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TABLE OF CONTENTS

New Directions in Case Management and Care Coordination
Janet Treadwell, PhD, RN, CMCN .................................................. 3

Value-driven Healthcare: The Role of Managed Care Nurses
Gene Gosselin, RN, MA, CCM, LPC ........................................... 4

Are You Paying a Price For Caring Too Much? Recognizing the Syndrome of Compassion Fatigue
Phyllis Quinlan, PhD, RN-BC ..................................................... 5

Challenges in Implementing Fall Prevention Programs for Older Adults: A Comparison of Two Models
Suzanne W. Brown, RN, MS, MPA, Gloriela Burns, MS, RN, CHIE and Maureen A. O’Mara, BSN, MBA ......................... 7

Transforming a Practice to a Medical Home: A Process of Discovery
Janet Treadwell, RN, PhD, CPHQ, Maria Jackson, RN, BSN, Lora Torres, MD and Angelo Giardino, MD, PhD .................. 10
The managed care industry has come to embrace the all-encompassing change in the healthcare delivery system. Value-based care, an explosion in Accountable Care Organizations and expanded coverage of Medicaid recipients, has compelled market adjustments just as the growing Medicare population and technology/pharma creation. Spurred by consumer, government, and employer demands, the accrediting entities are mirroring the requirements for defined value in areas of case management and care coordination.

Emerging roles within managed care organizations include embedded case coordinators, transition specialists, life-care planners, clinical analytics, and an evolving case management role. Not that these roles are all new to the managed care space, but new in organizational importance, scope of responsibilities, and job function. The changes in care delivery models focusing on patient-centered care and population management have brought recognition to the necessity of care coordination. These changes have expanded the sphere of collaborators and heightened the professional accountabilities of the managed care nurse in domains of clinical competence, community collaboration, quality of process and outcomes, as well as proficiency in technology and analytics.

Competencies of the managed care nurse include leadership and project management skills in addition to core skills of motivational interviewing, integrated assessment skills, successful interprofessional collaboration, cultural competency and awareness of the latest evidence-based practice.

The three to five year view of managed care nursing will see an increase in the use of interprofessionalism teams to gain connection and efficiencies across populations, communication and education of individuals across complexity levels. This is important to self-management and shared decision-making. Case managers will be leading teams including community health workers, health educators, social workers, and nurses to effectively support-optimal clinical and financial goals. Incorporating lean methods and reflective practice, the case manager will use the strengths of each team member to engage patients in their own care. Meeting the person’s needs and preferences, whether in acute care, primary care, or home settings to establish a trusting educative and supporting relationship is the key to success in this value-based environment. Case managers will not stop at facility borders or stay in a silo of specialty practice. Technology advances in telemedicine, home monitoring, web-based educational modules, and claim monitoring and alerts will allow care coordination to move across systems of care and setting transitions to promote maximum continuity and individualization of a plan that is shared across the treatment team.

Advances in technology and ability to track outcomes will add to the professional experience of the case manager/care coordination as the value of their contribution to the overall health of populations can be measured.

Janet Treadwell was asked to share her vision, on behalf of AAMCN, of where the care management and care coordination industry is going in the near future for the 2014 Case in Point Salary and Trends Survey. She was asked to write about the trends impacting this practice, core competencies that care managers/care coordinators must excel at now and 3-5 years from now, and what changes in healthcare are driving these permutations. Her article will be contributed to a Special Report.
Value-driven Healthcare: The Role of Managed Care Nurses

Gene Gosselin, RN, MA, CCM, LPC

Summary
As health care reimbursement shifts from volume to value, strategies to improve the patient’s experience of care and provide higher quality health care at a lower cost are being widely explored at the point of care. As more extensive implementation of such strategies occurs, managed care nursing professionals are positioned to play an even greater role in ensuring the safe and effective coordination of health services. As key members of the health care delivery team, managed care nurses must stay abreast of the rapid changes taking place in our health care system and consider ways to bring value to organizations implementing these new care delivery models.

A Shift from Volume to Value
There is widespread agreement that the United States health care system is fragmented and volume-driven, and disproportionately focused on caring for the acutely ill rather than on keeping people healthy. Often, patients receive treatments and medicines from multiple providers and are transitioned across settings or levels of care, with little communication occurring between these providers. Additionally, the fee-for-service reimbursement structure predominant today provides compensation for each unit of service. This reimbursement structure does little to align payment with quality and efficiency. When providers are paid separately for each service delivered, there is limited incentive to coordinate care or collaborate with other providers which can result in unnecessary or duplicative tests, medication errors and preventable hospital admissions and readmissions. For years, managed care nurses have worked to address the issues that result from such a fragmented system.

Increasingly, the U.S. healthcare system is shifting from this volume-driven structure, to one that is more value-driven. The Patient Protection and Affordable Care Act (ACA) contain numerous mechanisms designed to move the U.S. health care system toward value-based care.

