Program Snapshot:
The Safety Net Medical Home Initiative
**PROGRAM SNAPSHOT: THE SAFETY NET MEDICAL HOME INITIATIVE**

Qualis Health and its partner, the MacColl Center for Health Care Innovation, plan, administer, coordinate, and monitor the Safety Net Medical Home Initiative (the Initiative). The Initiative provides training and technical assistance to staff at five Regional Coordinating Centers (RCCs) across the United States, which then support local practices through practice facilitators. Facilitators support practices in patient-centered medical home (PCMH) transformation by translating materials received from the national hub (Qualis Health and MacColl) into tangible changes in practices’ processes at the local level.

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In this case study, we describe how Qualis Health and MacColl jointly built the Initiative’s facilitation program. We discuss the Initiative’s administrative structure and facilitation approach, including the processes for selecting, training, and monitoring this work. We conclude with lessons from the Initiative for others interested in developing a facilitation program.
Practice Facilitation Activities of the Safety Net Medical Home Initiative

The Safety Net Medical Home Initiative (the Initiative) is a 5-year demonstration project to develop a replicable model to help primary care safety net practices become high-performing PCMHs. The goal of the Initiative is to help practices redesign their clinical and administrative systems to improve patient experience and health outcomes, bringing the benefits of patient-centered care to the Nation’s most vulnerable populations. The Initiative, begun in 2008, provides training and technical assistance through a national hub to staff at five RCCs across the United States, which then give support to local practices through practice facilitators (or coaches). The Commonwealth Fund is the primary sponsor of the Initiative and contracts with Qualis Health and its partner, the MacColl Center for Health Care Innovation (MacColl) to plan, administer, coordinate, and monitor the Initiative. The Initiative currently includes 16 facilitators\(^1\) who support the transformation of 65 safety net practices into PCMHs, and provides a model for how to build regional capacity from a national hub. The Initiative offers several lessons for others interested in developing a PF program such as:

- Building on existing partnerships between organizations with complementary expertise can help form a robust PF program.
- Combining national and local strategies can enable the spread of an intervention.
- Using a QI framework supported by resources and tools and paired with technical assistance is one effective way to guide program implementation over multiple sites.
- Following a specific sequence of stages during the PF intervention is an effective method for supporting practices’ PCMH transformation.
- Ensuring that facilitators have core coaching skills and QI technical expertise is crucial.

I. Motivation for Developing the Initiative’s Facilitation Program

Qualis Health is a private nonprofit QI consulting firm whose mission is to generate, apply, and disseminate knowledge to improve the quality of health care delivery and health outcomes. In addition to providing services designed to improve health care quality and value to a broad range of public and private sector clients from its offices in six States, it has served as the Medicare QIO for Washington State and Idaho since 1984. MacColl is a research center at the Group Health Research Institute that is committed to linking research and practice by developing, evaluating, and disseminating innovations in health care delivery. MacColl is best known for its work in developing and testing the Chronic Care Model\(^2\) and its RWJF-funded national program “Improving Chronic Illness Care.”

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1 There has been turnover in facilitator staff, so the number of facilitators has fluctuated from 15 to 20.
2 See www.improvingchroniccare.org/index.php?p=The_Chronic_Care_Model&s=2
For Qualis Health, the Initiative was an opportunity for them to grow their PCMH capabilities, as a natural extension of the consultation and coaching-related QI work it already was doing in primary care, on health information technology (IT), and with learning collaboratives. Qualis Health partnered with MacColl to provide PCMH content expertise. Working with Qualis Health allowed MacColl to extend the Chronic Care Model to PCMH transformation and participate in developing a curriculum to support regional QI efforts.

II. Administrative Structure of the Initiative

The multilayered administrative structure of the Initiative includes several organizations (see Figure 1). The Initiative operates through one central national hub, which then builds regional capacity through five RCCs. Staff from Qualis Health and MacColl serve as the national hub for these RCC organizations, which each employ facilitators to implement the Initiative through 10 to 15 safety net practices per region. This approach ensures the quality and consistency of facilitation services, while also allowing the fixed costs of content/resource development and technical assistance services to be spread across several regions.

Figure 1. Administrative Structure of the Initiative
As the program administrator, Qualis Health developed the Initiative’s infrastructure and is responsible for delivering funding, training, and technical assistance to support practices in achieving PCMH transformation and meeting the Commonwealth Fund’s reporting and dissemination requirements. MacColl co-developed and helps deliver Initiative materials, including the PCMH transformation curriculum and measurement tools.

