

IHS Direct Service Sites without Patient
Centered Medical Home (PCMH)
Recognition: Lessons Learned from a
Quantitative Survey.

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Table of Contents

Acknowledgements	3
Background	4
Methods	4
Study Results	5
Table 1: Number of facilities in IHS Area.....	5
Figure 1: Organization for PCMH recognition	5
Table 2: Additional resources needed (multiple responses)	6
Table 4: Specific changes planned in order to achieve PCMH certification (multiple responses)	7
Figure 2: Significant Barriers to PCMH recognition	8
Summary	11

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Background

In 2008, the Indian Health Service (IHS) initiated its Improving Patient Care (IPC) initiative, in which IHS clinics received technical assistance to implement elements of the Patient-Centered Medical Home (PCMH) model of primary care. The IPC program targeted IHS direct service facilities and sought to improve the quality of care and health outcomes of patients receiving care in these facilities by expanding access, improving continuity of care, strengthening care management, and improving care coordination. Since 2008, numerous facilities have applied for and received PCMH recognition, while others are in the early stages of implementing the model. As of May 2017, seventeen (17) IHS clinics had applied for and obtained PCMH recognition.

The IPC program supports the transformation of the Indian health care system by establishing Patient Centered Medical Homes (PCMHs) and developing high-performing patient-centered teams to improve the quality and delivery of care, with an emphasis on prevention and wellness. Special General Memorandum 17-01, dated May 1, 2017, established the Indian Health Service (IHS) policy on PCMH certification/designation for all IHS ambulatory care facilities (excluding health stations) to improve quality of care. The IHS Chief Medical Officer (CMO) issued a directive that requires certification/designation of all federal facilities by December 31, 2021.

IHS Headquarters staff, in collaboration with the Department of Health and Human Services DHHS Office of the Assistant Secretary for Planning and Evaluation (ASPE), developed and implemented a questionnaire for federally operated Service Units that were working toward achieving PCMH recognition but had not yet received it. The purpose of this study was to identify challenges related to PCMH implementation at service unit sites that have not yet obtained PCMH recognition.

Methods

Staff of the IPC program, Division of Planning, Evaluation and Research at IHS Headquarters, in collaboration with the Department of Health and Human Services (DHHS) Office of the Assistant Secretary for Planning and Evaluation (ASPE), developed a survey, which utilized only quantitative methods. Proposed survey and tools were shared with all partners and feedback received was incorporated into the final assessment tool.

We conducted a cross-sectional survey of 46 federally operated service units who had **not yet** received PCMH recognition. The survey link was emailed to all service units who had not yet received PCMH recognition. Data collection was conducted over a four-week period using the survey monkey online tool. Completed surveys were analyzed and downloaded from survey monkey. Figures were generated using Microsoft Office Excel. We calculated descriptive statistics for all study variables.

Study Results

A 100% response rate was achieved with all 46-service units completing the survey. Responses from the service units are summarized in this section.

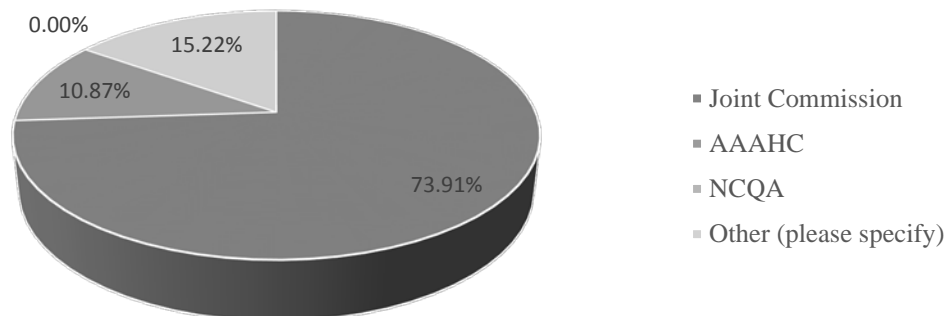
Table 1 below illustrates the number of facilities located in IHS areas. Health facilities in the Great Plains Area were 19.6% of all facilities. The facilities located in the Great Plains, Navajo, Oklahoma, and Phoenix Areas represent 70% (more than two-thirds) of the 46 facilities that responded to the ASPE/IHS-PCMH survey.