Broadly, the ACA seeks to align incentives to enhance the achievement of better health outcomes, higher quality and greater efficiency. It also includes provisions that encourage patient-centered care and the exploration of different care coordination models. What is evolving is a system where providers stand to share in the savings that result from better disease management and improved care coordination.

How Managed Care Nurses Add Value
Managed care nursing professionals are poised to play a broader and more important role as the health care system adopts new delivery models and payment reform encourages value-based health care. A focus on patient-centered, coordinated care is essential in these new models and health care organizations that provide high quality care in a cost-efficient manner will be rewarded. These new models also give payers and service providers ─ including physicians, nurses, pharmacists, case managers, behavioral health specialists and others ─ the opportunity to work together and create unique teams designed to facilitate patient interactions with the health care system, while also improving health outcomes.

This shifting health care environment presents an enormous opportunity for managed care nurses who possess the skills to assess, plan, facilitate, evaluate and advocate for options and services to meet an individual’s comprehensive health needs. As part of a patient-centered care team, the managed care nurse can assist in engaging the patient, evaluating his or her health care needs and help to coordinate services and providers to meet those needs. The managed care nurse also plays a key role in helping patients navigate complex systems and acts as a liaison between the payer, the treatment team, the patient, and the family.

Gene Gosselin is the Director of Customer Solutions at Pfizer Inc.

References

ARCHITOOLS
Building Improved Healthcare

In an effort to help facilitate this shift from volume to value, Pfizer has developed ArchiTools. ArchiTools is a comprehensive online platform that offers a wide range of tools and resources for use by managed care nurses and other health care professionals who want to understand the changing health care landscape, and lead the way in implementing new care coordination strategies. ArchiTools contains two Training Rooms and three Resource Centers. The training rooms provide fundamental education on Health Information Technology and Payment Reform, two essential components enabling the movement from volume to value. The three resource centers provide access to actionable tools and materials that can help care managers enhance population health efforts, engage patients in better self-management, improve patient interaction skills, identify risk, address avoidable readmissions and assist patients in finding ways to stay healthy.

• Team-Based Practice Resource Center contains materials that help enhance a holistic, team-based approach to health care delivery.
• Care Transitions Resource Center helps identify risks and address potentially avoidable admissions and readmissions through improved medication reconciliation and discharge planning.
• Prevention & Wellness Resource Center addresses the benefits of investing in prevention, and contains materials that encourage adults to participate more fully in their care and make choices that help them stay healthy.

To access ArchiTools and other important materials and resources available to AAMCN members, contact Lauren Skrobacz at lsksrobacz@aamcn.org.
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Are You Paying a Price For Caring Too Much? Recognizing the Syndrome of Compassion Fatigue

Phyllis Quinlan, PhD, RN-BC

Summary

Compassion fatigue is a relatively new concept that has made its way into the nursing literature in the early 1990's. This article recognizes the signs and symptoms of the syndrome and gives specific examples of remedies that will help realign with the principles of living a healthy, balanced life.

Key Point

• Nurses take their gift of caring for granted, unaware or resistant to the need to replenish themselves regularly in order to maintain the necessary fresh fuel to serve.

Many realize that one can develop the debilitating anxiety disorder known as Post Traumatic Stress as a result of experiencing or witnessing an event which may have threatened or actually caused grave physical harm. However, less is fully understood about the newest theory in the field of the post-traumatic stress secondary syndrome, Compassion Fatigue. Compassion fatigue can develop as a cost of prolonged caring for others. The concept is relatively new and only made its way into the nursing literature in the early 1990s.

What is Compassion Fatigue?

Compassion fatigue is the erosion of one’s caring nature. It can be the consequence of over exposure to patients or clients who need care complicated by a disregard for the need to care for oneself as well. The person experiencing compassion fatigue initially felt and demonstrated a great deal of concern and caring toward their patient. Over time however, there is a sense of physical, emotional, and spiritual exhaustion that affected his or her ability to maintain an interest in or derive satisfaction from caring. They perceive themselves in a continuous state of giving with little in return or no end in sight. (Figley 2002).

What Made You Choose A Profession In Caregiving?

As part of my personal and career coaching assessment, I ask my client why he or she chose a career in nursing. The overwhelming majority of answers have one common theme. A need to serve. Most individuals have the capacity to be empathetic. It is the odd soul that does not feel anything upon hearing about the loss of young life in a motor vehicle crash. However, professional caregivers have the unique gift of being able to consistently mobilize their compassionate nature into the action we call caregiving and make their profession one of human service.

To offer yourself and your talents to others who are vulnerable, ill or hurt is the highest form of generosity. It is an uncommon ability. So why do people chose a career in nursing? I propose that on some level they intuitively understand the interdependence of all things. They know that the only real way to stay connected with their awakened, compassionate natures is to give. They give so that they in turn will experience that wonderful sense of satisfaction that comes from making a difference.