RCCs were selected through a competitive process to identify organizations with the resources to recruit and support safety net practices in becoming high-performing PCMHs. The Qualis Health/MacColl team, with input from the Commonwealth Fund, evaluated potential RCCs based upon the strength of their existing connections and support from State Medicaid and local communities (including in-kind or matching resources and local co-funding), as well as the readiness of the set of practices recruited by the RCC and the facilitation staff’s qualifications and prior QI experience. Five RCCs were selected in geographically distinct and non-overlapping regions (see text box). Four of the five RCCs are State Primary Care Associations (some working in partnership with other organization types), and the fifth is a citywide consortium of stakeholders working to improve health care quality. The RCCs were each expected to recruit 10 to 15 practices, retain at least one FTE facilitator, and provide facilitation services to practices. Table 1 describes the primary roles and responsibilities of organizations involved in the Initiative.

**Table 1. Roles and Responsibilities of Participants in the Safety Net Medical Home Initiative**

<table>
<thead>
<tr>
<th>Organization</th>
<th>Primary Roles and Responsibilities</th>
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</thead>
</table>
| The Commonwealth Fund | Primary funder  
Provide guidance, strategic direction, monitoring, and oversight |
| Qualis Health and MacColl Center for Health Care Innovation | Develop administrative and organizational infrastructure  
Develop PCMH transformation framework, including resources and tools  
Select RCCs  
Provide technical assistance to RCCs and facilitators  
Analyze and monitor practice transformation data and progress  
Support external PCMH recognition  
Monitor/support PCMH payment and policy changes in participating States  
Support the sustainability and spread of PCMH transformation  
Publically disseminate resources and tools created in the Initiative  
Report to The Commonwealth Fund |
| Regional Coordinating Centers | Recruit safety net practices  
Hire and support facilitators  
Provide direct facilitation services to practices, including learning sessions  
Participate in a national learning collaborative  
Convene stakeholders for PCMH policy and payment discussions  
Report to Qualis/MacColl |
<table>
<thead>
<tr>
<th>Organization</th>
<th>Primary Roles and Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safety Net Practices</td>
<td>Commit to the PCMH transformation process and to working with a practice facilitator</td>
</tr>
<tr>
<td></td>
<td>Participate in national technical assistance offerings</td>
</tr>
<tr>
<td></td>
<td>Execute Initiative requirements, including submitting data to RCCs, Qualis Health, and the external evaluator</td>
</tr>
<tr>
<td>Regional Co-Funders</td>
<td>Co-funders include Beth Israel Deaconess Medical Center (Boston, MA) Blue Cross Blue Shield of Massachusetts Foundation; Blue Cross of Idaho Foundation for Health; The Boston Foundation; Colorado Health Foundation; Jewish Healthcare Foundation (Pittsburgh, PA); Northwest Health Foundation (Portland, OR); and Partners HealthCare (Boston, MA)</td>
</tr>
</tbody>
</table>

### III. Funding

The Initiative’s funding comes from the Commonwealth Fund and eight additional partners from the participating regions. The Commonwealth Fund provides core support for the Initiative through a $6.8 million, 5-year award to Qualis Health. This amount covers all administrative and staffing costs, as well as funding for MacColl, outside technical experts, training and technical assistance, PCMH recognition costs, partial core funding for the RCCs, and supplemental funding for RCCs and practice sites. Regional partners contributed varying amounts of core funds to the RCCs, ranging from $10,000 to $125,000 per year. RCCs use core funds to support facilitator salaries, local travel, and some learning activities with practices. RCCs also receive supplemental resources from the national hub to cover regional meetings and learning sessions, external training, and other activities ($20,000 to $70,000 a year/RCC). Participating practices are eligible to receive resources from the national hub to support special projects and field trips, and some RCCs provide practices with participation stipends.

### IV. The Initiative’s Practice Facilitation Approach

The goal of the Initiative is to help practices redesign their clinical and administrative systems to improve patient experience and health outcomes, bringing the benefits of patient-centered care to the Nation’s most vulnerable populations. Specifically, the Initiative aims to:

- Improve the operational efficiency and quality of care in primary care safety net sites.
- Improve patients’ health care experiences.
- Reduce disparities in access to care and quality of care.
- Enhance regional capacity to support and sustain practice improvements.
- Influence health policy by involving Medicaid and other stakeholders in action toward appropriate reimbursement levels to sustain practice efforts.