Table 1: Number of facilities in IHS Area

IHS Area	Number of Health facilities	Percent (%)
Albuquerque	5	10.87
Bemidji	2	4.35
Billings	3	6.52
Great Plains	9	19.57
Nashville	1	2.17
Navajo	8	17.39
Oklahoma	8	17.39
Phoenix	7	15.22
Portland	3	6.52
Total	46	100

Figure one below shows that approximately 75% of respondents indicated that they plan to obtain PCMH recognition/certification from the Joint Commission and approximately 11% plan to obtain PCMH recognition from the Accreditation Association of Ambulatory Health Care (AAAHC). “Other” respondents wrote in Centers for Medicare & Medicaid Services (CMS); Det Norske Veritas (DNV); The Joint Commission (TJC); both AAAHC and NCQA; or “unsure.”

Figure 1: Organization for PCMH recognition



Approximately 90% of survey respondents indicated that they plan to obtain their PCMH recognition/certification from the same organization they previously used for accreditation. “Other” respondents wrote in familiarity with process; quality of patient care; cost saving; IHS mandate; or “unsure.”

When asked about training tools or technical assistance used to implement elements of the PCMH model of care, approximately 83% of survey respondents mentioned IPC training tools and technical assistance. “Other” respondents wrote in: Joint Commission; IHI; AAAHC; PATH; IST; AMP; NNMC/TPC; Health Insight New Mexico; Idaho SHIP; webinars; mock surveys; and “nothing yet.”

Table 2. below, illustrates multiple responses from respondents concerning additional resources needed to implement elements of the PCMH model.

Table 2: Additional resources needed (multiple responses)

Resources	Number of Responses	Percent (%)
Additional staff	36	78.3
Changes in clinic space/facilities	33	71.7
Other (please specify)	28	60.9

Approximately 78% of survey respondents report they need additional staff, and 72% indicated that they need changes in clinic space in order to implement PCMH.

Sixty (60.9%) percent reported the following “Other” additional resources:

- a) Increase staff support (e.g. nurses, physicians, case managers, care coordinators)
- b) Expanded space in field clinics;
- c) Tribal involvement;
- d) Space designated for diabetes-related nutrition services;
- e) CAC and enhanced IT support, applicable software programs;
- f) Funding/financial and human resources;
- g) CME training on PCMH;
- h) Contract with phone answering service;
- i) Improvements to the EHR;
- j) Contracting/acquisitions support;
- k) Commitment and support from HQ and Area Office to provide needed resources.

Table 3 illustrates multiple responses from respondents regarding communication strategies to engage staff and patients in the process of implementing changes needed to achieve PCMH certification.

Table 3: Communication strategies needed for staff and patient engagement (multiple responses)

Communication Strategies	Number of Responses	Percent (%)
Other (please specify)	33	71.7
Consultation Meetings (e.g., with Tribal officials, patients and other community members)	28	60.8
Employee Newsletters	16	34.8

Approximately 72% of survey respondents (multiple responses) indicated the use of “Other” communications about PCMH:

- a) Patient newsletters encouraging empanelment and preventive health visits;
- b) Committee meetings; medical and monthly IPC meetings
- c) Patient/family feedback and HCAHPS surveys;
- d) Staff interactions with patients; patient education
- e) Implemented Patient First team-based care model;
- f) Social Media e.g. Website, Facebook page; email
- g) Tribal newspaper; radio; presentations at local gatherings;
- h) Training;
- i) Webinars;
- j) Action planning;
- k) Mandatory PDSAs;
- l) Robocalls;
- m) Scripts;

Sixty-one (61%) percent of survey respondents report holding consultation meetings as a communication strategy, and 35% utilize employee newsletters to communicate about PCMH implementation.

Table 4 illustrates multiple responses from respondents regarding specific changes service units planned to make in order to achieve PCMH certification.

Table 4: Specific changes planned in order to achieve PCMH certification (multiple responses)

Specific Changes	Number of Responses	Percent (%)
Staffing levels (please describe)	41	89.1
Staffing mix (please describe)	27	58.7
IT systems (please describe)	30	65.2
Infrastructure/Office or Clinic Space (please describe)	34	73.9
Patient panels (groupings) (please describe)	29	63.0
Scheduling procedures (please describe)	32	69.6
Other (please describe)	15	32.6