To have the ability to render care to another is a gift and it needs to be honored for the gift that it is. While nurses are often indispensable, they are not indestructible. Nurses tend to not connect with this fact. They take their gift for caring for granted unaware or resistant to the need to replenish themselves regularly in order to maintain the necessary fresh fuel to serve.

The thought of being separated from something as fundamental as your ability to derive satisfaction from your nursing practice is seemingly farfetched but it can happen. The seeds of the syndrome known as Compassion Fatigue are sown over time. It is an insidious process. The changes one experiences are so subtle that they often are attributed to a variety of other hectic-life reason. The challenge is to identify what is happening before the person’s personal and professional life become unmanageable.

The American Institute of Stress explains Compassion Fatigue is a state of physical, emotional and spiritual exhaustion secondary to poor self-care which is triggered by the stress of one’s personal and profession responsibilities, unresolved per-
sonal challenges, unhealthy work environments and a perceived lack of support.

The signs include, but are not limited to, a sense of increasing tension associated with having to render care. A growing inability to work in teams is not uncommon. There can be increased conflict at work that can often result in the person being perceived as a wildcard or bully. The person has excessive absenteeism secondary to a sense of being perpetually drained. Finally there is increasing insensitivity toward patients and their family members and progressive isolation from family and friends. (Joinson 1992).

The personal characteristics associated with the risk of developing compassion fatigue encompass the following features. Their person’s compassionate energies get caught up in try to fix things in an effort to maintain the status quo or a sense of justice.

The individual at risk for compassion fatigue has a tendency towards a fixed point of view. This temperament sets up a constant struggle with clinging to the need for control, accepting change and being open to options without the pervasive sense of always having to compromise values. There is a tendency toward ongoing self-sacrifice and a persistent reluctant to address self-care needs. Eventually, the person loses their sense of purpose and develops a strong sense of being alone as they face life’s challenges (Bush 2009).

Regaining A Healthy Perspective

The first step is to recognize that you are indeed experiencing something that is changing the way you feel and how you act. Listen to those who are trying to share their observations with you. Denial is the real enemy here not a concerned colleague or family member. Realigning with the principles of living a healthy, balanced life is the remedy but here are some specifics:

• Start putting yourself first. This is not a selfish act. It is actually very generous. What you are doing is maintaining your own availability by ensuring that you are renewed, flexible and ready to continue to give. The airline industry has been giving us the right instructions for years; put your own oxygen on first. You cannot be of service to anyone if you can no longer function.

• Accept help. There is no shame in understanding that you cannot do everything and embrace a lifeline when offered. This is the step away from isolation and back into a more authentic sense of belonging.

• Keep healthy boundaries at work. Do not allow your work ethic to be used against you. Finding yourself in the role of the go to person on a constant base is not always a compliment. The added stress can deplete you of your energy and sow the seeds of frustration which can then lead to resentment and anger.

• Seek out a sounding board. A little private time in a safe, confidential environment with a professional who can help you regain perspective can be priceless. Sometimes the caretaker deserves to be cared for and supported.

• Sleep. We all need at least six consecutive hours of rest. Even more when we are stressed. Catching four hours here and two hours there is not restful and will catch up with you. Develop a time to turn off and sleep routine. Begin a practice that will signal your mind that it is time to wind down. Let a hot shower, tub bath, or reading a few pages of a non-work related book start the relaxation process and create the mindset for fall asleep.

• Invest time in your own health. Make and keep the appointments for the doctor or dentist. Get to the gym or just walk twice a week. Drink more water and eat more fruit. Get a massage at least once a month.

• Invite stillness into your life: I realize that suggesting to a caregiver to sit quietly and do nothing is asking a lot. Making friends with the noise in your head takes practice. However, the rewards over time for sitting still and just breathing for 10 minutes can be increased patience, a sense of perspective and the ability to access your own innate, intuitive knowledge to help with problem solving.

• Make laughter a must. If you cannot find something to laugh about every day you are already in a danger zone. Avoid the relentless doom and gloom of the news media. Watch a comedy show or cartoons instead.

Healing takes time and cannot be rushed. So be generous and patient with yourself as you honor and guard that part of you that finds joy in helping another human being.

Phyllis Quinlan, PhD, RN-BC is the Legal Nurse Consultant with MFW Consultants

References


3. Compassion Fatigue Awareness Project. www.compassionfatigue.org


Challenges in Implementing Fall Prevention Programs for Older Adults: A Comparison of Two Models
Suzanne W. Brown, RN, MS, MPA, Gloriela Burns, MS, RN, CHIE and Maureen A. O’Mara, BSN, MBA

Summary
While there are numerous successful fall prevention programs for older adults worldwide, differences in programs can lead to unexpected outcomes. This paper discusses the implementation and evaluation of two independent fall prevention programs for older adults who were members of a Medicare Advantage plan. Both programs were developed and evaluated between 2009 and 2013, however, one of the programs focused on frail elders and included an in-home component, and the other program did not target frail elders, but was a program based where patients were either referred by a health care professional or had sustained a laceration or injury that resulted in an emergency room visit. A literature review, description of interventions, findings and lessons learned are presented.