**Change concepts.** To support facilitators in guiding practices through PCMH transformation, the Qualis Health/MacColl team, in consultation with a Technical Expert Panel, developed a QI framework—*Change Concepts for Practice Transformation.* “Change concepts” are general ideas used to stimulate specific, actionable steps that lead to improvement. These concepts are organized into four

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3 These goals were outlined in the original Commonwealth Fund request for proposals.
The Initiative’s Stages of Practice Transformation and Change Concepts

1. Laying the Foundation
   - Engaged leadership
   - Quality improvement strategy
2. Building Relationships
   - Empanelment
   - Continuous, team-based relationships
3. Changing Care Delivery
   - Patient-centered interactions
   - Organized, evidence-based care
4. Reducing Barriers to Care
   - Enhanced access
   - Care coordination

stages (see text box), which are each coupled with “key changes.” Key changes are the actionable steps practices must take to achieve each of the higher-order change concepts. Qualis Health/MacColl, in partnership with Initiative participants (facilitators and practices) and outside experts, developed a library of resources and tools to support this framework (http://www.safetynetmedicalhome.org/). [See Appendix A for a list of change concepts, key changes, and their connections to the Chronic Care Model.]

Stages of the PF intervention. When Qualis Health and MacColl began working with facilitators and practices, it did not prescribe a specific order for making changes, but instead allowed them to begin with the concept that interested them most. The rationale was that this would help RCCs harness the motivation of facilitators and practices. However, over time the team learned that the sequencing of changes was important, and that making some changes before others sped up the transformation process and provided a better platform for sustainability and future improvements. In the words of the project director, “it became clear that there were a few elements of the framework that were foundational—meaning practices couldn’t successfully adopt more advanced [change] concepts unless they had the foundational concepts in place.” Another benefit of following a sequence was that it facilitated peer learning across facilitators and practices, since they were sharing similar experiences in the same general time frame.

Thus, Qualis Health and MacColl’s current thinking is that the eight change concepts fall into four stages (see text box). The sequencing of these four stages is critical, but the sequencing of change concepts within a stage can be tailored to individual practices based on practice resources and needs. The first stage is laying the foundation. Change concepts in this stage—engaged leadership and QI strategy—reflect the fundamental base required to enable the practice to learn and implement changes. If these foundational changes are not addressed first, meaningful transformation cannot occur. The second stage addresses building relationships among teams and between patients and providers. This stage includes empanelment and continuous, team-based relationships, which both prepare the practice to deliver care efficiently and increase the likelihood of productive interactions between patients and care teams. The change concepts in the third stage focus on changing care delivery—patient-centered interactions and organized, evidence-based care. These changes encompass the practice system modifications associated with improvements in clinical performance. The final stage, reducing barriers to care, includes two change concepts—enhanced access and care coordination. These changes are no less important than the change concepts addressed earlier, but they are more difficult to implement in systems that are not already routinely providing well-organized,
patient-centered care. Although Qualis Health and MacColl believe that this is the ideal sequence for practices new to transformation, they also hope that QI eventually becomes an ongoing and continuous cycle. The deputy director at MacColl noted that “[the] trick is that at some point [the practices] have to do them all together; it means both working on the particular and seeing the whole.”

**Facilitator roles and core activities.** Facilitators work directly with practices, supporting them with PCMH transformation and implementing change concepts. Common facilitation activities include:

▲ Developing work plans
▲ Coaching on change concepts
▲ Establishing measurement strategies and reviewing data
▲ Identifying resources and tools
▲ Conducting workflow analysis
▲ Assessing and monitoring progress
▲ Providing overall support for change management
▲ Accelerating learning and shared knowledge

Facilitators, with support and guidance from the national hub, also link practices to experts and additional resources when special needs arise (for example, special topic Webinars or onsite consultation by subject matter experts). In addition to providing support to individual practices, facilitators at each RCC plan and conduct at least one full-day learning session for the group of practices in their region each year. These sessions provide a venue to reinforce core content, disseminate new content, and foster shared learning among practices.