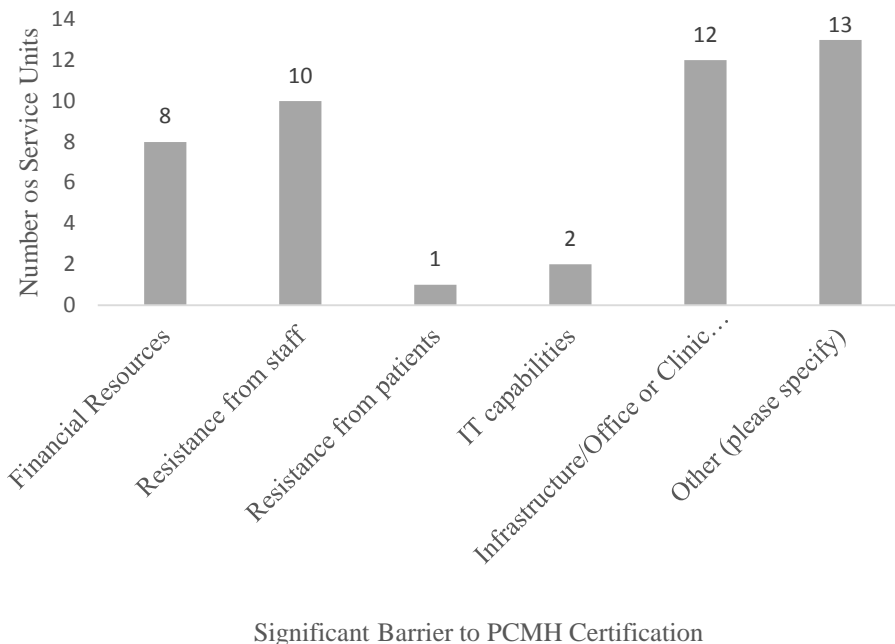
Approximately 90% of survey respondents plan to make changes to staffing levels; 74% plan to change infrastructure/office space/clinic space, and about 70% plan to change scheduling procedures. More than half of respondents plan to make the following changes: IT systems (65 percent); patient empanelment (63 percent); and staffing mix (59 percent).

One third of survey respondents plan the following “Other” changes:

- a) Community input;
- b) Patient education;
- c) Increase support staff involvement
- d) Increase same day appointments;
- e) Set up Wi-Fi;
- f) Improve training: I Care and PCMH training;
- g) Expanded call center for daytime phone access; nurse phone for after hours
- h) Providing screening care in patient rooms;
- i) Nurse protocols;
- j) Managed Services Accounts (MSA) scripting;
- k) Address self-management documentation possibilities;

Figure two below shows that twelve sites (26%) indicated that infrastructure/clinic space capacity was a barrier, ten sites (22%) indicated resistance from staff as a barrier and eight sites (17%) selected financial resources as a significant barrier to PCMH certification.

Figure 2: Significant Barriers to PCMH recognition



Thirteen sites selected “Other” barriers and among them, 28% mentioned clinic space/facilities; 26% mentioned buy-in, 17% mentioned financial resources, 9% mentioned staffing, and 7% mentioned IT issues.

Specific “Other” barriers include:

- a) Challenges with human resources processes;
- b) Tribal buy-in;
- c) Remote sites;
- d) Ability to track referrals to ensure continuity of care for patients that are referred out;
- e) After-hours nurse phone triage service;
- f) 24/7 process to respond to urgent care needs;
- g) Support from HQ and Area Office to provide resources.

When asked about PCMH implementation challenges unique to facilities (multiple responses), sixty-three percent of the survey respondents noted challenges existed for facilities located in remote/rural areas; thirty-nine percent mentioned challenges of not being a freestanding ambulatory clinic; thirty-seven percent mentioned challenges of being a small facility; thirteen percent mentioned challenges of being a low-volume facility.

Forty-one percent of multiple responses selected “Other” category. Specific unique challenges include:

- a) Staffing shortages and limited staff understanding of the PCMH model
- b) Lack of clinic space; old infrastructure
- c) Unreliable Internet access; limited local resources
- d) Large portion of user population is from surrounding areas;
- e) Lack of communication with patients; travel for PRC referrals;
- f) Patients do not have reliable transportation;
- g) Lack of Navajo translation services;
- h) Must use TJC or NCQA because AAAHC recognition is not applicable for certain sites;
- i) No access to specialty care and other resources;
- j) Frequent provider turnover results in patient dissatisfaction;
- k) Lack of executive leadership support;
- l) High volume of referrals for primary care creates higher patient load than patient spots;
- m) No option to cap patient empanelment;
- n) Care is fragmented and follow up is unreliable;
- o) Difficult to get patients invested in the idea of PCMH and scheduling visits;