Key Points
• Even when best practice models are used, program implementation is not always successful
• Willingness to accept a home visit and lack of a recent fall may have been drivers of the differences in outcomes between the two programs
• Future study is needed on timing based on the effects of the fall and program participation and outcomes

WHILE THERE ARE NUMEROUS SUCCESSFUL FALL PREVENTION programs for older adults worldwide, implementing them may be challenging even when programs are built based on evidence based models. This paper discusses the implementation and evaluation of two independent fall prevention programs for older adults who were members of a Medicare Advantage (MA) plan. The programs were developed and evaluated between 2009 and 2013. Both programs were voluntary and were provided at no cost to members. However, one of the programs focused on frail elders and included an in-home component, and the others program did not target frail elders, but patients were either referred by a health care professional or had an ER claims for a contusion, laceration or injury. A literature review, description of interventions, findings and lessons learned are presented.

Literature Review
There is an extensive body of information related to fall prevention, from numerous sources, including, for example, hospitals, skilled nursing facilities, home health, telemedicine, community and government organizations as well as health plans. According to the Center for Disease Control, more than one out of three older Americans falls each year with an associated cost of $28.2 billion in 2010 dollars\(^1\). The cost to older adults of a fall is staggering, and not just from a health care perspective. Falls are the leading cause of injury among older adults, with 20 – 30 percent suffering moderate to severe injuries, from a hip fracture to a traumatic brain injury\(^1\). In 2007, it was reported that 58.5 percent of older adults with fall related injuries would require help with activities of daily living for 6 months or more\(^2\). In addition to injuries, there were 21,700 fall-related deaths in 2010, and the number of fall-related deaths per year has been rising\(^1\). In 2005, the percent of men and women who fell was similar, 16 vs. 15 percent, but women were more likely to have a serious injury 36 vs. 25 percent\(^3\). Further, the older a member is, the less likely they are to be able to return to independent living\(^4\). Even if an older adult is not injured, some develop a fear of falling which may impact quality of life while reducing mobility and fitness, further increasing fall risk\(^5\).

For all of these reasons, the focus on fall prevention continues to grow, with States enacting legislation, interagency and cross-community interventions, with technology as a support, including, for example, reminders to use grab bars and telemedicine.\(^4,5,6\) Fall prevention is also key focus for MA Plans, from prevention of morbidity and mortality to maintaining quality of life and independence of older adults. Fall prevention is also addressed through quality monitoring by the MA Star program\(^7\). The Star program, also known as the “Plan Quality and Performance Program”, is used by the Center of Medicaid and Medicare Service to compare and contrast health plan quality. Two questions from the Medicare Health Outcomes Survey (HOS) are used. First is discussing fall risk with a provider...
**Table 1. Program Comparison**

<table>
<thead>
<tr>
<th></th>
<th>Non-Frail MA Members (N=135, Refusals/Unable to Contact = 116)</th>
<th>Frail MA Members (N=153 pre, N=46 post)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Plan: Eligibility criteria</strong></td>
<td>Recent ER visit for a laceration, or clinical referral</td>
<td>Algorithm used to identify frail elders. Members did not need to have had a fall history prior to enrollment</td>
</tr>
<tr>
<td><strong>Do: Percent of eligible members agreeing to participate</strong></td>
<td>54%</td>
<td>60%</td>
</tr>
<tr>
<td><strong>Medication Assessment</strong></td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Vision/Cognitive Assessment</strong></td>
<td>Yes (hearing screen also done)</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Physical needs assessed, orthostatic BP and P, need for assistive devices/use of assistive devices</strong></td>
<td>Phone screen, only 1 member accepted home visit (3%)</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Home Safety (Environmental) Risk Assessment, including need for grab bars, lighting, etc.</strong></td>
<td>Offered, only 1 member accepted (3%)</td>
<td>Yes, assistance with coordination was provided as needed</td>
</tr>
<tr>
<td><strong>Exercise Support including educational material/referrals</strong></td>
<td>Recommendations, information provided on how to self-access</td>
<td>Information and training provided</td>
</tr>
<tr>
<td><strong>Check: Change in rates (rounded)</strong></td>
<td>Using codes consistent with falls, rate was 23% for participants, 14% for eligible non-participants who refused or who could not be reached (6 month comparison)</td>
<td>Decrease in fall rate from 33% to 22% based on self-report (annual comparison)</td>
</tr>
<tr>
<td><strong>Act: Next Steps</strong></td>
<td>Program discontinued early due to findings. Plan to develop new intervention.</td>
<td>Program modified to add more specific tools, such as the Vulnerable Elder Survey</td>
</tr>
</tbody>
</table>

for members over 75 years of age or 65 to 74 years of age with balance or walking difficulties or a fall in the past 12 months7. According to the Center for Disease Control, less than half of patients over the age of 65 with a fall talk to their healthcare provider about the fall1. The second HOS measure reports whether members with fall risks received treatment to prevent falls or assistance with balance or walking. The Physician Quality Reporting System (PQRS) also incorporates fall prevention measures8. In July 2014, there was a proposal in the Federal Register that PQRS measures be publically reported9.

