AHRQ Transforming Primary Care Grants

Transforming Primary Care Practice

Principal Investigator: David L. Driscoll, PhD, MPH, MA
Institution: University of Alaska, Anchorage
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Overview of Transformation Efforts

In 1998, Southcentral Foundation (SCF) assumed responsibility for providing primary care services to the American Indian/ Alaska Native population in southcentral Alaska after more than 50 years of management by the Indian Health Service. The following year, SCF introduced the SCF Nuka System of Care, a patient-centered medical home (PCMH) model developed with input from patients (SCF refers to patients as "customer-owners"). The model emphasized three key PCMH elements: enhanced access, team-based care and care coordination, and patient empanelment—matching patients to an integrated and comprehensive care team (at the time SCF assumed responsibility, only 35% of the total local population had a designated primary care provider, and of these, 43% could not name that designated provider).

Number and Type of Practices

This project included adult and pediatric primary care practices at SCF, a tribally owned and managed primary care system serving an American Indian/Alaska Native population.

SCF provided primary care services to 48,000 adult and pediatric patients in 2009.

Location

Southcentral Alaska

Transformational Elements

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

The three elements listed above were implemented over 6 years, beginning with patients selecting or being assigned to a primary care provider. SCF facilitated the empanelment process by creating a "culture of choice," offering patients biographies of providers and assistance in selecting a care team to meet their needs. SCF improved access to care by implementing open (often same-day) scheduling, expanding office hours, and offering patients the option of communicating with providers electronically. Schedulers were also added to each team to facilitate the appointment process. Care was provided by multidisciplinary teams, which included a primary care physician, a medical assistant, a physician's assistant, a scheduler, and a nurse specialist who worked directly with patients and other team members to proactively control and manage chronic conditions. Ultimately, behavioral health consultants and registered dieticians were also integrated into the teams. Team-based care and care coordination was further enhanced by facilitating patient access to other services, improving communication between primary care and specialty providers, and developing a new primary care facility where team members were co-located to facilitate communication.

Results of Transformation Efforts

In 2010, SCF was recognized as a Level 3 PCMH by the National Committee for Quality Assurance. SCF also earned the Malcolm Baldrige Award for quality excellence in 2011.

Key Impacts of Transformation

Access:

- Patients reported increased access to primary care services and same-day appointments after PCMH transformation.

Utilization:

- Before PCMH implementation, overall emergency care use was increasing. Emergency care use declined significantly during and after PCMH implementation before stabilizing in the later post-implementation period (i.e., in 2005). Emergency care use for asthma and unintentional injuries, specifically, also showed a significant and steadily decreasing trend following PCMH implementation.
- Hospitalization rates for all patients, including those with diabetes, were stable before PCMH implementation, and began a steady and significant decline in 2001 before leveling off in the later post-implementation period.

Patient Satisfaction:

- Among patients who were interviewed, 67 percent described an improved doctor-patient relationship following PCMH transformation, including improved communication and increased feelings of safety and trust.

Challenges to Transformation

Demand for primary care services steadily increased during PCMH implementation and initially outpaced the rate of growth in resources. During this time, providers and staff struggled to accommodate demand and some patients experienced long wait times. The process stabilized as additional primary care providers, schedulers, and other team members were added to the primary care teams.

While many patients found the opportunity to select a primary care provider empowering, others described the process as confusing and frustrating. Initially, patients who moved from one primary care provider to another in search of an optimal match complicated the process; however, interventions such as sharing provider biographies and providing direct assistance with identifying a primary care team helped patients make a smoother transition.

Lessons Learned and Implications for Others

- Important practices for PCMH leaders included: communicating management decisions and mandated practices in a clear and transparent manner; monitoring staff for change fatigue; creating and sustaining a collaborative learning environment; and developing an infrastructure (e.g., buildings, co-location of services) that supported PCMH practices. Workforce and patient satisfaction surveys can be helpful in identifying factors that contribute to employee stress and/or compromise care quality and efficiency.
- Continuity of care and good relationships between patients and providers and among team members were

Multiple factors contributed to decreased use of emergency care, including increased availability of primary care services and same-day appointments, care management by nurse specialists, and an integrated team-based approach to care that focused on proactive control of chronic conditions.

enhanced by shared responsibility and responsiveness of team members. This included "warm" patient handoffs, in which providers directly introduced patients to other clinicians, and proactive communication among team members and between specialty and primary care providers.

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

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