**Intensity and form of facilitation work.** Although the PCMH content is standard across the Initiative, the amount of time facilitators spend with practices and how they fulfill their roles varies across the five regions (see Table 2). Factors that affect variation include prior experience of the RCC with the PCMH and facilitation; historical relationships between the RCC and participating practices; historical work in the region around PCMH transformation; personalities and skills of facilitators; whether facilitators are full-time; geography of the region; and differences in expectations and capacity at the RCC-, facilitator-, and practice levels. Facilitators across the Initiative work with each practice for 4 years—a much longer time frame than typical facilitation interventions; however, the Commonwealth Fund understands that PCMH transformation is a complex and time intensive endeavor requiring robust support for optimal success.

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*With the exception of the Pittsburgh region, which has a citywide focus, the other regions are statewide.*
Table 2. Variation in Facilitation Approach Across Regions of the Initiative: 2012-13

<table>
<thead>
<tr>
<th></th>
<th>Colorado</th>
<th>Massachusetts</th>
<th>Idaho</th>
<th>Oregon</th>
<th>Pittsburgh</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of facilitation staff (people, not FTEs)</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>FTE per facilitator (range)</td>
<td>0.4 to 0.47</td>
<td>0.1 to 0.85</td>
<td>0.4-1.0</td>
<td>0.25 to 0.5</td>
<td>0.23 to 0.62</td>
</tr>
<tr>
<td>Total facilitation FTE per region for 2012-2013*</td>
<td>0.87</td>
<td>1.45</td>
<td>1.40</td>
<td>1.95</td>
<td>1.70</td>
</tr>
<tr>
<td>Number of practices served in past 24 months</td>
<td>13</td>
<td>14</td>
<td>13</td>
<td>15</td>
<td>10</td>
</tr>
<tr>
<td>Number of practices typically served by 1 facilitator</td>
<td>131&lt;sup&gt;a&lt;/sup&gt;</td>
<td>2 to 8</td>
<td>13</td>
<td>2 to 7</td>
<td>1 to 4</td>
</tr>
<tr>
<td>Frequency of PF site visits</td>
<td>Quarterly</td>
<td>Monthly</td>
<td>Quarterly</td>
<td>Quarterly</td>
<td>Weekly or Monthly</td>
</tr>
<tr>
<td>Frequency of telephone check-ins</td>
<td>Monthly</td>
<td>Ongoing</td>
<td>Monthly</td>
<td>Monthly</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Other PF intervention activities and schedule</td>
<td>Monthly NCQA standards review</td>
<td>Ongoing email contact</td>
<td>Bi-monthly roundtable calls; bi-weekly NCQA consultation calls; ongoing email contact</td>
<td>Monthly QI Webinars; email for on demand support and resources; bi-annual learning sessions</td>
<td>Regular update of Tomorrow’s Healthcare site to communicate announcements and deliverables</td>
</tr>
</tbody>
</table>

<sup>a</sup> Does not include FTE from non-facilitation staff members that support the Initiative within the region, including Executive Sponsors, Policy Support, Administrative Support, etc.

V. Hiring and Supervising Practice Facilitators

The RCCs hire and supervise their facilitators without the direct involvement of Qualis Health or MacColl. The Initiative currently includes 16 facilitators, ranging from 0.1 to 1.0 FTE, some of whom are employees of the RCC home organization and others who are contracted staff. Currently, only one RCC employs a full-time facilitator and the others have multiple part-time facilitators, often with one lead facilitator or an additional staff person providing supervision and monitoring.

The RCCs directly supervise their facilitators’ work and the fidelity of intervention implementation. Qualis Health and MacColl also indirectly monitor facilitators’ work by observing training and technical assistance activities, and reviewing practices’ transformation progress. Qualis Health and MacColl observe how facilitators and practices interact and how practices are responding to PCMH transformation activities, contacting RCCs and facilitators directly when issues arise. [See Section VII on Monitoring the Quality of the Facilitation Intervention for more information.]

VI. Training Practice Facilitators

The Qualis Health/MacColl team provides training and technical support on PCMH transformation content to facilitators, based upon a curriculum that they developed and refined. As the deputy director at MacColl stated, “In the early days, we were developing the material as we were also asking

<sup>a</sup> Facilitators at this RCC work in a team, while at all others, they work individually with practices.
[the facilitators] to teach the practices the materials. It was an iterative process, and we polished the material into the implementation guides." The curriculum is available on the Initiative’s Web site: www.safetynetmedicalhome.org. These materials are used by Qualis Health to train facilitators, by facilitators to support practices, and as self-directed learning supports by facilitators and practices both within and outside of the Initiative.