Fall prevention programs typically incorporate one or more of an array of components, such as support of physical activity and exercise; environmental and physical safety review and recommendations; patient functional, vision, hearing and medication assessments; osteoporosis evaluation and if needed, treatment; and education10, 11, 12, 13. However, not all programs are successful14, 15.

**Non-Frail Older Adults, Telephonic Care Management**

Eligibility for the non-frail program was through emergency room claims for a contusion or laceration, or a referral due to a fracture or other risks identified through case management or a physician referral. Members who were part of the program described below, not living at home, or receiving home health care were excluded.

A dedicated RN care manager telephoned potentially eligible members to confirm that a fall had occurred, and if so, invited them to participate in the program. The first step was to complete a phone screen to obtain a risk score. While all members were offered a medication review, other interventions varied based on individualized risk factors, with low risk members receiving educational materials only and those at moderate risk receiving educational materials and a referral to balance and exercise classes if needed. The educational materials promoted exercise, balance program participation, use of the health plan’s fitness program, osteoporosis prevention and medication management.

In addition to the educational information, moderate and high risk members were offered a Home Safety Risk Assessment. A week after the in-home assessment, the member received a call to discuss the home assessment, encourage compliance with recommendations, and inquire about satisfaction with services. The care manager also provided a follow-up call within a month of the initial outreach.
even if the home assessment was refused, to provide additional support. Also, the care manager sent a a letter to the member’s physician highlighting fall-related risks and recommendations so the physician could discuss them with the member and, as appropriate, incorporate them into the member’s ongoing care plan.

While multiple program evaluation criteria were identified, unforeseen barriers impacted findings. ER utilization was less helpful in identifying members than anticipated. Over 20 percent of members sustained an unrelated injury. Further, others did not return home after emergency room discharge due to temporary or longer term placement. Discharge to places other than home impacted recruitment for both programs. Further, almost all participants refused home safety assessments, often stating they had had one previously and did not want another. This was unexpected, and in direct contrast to the frailty program which required a home visit for participation.

Frail Elder Home-Based Program

In late 2009, a program for frail elders began that included both home and telephonic components. This program was designed to maintain patients in the community as long as possible with an optimum level of health principally through care management and support of the provider’s care plan. Care management was provided by RNs supervised by a physician medical director, with direction from an administrative RN leader, a social worker, and clinical care coordinators. Members were identified through predictive modeling by RNs supervised by a physician medical director, with direction from an administrative RN leader, a social worker, and clinical care coordinators. Members were identified through predictive modeling software prior to being invited to participate in the program.

Before 2012, interventions to prevent falls were at the discretion of the care manager, and improvements had been modest. To improve outcomes, predefined interventions associated with fall risks were developed. These included assessing for visual impairments, cognitive evaluation, focused medication review; appropriate use/need for mobility aids such as canes, walkers, or wheel chairs, as well as Durable Medical Equipment installation, such as grab bars, as need identified during the home safety review. Members were assessed for the need for physical conditioning and taught and participated in various strengthening and balance exercises at home and when appropriate, were also referred to formal programs geared for the senior population.

Discussion/Lessons Learned

While different data sources were used, self-report data for falls are considered valid enabling program evaluation. Both groups were similar in age, with an average of 74 in the non-frail group and 77 in the frail group, and slightly more women in both, and both programs used risk scores and an algorithm for interventions. However, willingness to accept a home visit, lack of a recent fall and the assistive role of staff in the frail model, as opposed to promotion of self-management with the non-frail may have led to different outcomes. In addition, the role of leadership in program effectiveness cannot be underestimated.

Future study is needed on timing, based on the effects of the fall and program participation and outcomes. In addition, there may be opportunity to more proactively identify members before they are at risk, for example, at the time of health plan enrollment. Those with incontinence, vision, hearing devices or functional/physical limitations should be considered for a fall prevention program. Patient activation assessment may also provide insight into member motivation to not only learn about fall prevention options, but make changes that lead to help optimize health.

