AHRQ Transforming Primary Care Grants

Health Care Transformation Among Small Urban Practices Serving the Underserved

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Overview of Transformation Efforts

Eighty-three small, urban primary care practices participating in the New York City Department of Health and Mental Hygiene's Primary Care Information Project implemented several elements of a patient-centered medical home (PCMH) beginning in 2005. Each of the practices served a diverse and disadvantaged patient population. On average, two thirds of the patients were nonwhite, almost half were covered by Medicaid, and one third were more comfortable speaking a language other than English. The Primary Care Information Project facilitated PCMH transformation by assisting the practices in implementing an electronic health record and providing training and consultation on quality improvement (QI) processes, as well as assistance in applying for National Committee for Quality Assurance PCMH recognition.

The practices implemented elements of the PCMH using existing resources, reflecting their small size and resource limitations. For example, rather than implementing formal care teams and care managers, the practices developed informal teams in which providers and available staff met regularly to review and plan care for patients. Many of the practices also implemented QI efforts to improve patient satisfaction. While they did not consistently use the "Plan-Do-Study-Act" model for improvement, the practices often used data to assess the impact of QI efforts. Most practices also implemented structured processes and strategies to: ensure timely access to services, including off-hours access; to remind patients of appointments; follow up on missed appointments; monitor patients with chronic conditions; coordinate referrals and hospitalizations; and communicate with non–English-speaking patients.

Number and Type of Practices

This project included 83 primary care practices that served racially diverse adults and predominantly low-income communities. All the practices had five or fewer physicians; two thirds were solo practices and a majority were independent.

Location

New York City

Transformational Elements

- Accessible Services
- Comprehensive Care
- Coordinated Care
- Health Information Technology
- Patient-Centered Care
- Quality & Safety

Results of Transformation Efforts

Seventy-three percent of practices implemented structured processes to remind patients of appointments, follow up on missed appointments, and monitor patients with chronic conditions. Nearly one half of the practices reported having informal care teams and monthly or more frequent meetings to discuss patient care, while 40 percent began using staff at the top of their skill set (e.g., engaging nurses or medical assistants in patient education, taking histories, or chronic disease screening).

More than one half of the practices implemented QI efforts to improve patient satisfaction and reported using data to assess the impact of QI efforts. However, few of the practices used formal performance measurement systems for individual clinicians or the whole practice.

Forty-seven of the practices applied for National Committee for Quality Assurance PCMH recognition and either achieved Level 1 recognition or were awaiting notification when the study ended. The remaining practices did not pursue recognition.

Key Impacts of Transformation

Quality of Care

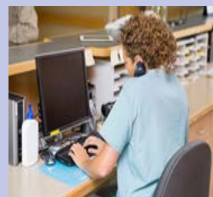
- In 78 percent of practices, patients usually or always saw the same clinician.
- Providers in a majority of practices coordinated patient care by regularly sharing clinical information with specialists and by speaking with patients about the results of their visits to specialists.
- Providers in a majority of practices increased the comprehensiveness of care by usually or always discussing diet and exercise guidelines as well as stress and anxiety with patients.

Challenges to Transformation

Most of the practices were independent; operated with limited budgets and staff; and did not have access to networking opportunities, additional expertise, and other resources that are more readily available in larger institutions. While resource constraints complicated PCMH transformation for these small practices, many used available resources in innovative ways to implement key PCMH elements.

Lessons Learned and Implications for Others

- The PCMH model is a logical extension of the normal approach to care for many small, community-based practices. With few providers in each practice, patients were generally seen by the same provider at each visit, and providers developed an understanding of the different cultures represented among patients in their practice and created ways to address language barriers and cultural factors affecting care.
- In small practices, a modest amount of assistance (e.g., with obtaining and implementing an electronic health record, targeted QI support, and care coordination) can go a long way in facilitating PCMH transformation.



Small practices can achieve important aspects of the PCMH model by using a combination of formal and informal strategies to enact PCMH-like functions. For example, although these clinics had no official "care manager," someone in the front office often performed this role.

For additional information about this grant, please visit: http://www.ahrq.gov/professionals/systems/primary-care/tpc/tpcbib.html#urban.

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