The Initiative’s facilitator training emphasizes virtual training and centers around the Change Concepts for Practice Transformation, the barriers and challenges involved in transformation, and how to help practices move through the stages of transformation. Qualis Health and MacColl use multiple training and technical assistance methods, based on a train-the-trainer model, to transfer knowledge to facilitators at each of the RCCs. Facilitators then train practices to apply the material to make changes in their work. In this way, the Initiative is building regional capacity for practice transformation. National training methods include:

- ▲ Webinars for facilitators and practice staff to teach transformation content (monthly)
- ▲ Conference calls for facilitators to discuss case presentations, challenges, and successes (monthly)
- ▲ In-person learning sessions for facilitators focused on peer-to-peer learning, as well as some content and skills training (2 to 3 per year)
- ▲ A social learning Web site that includes a listserv and tool exchange functions

Support for individual or small groups of facilitators with common and emerging training needs is arranged via methods such as special topic Webinars, telephone support, and field trips. When Qualis Health and MacColl cannot support facilitators sufficiently on their own due to the specificity of the particular issues, they link facilitators to expert consultants.

“One of the most valuable contributions [of the Initiative] is the development of all these materials. They help us think through how to structure facilitation interventions and help practices figure out where to go next. They’re road maps for each of the different change concepts. They’re really useful—concrete and very easy to use. Practices can follow them too.”

Supervisor at the Massachusetts RCC

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6 Resources include detailed descriptions and examples of transformation strategies, Web-based core curriculum (26 Webinars), print materials (18 implementation guides), interactive tools (for example, a patient acuity calculator), and assessment resources for facilitators and sites.

7 The model is based on adult learning theory, which says that people who train others remember 90 percent of the material they teach, and diffusion of innovation theory, which states that people adopt new information through their trusted social networks. See www.healthpolicy.ucla.edu/healthdata/datademo.html
Through ongoing training and support, the Initiative has built a learning community where facilitators can share tools, ideas, and strategies for overcoming challenges, which accelerates the growth of facilitators and the transformation progress of their practices. Several members of the Qualis Health/MacColl team shared how they learned over time that sending information in only one direction—from the national hub to facilitators—undervalued the facilitators themselves as resources. The community capitalizes on the interchange of information and peer learning among facilitators across the RCCs. In fact, the project director at Qualis Health stated that establishing a learning community “might be the most practical approach” for supporting facilitators in programs with few resources. Similarly, the community may outlast the Initiative, allowing facilitators to continue to share learning after the Initiative ends.

The Initiative, which provided only general guidance to RCC applicants about whom to hire as facilitators, learned that some core competencies and change management skills are more easily taught than others. Although the lead facilitators originally selected and proposed by the RCCs had QI experience, most did not have specific experience with PCMH transformation. The project team anticipated this, and the Initiative was designed to provide facilitators with PCMH content training through the change concepts and associated curriculum. Early lessons learned indicate that programs should be prepared for: 1) turnover, 2) training and re-training over time, and 3) training on both QI content and core facilitation skills.

**VII. Monitoring the Quality of the Facilitation Intervention**

Qualis Health and MacColl have established mechanisms that monitor practices’ transformation progress—and that also indirectly monitor facilitators’ work. To monitor practices’ progress, Qualis Health and MacColl adapted a tool from the IHI Collaborative Model for Achieving Breakthrough Improvement that prompts facilitators to identify how each of their practices is functioning on a continuum from red (limited participation, needs close monitoring) to yellow (actively engaged, requires additional support) to green (high capacity for transformation, minimal support needs). According to the coaching lead at Qualis Health, this is a “gut level assessment based on facilitators’ knowledge of the practice team and how they think they are doing. It’s a way for [Qualis Health] to keep a tab on what’s going [on] in the sites and a flag for us to know how the practice is doing.” Facilitators also assess their practices using an additional tool that tracks practices’ overall transformation progress using criteria such as leadership/resources, data and QI strategy, congruence with PCMH content, and other distinguishing characteristics.

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**Best Practices in Training Modes**

- **Virtual learning methods**, such as Webinars and conference calls, are most helpful when teaching specific, sequential, and “how-to” content; answering basic questions and answers; or sharing case studies or tools.
- **In-person group meetings** and direct support (for example, site visits, field trips, consultation) are effective when teaching complex content, or when trying to foster collaboration and team building.