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References

Transforming a Practice to a Medical Home: A Process of Discovery
Janet Treadwell, RN, PhD, CPHQ, Maria Jackson, RN, BSN, Lora Torres, MD and Angelo Giardino, MD, PhD

Summary
Many primary care practitioners are in the midst of aligning their internal practices with the standards of patient-centered medical homes. This article is a study of improving performance across medical home domains in one primary care practice in Texas serving 6,687 patients. The overall aim of the practice transformation was to develop team skills, enhance patient/family perceptions of care, improve operational efficiency, and positively impact quality of care through improving performance across medical home domains.

Key Point
• Interprofessional collaboration has an opportunity to transform healthcare practice and health outcomes

Many primary care practitioners are in the midst of aligning their internal practices with the standards of patient-centered medical homes. This is being done to meet accrediting standards and/or to comply with managed care contracts that pay a premium for medical home designation. Domains of activity defining medical homes practice concept include organizational capacity, chronic condition management, care coordination, community outreach, data management and quality improvement (Cooley, McAllister, Sherrieb & Clark, 2003). Additional to the measurement of domains of performance, it is necessary to achieve a team-based culture within practice staff to enable efficiency in the above measures. The use of teams has grown significantly in health care organizations, becoming a critical part of the way in which care is delivered (Valentine, Nemhard, & Edmondson, 2013).

Patient centered medical homes that develop competency in medical home domains are able to improve efficiency and effectiveness of primary care practices (Wagner, Coleman, Reid, Phillips, Sugarman, 2012). However, the zeal to achieve medical home status can be diminished after realities of the substantial cultural and system changes required from the organization. For example, development of an effective quality improvement strategy, staff cross training, use of effective electronic medical record systems, and improved access/prioritization of visits all require evaluation and move to standard in the transformation process of practice operations. On the relationship side of patient centered medical home development are changes in communication with patients/families/staff inclusive of shared decision-making and solicitation of opinions using an advisory group and satisfaction surveys.

Teams are an important part of medical homes. In establishing teams it is useful to develop a goal to provide general and unified focus (Chaudry, 2007). Specifically in a small practice, there is usefulness to steer momentum toward a goal to engage employees, improve patient satisfaction and reduce costly turnover. Interprofessional collaboration is an important part of the medical home culture build as evidenced in attributes of shared decision making, mutual trust, clear communication and professional accountability (Orchard, 2012). Successful practices focus on the organizational areas of governance, people, processes, and technology to begin their review. This includes communication, teamwork and optimal use of staff in light of their license/ training (Bendix, 2012).

In the context of a patient-centered medical home the practitioners included in the patient’s team expand beyond one practice to include all health care professionals delivering care to the person. Therefore, the team should include the individual, family/caregivers, and providers across disciplines such as therapy providers or physician specialists (Curtis, Hodin, & Seifert, 2009). In the situation of complexly ill individuals, the team should also include personal care assistants or private duty/home care staff due to their frequent and ongoing interactions with individuals receiving care (Sobolewski, 2008). Quality of care improvements using team-based care coordination offer patients a higher level of support, resulting in improved clinical outcomes (Brown, 2009). Whether these teams are internal to the patient/practice or wider in scope across the care continuum assessment and studies of improvement are valuable to patients and staff. Knowing that team-based care coordination focusing on individualized needs and desires translates to decreased hospital admissions and healthcare spending should be enough to generate some team enthusiasm (Nelson, 2012). Specifically, there is evidence that the use of a registered nurse as a care coordinator on a team positively impacts emergency room visits and unnecessary office visits through use of effective communication across the team (ANA, 2012).

Barriers to implementing transformational change include inadequate leadership, staff perception of lack of power or trust, existing negative subcultures, or unnecessary use of professional hierarchy (Scott, et al, 2003). Use of an inclusive leadership style
Purpose
The overall aim of the practice transformation was to develop team skills, enhance patient/family perceptions of care, improve operational efficiency, and positively impact quality of care through improving performance across medical home domains. Recognition of the value of staff members in facilitating practice transformation focused on employee engagement and opportunities for open communication.

Setting
The setting was one primary care practice located in Texas with a panel size of 6,687 patients. This practice is an urban location, having been at this same address for twelve years. The office sees Commercial and Medicaid patients with the largest percentage of the practice receiving public funding. The hours of operation are Monday through Friday without weekend hours. One physician and one pediatric nurse practitioner provide primary care staff in this urban setting along with five support staff. One care coordinator, supported by a health plan, provides service coordination and consulting in the practice one day a week.

Method
The study began with a baseline Medical Home Index (MHI) in January 2012. The Medical Home Index (http://www.medicalhomeimprovement.org/pdf/CMHI-MHI-Pediatric_Full-Version.pdf) has been validated for internal consistency, reliability and validity for pediatric primary care practices (Cooley, 2003). The tool assesses twenty-five indicators and organizes them across six domains. The tool creates a total tool score as well as subscale scores across the domains, using an 8-point Likert scale.

