HCH Quality Leaders: A Case Study

Key Practices Supporting Quality of Care and Improvement Processes

National Health Care for the Homeless Council
November 2012

NATIONAL HEALTH CARE *for the* HOMELESS COUNCIL

DISCLAIMER

This publication was made possible by grant number U30CS09746 from the Health Resources & Services Administration, Bureau of Primary Health Care. Its contents are solely the responsibility of the author and do not necessarily represent the official views of the Health Resources & Services Administration.

Suggested citation: National Health Care for the Homeless Council (November 2012). *HCH Quality Leaders: A Case Study (Key Practices Supporting Quality of Care and Improvement Processes).* [Author: Sarah Knopf, Research Assistant.] Nashville, TN: Available at: www.nhchc.org.

ACKNOWLEDGEMENTS

Special thanks are owed to the staff members from the quality leader grantees who kindly agreed to participate in this case study. Without their willingness to share valuable information about how their organizations function, this case study would not be possible. Additional thanks to the National Health Care for the Homeless Council staff members who reviewed and contributed to this research process and publication.

TABLE OF CONTENTS

INTRODUCTION

Health Care for the Homeless (HCH) grantees are continually seeking to deliver the highest quality of care to their patients. Those excelling at this are considered quality leaders. However, not enough is known about what operational practices drive this success, particularly for health centers serving patients outside of the economic and medical mainstream, such as persons experiencing homelessness. In order to provide HCH grantees with the guidance needed to make meaningful quality improvements in their care processes and outcomes, the National Health Care for the Homeless Council (NHCHC) has identified a sample of HCH quality leaders to highlight their operational drivers for success. The four quality leaders were selected based upon analysis of clinical measures for diabetes and hypertension control, with data drawn from the 2010 Uniform Data System. This case study will document their practices, including their successes, struggles, and strategies for achieving quality performance; methods used to track and evaluate performance; quality improvement processes; experiences with national quality recognition models; and key lessons from the field for fellow HCH grantees. The final product will be translatable strategies, which grantees can incorporate into their quality improvement efforts.

BACKGROUND

The Health Resources and Services Administration's (HRSA) strategic goals for Fiscal Year 2012 are to improve access to quality health care and services, strengthen the health workforce, build healthy communities, and improve health equity.[1] High quality health centers are foundational to achieving these aims. According to HRSA, quality health care is safe, effective, patient-centered, timely, efficient, and equitable. This quality-driven model of care is a catalyst for reducing cost and unnecessary utilization, expanding access, and improving patient outcomes. A focus on the quality of care provided to patients, rather than productivity objectives, can bring about these systemic changes. Because HRSA has no minimum annual productivity requirements, health centers can focus solely on quality improvements, which can be jeopardized by extraneous productivity pressures. In addition to health centers' operational practices, which will be articulated later, a number of quality improvement strategies can be employed to track and increase these quality outputs. Examples include clinical performance improvement through data collection and analysis, meaningful use of a certified Electronic Health Record (EHR) system, and the achievement of national quality recognition.

Data-Driven Performance Evaluation

Process and outcome data are powerful tools for evaluating health center performance. Quality audits of this data can be expressed in many ways, including dashboard reports, provider report cards, and data walls. But first, appropriate measures and benchmarks must be set in order to collect and evaluate such data. It is important for health centers to consider what measures to select and how to use their results to guide quality improvement. Patient demographics, health status, and needs, as well as conditions of the delivery system itself, play a key role in developing these performance indicators so they best capture a health center's environment.

The health care field uses a variety of quality measures to assess performance and inform quality improvement processes. To help and guide HCH grantees, HRSA's Clinical and Financial Performance Measures are incorporated into the Uniform Data System (UDS) as reporting requirements. These measures are structured to track health outcomes while demonstrating the value of care delivered by health