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8 Available at [www.ihi.org/knowledge/Pages/IHIWhitePapers/TheBreakthroughSeriesIHI'sCollaborativeModelforAchievingBreakthroughImprovement.aspx](http://www.ihi.org/knowledge/Pages/IHIWhitePapers/TheBreakthroughSeriesIHI'sCollaborativeModelforAchievingBreakthroughImprovement.aspx).
Facilitators and RCCs also submit reports to Qualis Health that detail their own accomplishments with each practice, strategies that did and did not work well, and future intervention plans, including the types of assistance that they need from the national hub. Qualis Health uses information from these sources to identify common challenges, which inform future training and support needs.

Practices submit information directly to Qualis Health every 6 months, including results from the PCMH-A, a self-assessment tool that tracks progress toward implementation of key design features of the PCMH as described by the Change Concepts for Practice Transformation. Qualis Health analyzes PCMH-A data shares it with practices and their facilitators. These results allow Qualis Health to track each individual practice’s transformation progress, as well as trends by region and for the Initiative overall. Additionally, each practice selects at least six indicators of clinical and operational PCMH improvements to submit quarterly. Qualis Health then feeds trended data back to the RCCs, which are used to guide their local work. Because the Initiative did not require standardized indicators across practices and regions, it is challenging to assess and communicate progress for the Initiative as a whole.

The external evaluation, conducted by researchers at the University of Chicago and funded by the Commonwealth Fund, will evaluate whether participating practices transform into PCMHs, how being a PCMH affects quality and efficiency, and what factors are associated with a practice’s successful transformation. Qualis Health and MacColl are not involved in external evaluation data collection or analysis.

**VIII. Lessons Learned**

A number of lessons emerge from the experiences of the Qualis Health/MacColl team that could be useful to others interested in developing a facilitation program. These lessons may be useful for individual organizations working with selected practices, as well as for larger organizations convening others to provide PF services through a train-the-trainer model. Lessons include:

**Building on existing partnerships between organizations with complementary expertise can help form a robust PF program.** Qualis Health and its partner MacColl have a long history of collaboration, and together, they have the content expertise and skills needed to lead the Initiative.

**Combining national and local strategies can enable the spread of your intervention.** A program that is regionally operated, but nationally supported, can build local capacity for PF. This is especially so when regional programs receive resources, knowledge, and support from a national hub and have opportunities for facilitated sharing and collaboration across regions (e.g., learning community). This is one strategy for building facilitation capacity across long distances.

**Using a framework supported by resources and tools and paired with technical assistance is one effective way to guide program intervention over multiple sites.** Having a centralized and prescribed framework that is sensitive to local needs can help maintain program consistency and quality across sites.

**Following a specific sequence of stages during the PF intervention is an effective method for supporting practices’ PCMH transformation.** The Qualis/MacColl team learned that the sequencing

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of PCMH work is important and that making some changes before others sped up the transformation process and provided a better platform for sustainability and future improvements. There also are advantages to practices moving through a similar sequence at the same time, in that it facilitates peer learning across facilitators and practices.

**Ensuring that facilitators have core coaching skills and QI technical expertise is crucial.** As stated by the project director, “If an organization is building a new PF program, they should have a number of things in place before working with sites, including a staffing and training model that ensures coaches have a basic set of core skills and content knowledge.” Many organizations likely to house PF programs may be better equipped to train on technical content than on core facilitation skills. These organizations could develop needed resources and build in time to support facilitation skill development or contract with other organizations that specialize in core coach training. Another possibility is to rely on a learning community among facilitators to support the development of core facilitation skills, which allows them to capitalize on the interchange of information and learning among peers. Whichever model is chosen, establishing formal processes for educating new staff over time is critical.

**Training facilitators often takes longer than anticipated.** The Initiative’s facilitators had to learn technical PCMH content at the same time that they were working with practices to apply that content. Because there are costs to practices in working with facilitators (for example, unbillable hours, extra work), programs should build in adequate time for training before facilitators begin working directly with practices to ensure initial interactions that are positive and productive. As the project director said, “You don’t want a site to have low confidence in the coach. You want to make sure that sites see their interaction with the coach as a benefit. If that means enrolling sites 1 month, or 2, or 6 months later—it might be worth it.”