In September of 2012 the physician leader joined a state-wide collaborative on the topic of medical homes, sharing with stakeholders, methods and examples of how to make changes to drive toward becoming a medical home. In Fall 2013, the practice engaged in TeamStepps Primary Care Version training. TeamStepps is a program developed by the Department of Defense and the Agency for Healthcare Research and Quality to promote teamwork as a means of enhancing safety and quality of care for patients (http://www.ahrq.gov/professionals/education/curriculum-tools/teamstepps/primarycare/). The curriculum offers videos and role-play to assist teams in insightful discovery as well as gain tools for improved communication and professional accountability. Similarly, introduction of lean techniques into a practice can help identify efficiencies that engage staff creativity and mutual trust as every member is asked to contribute in the review of practice operations.

Results
The baseline Medical Home Index of the practice showed organizational capacity as the lowest domain (4.14 of 8). Incremental improvements were seen in Chronic Care Management (4.33 of 8). The study began with a baseline Medical Home Index (MHI) in January 2012. The Medical Home Index (http://www.medicalhomeimprovement.org/pdf/CMHI-MHI-Pediatric_Full-Version.pdf) has been validated for internal consistency, reliability and validity for pediatric primary care practices (Cooley, 2003). The tool assesses twenty-five indicators and organizes them across six domains. The tool creates a total tool score as well as subscale scores across the domains, using an 8-point Likert scale.

The third part of this study involved patient families. Both quantitative and qualitative methods were used with families in an attempt to understand how the practice was meeting their needs as a medical home. As an instrumental part of the team, families were first surveyed using the CMHI: Medical Home Family Index Tool. A convenience sample was the model using available families as they were at the practice setting for an appointment. As an instrumental part of the team, families were first surveyed using the CMHI: Medical Home Family Index Tool. A convenience sample was the model using available families as they were at the practice setting for an appointment.

The last part of the study included a repeat Medical Home Index (12 months after the baseline index) and development of an action plan and lessons learned based upon findings of the transformational work.

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The last part of the study included a repeat Medical Home Index (12 months after the baseline index) and development of an action plan and lessons learned based upon findings of the transformational work.
and a parent partner from the sponsoring health plan facilitated care was provided as needed by office staff so the parent(s) could share their knowledge and expertise as a parent (Q4, 37%) and the physician asking the parent to create a written plan of care for my child (Q8, 36%). The physician also believed the provider listened (Q6, 80%) and respected the child’s condition, history and concerns/priorities. The families identified concern around appointments. Families voiced a need to have timely return of phone calls, receive information on progress of a request, get a same day appointment when their special needs child is ill and be taught related to their child’s condition. In the area of care plans, parents described information they wanted to have included on a care plan they could use across providers and with school providing one document with a plan and health history. The last area surrounded communication. Parents verbalized being grateful for the opportunity to give input and participate in the group.

In January 2014, 24 months after the baseline Medical Home Index was completed, the tool was again completed. The findings indicated while all scores improved, Organizational Capacity and Community Outreach were the most changed (Table 5). Organizational Capacity moved from 4.14 to 5.57 and Community Involvement from 4.50 to 6.0. Data Management and Quality Improvement each moved up one point from 2012 to 2014.

Discussion
After the initial Medical Home Index results in 2012, the practice received support of a care coordinator, one day a week, supported by a health plan. The case manager presence likely had influence on improvements in the domains of Chronic Condition Management 4.33 to 5.00 and Care Coordination 5.17 to 5.33. The health plan provision of TeamsStepps training to the office staff was able to influence two other domains, that of organizational capacity and quality improvement. The fifth domain of Community Outreach was addressed through health plan support initiating the family

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**Center for Medical Home Improvement Medical Home Family Index**

Sample questions and Percent of Positive Response (n=50)

- **Q23**: From my experience, I believe that my PCP and the staff at his/her office have a commitment to provide the quality care and family supports that we need. 98%
- **Q14**: Office providers or staff who are involved with my child’s care know about their condition, history, and our concerns and priorities. 89%
- **Q6**: My PCP listens to my concerns and questions. 80%
- **Q2 b**: Staff respect our needs and requests. 74%
- **Q4**: My PCP asks me to share with him/her my knowledge and expertise as the parent of a child with special health care needs. 37%
- **Q5**: I am asked by our PCP how my child’s condition affects our family. 33%
- **Q8**: My PCP and staff work with our family to create a written care plan for my child. 36%
- **Q10**: My PCP and his/her office staff use and follow through with care plans they have created. 44%