[1] Department of Health and Human Services (Health Resources and Services Administration). (2012). Justification of estimates for Appropriations Committees. Retrieved from http://www.hrsa.gov/about/budget/budgetjustification2012.pdf

center grantees. Selected measures are nationally-standardized, in line with the National Quality Forum (NQF), Meaningful Use, Healthcare Effectiveness Data and Information Set (HEDIS), Ambulatory Care Quality Alliance (AQA), National Care Forum (NCF), National Committee for Quality Assurance (NCQA), and other nationally recognized quality metrics. HRSA's 2012 clinical measures cover Outreach/Quality of Care (pre-natal and perinatal care, immunizations, obesity, tobacco cessation, asthma, coronary artery disease, ischemic vascular disease, colorectal cancer screening, cervical cancer screening), Health Outcomes/Disparities (diabetes, hypertension, birth weight), and Additional Measures (grantees include one behavioral health and one oral health measure of their choice). Other measures are in place for Financial Viability/Costs (total cost per patient, medical cost per medical visit, change in net assets to expense ratio, working capital to monthly expense ratio, long term debt to equity ratio). Grantees report UDS measures annually to HRSA utilizing the UDS Manual. This manual is updated every year to reflect changes and provide reporting instructions.

Additional sets of performance measures are used outside the Health Center Program. Perhaps most prominent is Healthy People 2020, a set of objectives with 10-year targets released by the U.S. Department of Health and Human Services for the last three decades. Designed to guide national public health improvements, Healthy People 2020 can be used at all levels, including the federal government, state government, local government, and public and private organizations. Its 26 Leading Health Indicators cover 12 topic areas, including Access to Health Services; Clinical Preventive Services; Environmental Quality; Injury and Violence; Maternal, Infant, and Child Health; Mental Health; Nutrition, Physical Activity, and Obesity; Oral Health; Reproductive and Sexual Health; Social Determinants; Substance Abuse; and Tobacco.[2] Healthy People 2020's Leading Health Indicators for Diabetes and Hypertension control will be compared to the performance of the top 10 HCH quality leaders in a later section.

The Commonwealth Fund recently published a new method for measuring system-wide performance at the local level.[3] To assess local health systems, a scorecard was developed, which allowed for geographic comparisons of health access and quality of care. The scorecard tracked 43 indicators, which covered access, prevention and treatment, costs and potentially avoidable hospital use, and health outcomes. The report evaluated 306 local health care areas and found that outcomes varied widely throughout the communities. High performing health systems were concentrated in the Upper Midwest and Northeast, while areas in the Gulf Cost and South-Central states performed the lowest.

Many organizations have devised other performance metrics that health centers can reference, including the Agency for Healthcare Research and Quality's (AHRQ) National Quality Measures Clearing House, AQA, NQF, Physician Consortium for Performance Improvement (PCPI), Centers for Disease Control (CDC), and U.S. Preventive Services Task Force.

National Quality Recognition and Delivery System Redesign

Given the wealth of performance measures available, health centers can obtain a clear assessment of their successes and shortfalls. The next step is to determine a course of action to address areas of low performance. In its pivotal report on quality deficiencies in the health care system, the Institute of Medicine stated, "The current care systems cannot do the job. Trying harder will not work. Changing systems of care

[2] U.S. Department of Health and Human Services. (2010). ODPHP Publication No. B0132. Retrieved from http://www.healthypeople.gov/2020/TopicsObjectives2020/pdfs/HP2020_brochure_with_LHI_508.pdf

[3] The Commonwealth Fund Commission on High Performance Health System. (2012). Rising to the challenge: Results from a scorecard on local health system performance. Retrieved from http://www.commonwealthfund.org/Publications/Fund-Reports/2012/Mar/Local-Scorecard.aspx

will."[4] To make the expansive changes necessary to improve quality of care, health centers can opt for delivery system redesign. One option is the Patient-Centered Medical Home (PCMH) model, now seen as a blueprint for practice transformation with a strong consensus of support.[5] The model's characteristics include comprehensive, team-based care; person-centered orientation; coordinated care; accessible services; and quality and safety.[6] Research has demonstrated that PCMH increases the quality of clinical care, reduces costs, reduces hospital and emergency room use, and improves patient and provider experiences.[7]

Transformation to the PCMH model is one way health centers can receive national quality recognition, a priority supported by HRSA. HRSA encourages all grantees to become nationally recognized as quality providers through its Accreditation and Patient-Centered Medical/Health Home (PCMH) Initiatives. The Accreditation Initiative offers accreditation surveys through the Accreditation Association for Ambulatory Health Care and The Joint Commission, while the PCMH Initiative offers surveys through NCQA. HRSA also offers supplemental funding for Quality Improvement and PCMH transformation.