**Monitoring helps maintain program quality.** When working with regional or local entities, recognize that not all groups are equally ready to support practice transformation. Regional centers, like practices, should be assessed and re-assessed for readiness and capacity to support practices in the transformation process. The Initiative includes a useful combination of subjective facilitator-completed tools and objective practice indicator tracking. For those interested in aggregating results across sites, it may be important to specify the information and indicators to be reported (and the timeline for reporting), rather than letting regional centers or practices do this on their own.

**Funding infrastructure development can enhance capacity and support sustainability.** As intended by the project’s design, the RCCs have built capacity to offer facilitation support for PCMH transformation. Most sites have received additional funding from other sources and are working with practices outside the Initiative.
This case study was prepared by Dana Petersen, Erin Fries Taylor, and Kristin Geonnotti, Mathematica Policy Research.

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### Appendix A

The Safety Net Medical Home Initiative’s Change Concepts, Key Changes, and Links to the Chronic Care Model

<table>
<thead>
<tr>
<th>Change Concept</th>
<th>Key Change</th>
<th>Chronic Care Model Elements</th>
</tr>
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</table>
| Engaged leadership           | Create visible leadership for culture change and QI  
Ensure time and resources for transformation  
Ensure protected time for QI  
Build PCMH values in staff hiring and training | Health care organization                           |
| Quality improvement strategy | Use formal QI model  
Establish metrics to evaluate improvement  
Involve patients, families, and staff in QI  
Optimize use of health IT | Health care organization  
Information systems | Information systems  
Proactive care | Practice redesign (team care) |
| Empanelment                  | Assign all patients to a provider panel  
Balance supply and demand  
Use panel data to manage the practice population | Information systems  
Proactive care | Practice redesign (planned care)  
Decision support  
Information systems | Information systems  
Proactive care |
| Continuous team-based relationships | Establish support and care delivery teams  
Link patients to provider and care teams  
Ensure that patients see their provider  
Distribute roles and tasks among the team | Practice redesign (team care)  
Practice redesign (planned care)  
Decision support  
Information systems | Information systems  
Proactive care  
Practice redesign (team care) |
| Organized, evidence-based care | Use planned care according to patient need  
Manage care for high-risk patients  
Use point-of-care reminders  
Use patient data to enable planned interactions | Practice redesign (planned care)  
Decision support  
Information systems | Information systems  
Proactive care  
Self-management support |
| Patient-centered innovations | Respect patient and family values  
Encourage patient involvement in health and care  
Communicate so that patients understand  
Provide self-management support at every encounter  
Obtain patient and family feedback and use it for QI | Practice redesign (planned care)  
Decision support  
Information systems  
Self-management support | Information systems  
Proactive care  
Self-management support |
| Enhanced access              | Ensure that patients have 24/7 access to care team  
Provide appointment scheduling options  
Help patients obtain health insurance | Information systems  
Proactive care  
Self-management support | Information systems  
Proactive care  
Self-management support |
| Care coordination            | Link patients with community resources  
Integrate specialty care through collocation or agreements  
Track and support patients obtaining outside services  
Follow up after emergency room visits or hospitalizations  
Communicate test results and care plans to patients | Community resources  
Practice redesign (care management) | Community resources  
Practice redesign (care management) |

RESOURCES

Safety Net Medical Home Initiative Web portal, including access to all resources listed below and more: www.safetynetmedicalhome.org/

General Background on the Initiative: www.safetynetmedicalhome.org/about-initiative

Coaching Guides


Change Concepts and Implementation Guides: www.safetynetmedicalhome.org/change-concepts

▲ Engaged Leadership

▲ Quality Improvement Strategy

▲ Empanelment

▲ Continuous & Team-Based Relationships
  • www.safetynetmedicalhome.org/sites/default/files/Implementation-Guide-Team-Based-Care.pdf
  • www.safetynetmedicalhome.org/sites/default/files/Implementation-Guide-Supplement-Team-Based-Care.pdf
▲ Patient-Centered Interactions

▲ Enhanced Access

▲ Care Coordination
  • www.safetynetmedicalhome.org/sites/default/files/Implementation-Guide-Care-Coordination.pdf
  • www.safetynetmedicalhome.org/sites/default/files/Implementation-Guide-Care-Coordination.pdf

▲ Practice Transformation

Newsroom (publications, press releases and announcements from The Commonwealth Fund):
www.safetynetmedicalhome.org/about-initiative/newsroom