in achieving consensus among clinical leaders regarding data entry practices to ensure accurate reporting, lack of adequate reporting and registry functionality in EHRs, and insufficient training and support to facilitate data collection and analysis.

DISCUSSION

As the first national demonstration project to focus on accelerating medical home transformation in the safety net, the SNMHI provides important insights into the challenges and opportunities associated with redesigning primary care among practices serving vulnerable and underserved populations. Many of these lessons are likely generalizable to other settings as well.

Although definitive statements regarding the impact of the SNMHI on quality, efficiency, and patient and provider satisfaction must await the results of the independent evaluation, the available data suggest that most participating practices made considerable progress in their efforts to build medical homes.

Results from the PCMH-A show that over a 4-year period practices made steady and significant progress in implementing the elements of the PCMH as defined in The Change Concepts for Practice Transformation.

Implementation of these changes is reflected in part by the high level of achievement of external recognition by national or state programs. In addition to the survey and report responses indicating that the vast majority of sites reported that participation in the SNMHI helped support their
practice transformation efforts, case studies from participating practices affirm the impact of the initiative on accelerating change in diverse settings.26,27

Previous demonstration projects have found that practice transformation has been difficult to achieve in the context of relatively brief (such as 2 y) demonstration projects,28 and many successful efforts have occurred in organizations only after years of foundational work to develop an infrastructure and context for significant transformational achievements.5,6,29 We found that, although results from the PCMH-A reflected significant progress even in the short term, two thirds of practices that ultimately accomplished substantial implementation of the medical home changes did not achieve that level of success until the second half of the 4-year SNMHI action period. An important element of transformation was reflected in the trajectory of key changes related to patient engagement over the course of the initiative. Although few practices reported meaningful engagement of patients at the beginning of the initiative, by the conclusion of the SNMHI over half included patients on improvement teams, and all had processes in place to capture patient experience or satisfaction with care.

SNMHI sites that achieved NCQA PCMH Recognition early in the Initiative had slightly higher PCMH-A scores than those that obtained recognition later, or were not seeking recognition. Further, even after achieving NCQA PCMH Recognition, practices continued to transform as reflected in PCMH-A scores. However, we occasionally observed a tension between recognition and transformation efforts. Most SNMHI practices understood the purpose and value of recognition, applied for it when ready, and understood it as a part of the journey and not the primary objective. Others, however, had difficulty balancing the work of meaningful transformation with the documentation processes required for recognition programs. For example, some coaches reported sites saying they had to “stop their PCMH work because they were doing NCQA.” Even when there is clarity on the purpose and process for pursuing recognition, the work of completing an NCQA PCMH Recognition application was often underestimated, which led to delays and staff frustration.

Our experience in the SNMHI was consistent with previous observations about the challenges of practice transformation,28,30 but the progress made by the participating practices demonstrates that such transformation is possible even in the challenging, resource-constrained environments that characterized the practices participating in the SNMHI. From Federally Qualified Health Centers, to homeless clinics, to primary care centers associated with complex urban institutions, to small rural physician groups, participating practices made significant—and sometimes dramatic—changes in their practices.26

Experience from the SNMHI provides several important lessons for future primary care transformation initiatives. First, participating practices benefited from a multimodal technical assistance approach based on an explicit change model supported by a comprehensive set of tools to support implementation. Successful implementation relies on a sequential approach to transformation, with an early focus on the foundational change concepts of engaged leadership and introduction of a robust quality-improvement strategy.27 Systematic and sequential introduction of the change concepts typically requires years, not months, and our data suggest that 3–4 years may be required for many practices to make substantial progress in medical home transformation.

Second, direct, and often face-to-face, peer-to-peer interaction in learning community events and site visits was often cited as an inspirational and transformative element of the SNMHI. Such events differ from typical conferences and didactic sessions that do not allow for facilitated peer-to-peer interactions. Third, it is critical to distinguish between meaningful practice transformation that can subsequently be acknowledged through external recognition programs from compliance with recognition criteria as an end in itself.

The SNMHI framework, although specifically developed for safety net practices, is likely generalizable to other settings. This belief is supported by the fact that numerous private practices and health systems caring primarily for commercially insured populations have spontaneously approached the national program team to indicate that the framework and tools have been useful in supporting their practice transformation efforts. The SNMHI Change Concepts were used in a 2-year transformation initiative sponsored by the Harvard Medical School Center for Primary Care, and results among the nineteen Harvard-affiliated practices were comparable with the results from the first 2 years of the SNMHI.31

A key goal of the SNMHI was to develop and implement a replicable and sustainable approach to accelerate medical home transformation among safety net practices. The tools and resources developed to support the project have been made accessible in the public domain.32 These resources may contribute to the success of future efforts seeking to replicate the achievements of the 65 SNMHI practices, and to transform primary care deliver to improve quality, efficiency, patient experience, and staff experience in the safety net, and beyond.

Additional information: additional information and all cited materials are available on the SNMHI Web site: http://www.safetynetmedicalhome.org.

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REFERENCES