8), Community Outreach (4.5 of 8), Mean Score (4.68 of 8), Quality Improvement (5 of 8) and Care Coordination (5.17 of 8). The highest score on the tool was Data Management at 6 of 8 (Table 1). Combined scores for the seven practice participants on the Assessment of Interprofessional Team Collaboration Scale indicated an overall tool mean of 207 compared to an intervention group benchmark mean of 172.68. The subscale score of Partnership (19 items) had a mean of 69 as compared to the comparative intervention clusters of 74. The Cooperation subscale (11 items) revealed a mean of 48 which mirrored the comparison intervention cluster mean score. The Coordination subscale (7 items) had a practice mean of 32 compared to the benchmark intervention group mean of 31 (Table 2). The topic of the chosen quality project used to assist the team members in using newly learned teaming techniques, was conducting a morning huddle. Results of the rapid cycle improvement study showed each team member had something to contribute and there was value in setting shared expectations for the day in consideration of individual patient needs and professional roles. Team members were able to experience mutual respect and shared decision-making throughout the study as well as use skills of clear communication and professional accountability.

Fifty family members completed the Center for Medical Home Improvement’s Medical Home Family Index Survey as they came to the office for scheduled visits. Thirty-four families completed the English version and sixteen the Spanish version. The tool has 37 questions, using a mix of 4-point Likert scale and yes/no responses. Response to Question (Q) 23 showed an overwhelming belief that the practice had a commitment to provide quality care and family support (98%). The families also responded (Q14, 89%) that the office providers or staff involved in care knew the child’s condition, history and concerns/priorities. The families also believed the provider listened (Q6, 80%) and respected the family needs (Q2b, 74%). Lower results were found in the frequency with which the physician asks how the child’s condition affects the family (Q5, 33%), working with the family to create a written plan of care (36%). The physician asking the parent to share their knowledge and expertise as a parent (Q4, 37%) and the physician and office staff following through on a care plan (Q10, 44%) were found to be areas of improvement (Table 3).

The Parent Advisory meeting was held on a Saturday morning. Eight families were represented out of the twenty invitees. Childcare was provided as needed by office staff so the parent(s) could more easily participate. The lead physician made introductions and a parent partner from the sponsoring health plan facilitated three questions (Table 4). After a break for lunch, a period of open questions and sharing of resources resulted in open discussion. Notes transcribed by an additional health plan attendee assisting with the meeting indicated three themed areas. First, there was an identified concern around appointments. Families voiced a need to have timely return of phone calls, receive information on progress of a request, get a same day appointment when their special needs child is ill and be taught related to their child’s condition. In the area of care plans, parents described information they wanted to have included on a care plan they could use across providers and with school providing one document with a plan and health history. The last area surrounded communication. Parents wanted assistance with both resources in the community and advocacy in school environments. They verbalized being grateful for the opportunity to give input and participate in the group.
survey, analysis and Family Advisory Committee meeting. That meeting clarified the need for additional programming to enable care plan development responding to family need, thus addressing the final domain of Data Management.

The practice was surprised by family desire for a shared care plan and the family receptiveness to acquiring additional skills. Both the staff team and the more inclusive team of family and staff verbalized satisfaction in participating and being valued for opinions and contribution.

Operational changes resulting from the meeting included clear indication on a patient file of individuals with special healthcare needs and empowerment to staff to enable quick appointments for those children when needed. Creating a central contact to ensure returned phone calls and progress updates was a positive move to address family concern as was a contract with a developer to create a more robust care plan to be shared among all stakeholders.

Changes in an electronic medical record system (EMR) are costly and time consuming. This move demonstrates leadership commitment to the process of practice transformation and mastery of the medical home domains.

Opportunities to teach parents additional care skills and include them in support of other parents, is in planning along with scheduling of a second meeting of the Parents Advisory Committee. Additional parents have already heard of the group and have voiced interest in participation. Advocacy work with schools is also underway as is community resource research to meet family needs. Although the work is not complete, there is positive momentum and a valuing relationship growing between all team members.

Conclusion
Organizational culture is created over extensive periods through policies, reward structure, physical space, celebrations, and interaction patterns (Scott, Mannion, Davies, Marshall, 2003). Including all roles within the practice and across disciplines and settings, as well as the individual, and family caregivers creates a truly cohesive and effective team. Front line roles serve in a valued team role due to their frequent and consistent patient relationship (AHRQ, 2008).

Realistically, a set of training sessions, focus groups, or adoption of a new set of policies should not be expected to result in transformation to a successful team culture across multiple areas of functioning. Change takes time and persistent leadership. The trainings, quality focus, and open communication style being developed by this practice suggest that an organizational culture is being created to deliver family-centered care and to create a collaborating environment for all staff members supporting retention and job satisfaction.

This case study shows that an independent practice can be responsive to new information and exploratory findings. This practice now shares a vision of using a team-based, interprofessional approach. They concur with evidence suggesting team-based care and provision of patient care coordination with open communication, delivers an improved work environment for staff supporting role satisfaction, thus improving quality of care (Brown, 2009). This model can and should, be replicated by other primary care practices as they seek to move toward a practice model of being a patient-centered medical home.

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