Survey respondents listed the following data collection activities they conduct and indicators they track:

- Patient and staff satisfaction surveys, RPMS, GPRA measures
- Time-care-takes surveys
- Diabetes Audits
- Continuity of care, provider productivity
- Same day appointments

- Tracking measures by IPC Team, such as Tobacco counseling, Colorectal screening, Retinopathy exams, controlling high blood pressure.
- Supply/demand for primary care appointments
- Number of empaneled providers, panel sizes
- Wait times, workload, visit volume
- Number of walk-in visits vs. number of appointment visits
- Dashboard including empanelment, continuity, access, quality measures
- QAPI dashboard
- PCMH Implementation Team spreadsheet
- Data collection including education types provided to the patient, patient outside phone calls, patient referrals, and patient progress with chronic health problems, care processes and outcomes, appointment availability, missed appointments, cancellations, turnaround times.
- Net promoter scores
- Joint Commission self-assessment for PCMH
- Annual mock surveys sponsored by the Area Office

Service units' number of FTE responses ranged from zero to 1300 FTE's. Percent of FTE's at service units providing clinical care (including medical, dental and behavioral health) and case management ranged from zero to 100%, with an average of 46.2%. Percent of current staff who are contractors providing clinical care (including medical, dental, behavioral health) and case management services ranged from zero to 65%, with an average of 14.6%.

Responses to the total empanelment at services units by clinic:

- Primary Care Clinic
 - Responses ranged from 0 to 26650; three responded “not applicable”
- Pediatric Clinic
 - Twenty-two respondents ranged from 99 to 16500; others responded “not applicable”
- Behavioral Health
 - Three respondents ranged from 32 to 800; others responded “not applicable”
- Medical Specialty
 - Only one respondent with 286; the others responded “not applicable”

Staff positions with highest vacancy rates ranked as follows:

- a) Seventeen respondents ranked Physicians as having the highest vacancy rate:
- b) Eleven respondents ranked Nurse/Advanced Practice Nurse as having the highest vacancy rate,
- c) Six respondents ranked Dentist as having the highest vacancy rate,
- d) Four respondents ranked Behavioral Health as having the highest vacancy rate,
- e) Four respondents ranked Dental Assistant/Dental Hygienist as having the highest vacancy rate,
- f) Three respondents ranked Medical Assistant/Certified Nurse Aide as having the highest vacancy rate
- g) Two respondents ranked Physician Assistant as having the highest vacancy rate

Summary

The purpose of this study was to identify challenges related to PCMH implementation at service unit sites that have not yet obtained PCMH recognition. For this study, 46 IHS direct service facilities without PCMH recognition (as of October 2017) completed an online survey about challenges they face and their plans for implementing PCMH. Significant barriers to PCMH implementation included:

Infrastructure/Clinic Space capacity, resistance from staff, information technology capabilities, financial resources and human resources issues. A unique barrier to PCMH implementation was difficulty in recruiting permanent staff.

Several needs were identified by direct service facilities without PCMH recognition and they included: support from IHS Headquarters and Area Office leadership, expanded clinic space, better IT capabilities, more staff and less provider turnover to enable empanelment, buy-in from staff and patients, resources to provide 24/7 response for urgent care (e.g., nurse call line).

Approximately 90 percent of the survey respondents intended to obtain their PCMH recognition/certification from the same organization they use for their accreditation. Seventy-six percent of survey respondents planned to utilize the Joint Commission.

Majority of survey respondents (83%) were using IPC training tools or technical assistance to implement elements of the PCMH model of care. Specific changes planned by service units to achieve PCMH certification included: staffing levels, infrastructure/Office or Clinic Space, scheduling procedures and IT systems.

Additional staff (78%) and changes in clinic space/facilities (72%) were the main additional resources mentioned to implement elements of the PCMH model of care.

The main communication strategies with patients and staff regarding PCMH implementation was consultation meetings with Tribal officials and community members and employee newsletters.

Recommendations

Improving staff recruitment and human resources processes, especially at IHS sites located in rural areas will help retain permanent staff. There needs to be increased focus to address infrastructure needs like clinic space. Additional recommendations include enhancing IPC technical assistance activities using expertise and lessons learned from other HHS agencies such as HRSA, CMS, and AHRQ. Other recommendations include, educating health care providers and patients about potential benefits of the PCMH model of care on improved quality of healthcare and providing support for staff training, data monitoring, and interdisciplinary care teams for PCMH implementation.