Transformation to the PCMH model is an attainable goal for HCH grantees. The HCH model of care that grantees already employ provides a strong platform for PCMH transformation given its foundation in integrated, whole-person care. The core HCH model is in close alignment with the standards of the PCMH model, although some challenges unique to HCH grantees make certain PCMH standards harder to achieve. The primary challenges include the transient nature of consumers experiencing homelessness, the prevalence of complex co-morbidities, the financial investment required for transformation, and the struggle for care continuity due to the frequency of part-time providers and outside referrals.[8]

Identifying Top Performers

Identifying the top performers among health centers is a complex endeavor given the variance in patient populations, environments, and other mitigating factors that influence performance. However, the value derived from identification, including the documentation of successful practices suitable for replication, makes the effort a worthy one. Some identification attempts have been made among health centers, although not specifically for HCH grantees at this time.

In "Going from Good to Great," the National Association of Community Health Centers (NACHC) sought to identify "great Community Health Centers (CHCs)" and understand the characteristics that define them.[9] NACHC conducted focus groups in six areas, including patient experience, operations,

[4] Institute of Medicine of the National Academies Committee on Quality of Health Care in America, Institute of Medicine, (2001). *Crossing the quality chasm: A new health system for the 21st Century.* Washington, DC: National Academies Press.

[5] Wagner, E.H., Coleman, K., Reid, R.J., Phillips, K., and Sugarman, J.R. (2012). *Guiding transformation: How medical practices can become patient-centered medical homes.* The Commonwealth Fund. Retrieved from http://www.commonwealthfund.org/Publications/Fund-Reports/2012/Feb/Guiding-Transformation.aspx

[6] Agency for Healthcare Research and Quality. (2012). Patient-centered medical home resource center: Defining the PCMH. Retrieved from http://pcmh.ahrq.gov/portal/server.pt/community/pcmh__home/1483/PCMH_Defining%20the%20PCMH_v2

[7] National Committee for Quality Assurance. (2011). *Patient-Centered Medical Home 2011 Recognition Program.* Retrieved from http://www.ncqa.org/Portals/0/Public%20Policy/PCMH_2011_fact_sheet.pdf

[8] National Health Care for the Homeless Council. (2011). Key elements of integrated care for persons experiencing homelessness: A guide for Health Care for the Homeless providers. Retrieved from http://www.nhchc.org/wp-content/uploads/2011/10/Key-Elements-of-Integrated-Care.pdf

[9] Schmidt, J.B., and Williams, H. (2011). Going from good to great: An exploration of paths to greatness for community health centers. National Association of Community Health Centers. Retrieved from http://www.nachc.com/client/documents/Going%20from%20Good%20to%20Great.pdf

clinical, finance, leadership, and governance; interviewed key experts; and examined those CHCs identified as great performers. The study revealed six common attributes of great CHCs, which included patient-centeredness, partnership and linkage, more focus on outcomes, managed patient care, selecting and retaining the right people, and clinical practice knowing and following evidence-based practice.

Another study published in 2012 identified CHCs performing well on care quality and cost indicators and shared their operational practices associated with success.[10] A Medicaid claims analysis using quality (well child visits, timely prenatal care, timely post-partum care, avoidable hospitalizations, avoidable ER use) and cost (outpatient services, inpatient services, total services) measures was performed to evaluate CHC performance and identify high performers. Case studies were done to understand operational drivers of high performance at the eight identified CHCs. Common attributes were identified among the high performing CHCs, including facilitated care access, managed referral system, provider support, patient support, and quality improvement. The study noted that these attributes reflect the core elements of the PCMH model.

Discussion

Much research has been conducted on quality of care, quality improvement strategies, and attributes of high performing health centers, but little has focused on how this applies to the HCH field. Given the vulnerable population served by HCH grantees, this subset of health centers requires additional exploration so that practices successful in this unique and challenging environment can be identified. The HCH model of care is already rooted in a focus on quality over productivity, so many grantees are proactively fulfilling the keystones of PCMH and other quality primary care models. By identifying quality leaders in the HCH field, this case study will reveal the integral practices contributing to exceptional quality of care among homeless consumers.

[10] Gurewich, D., Capitman, J., Sirkin, J., & Traje, D. (2012). Achieving excellence in community health centers: Implications for health reform. *Journal of Health Care for the Poor and Underserved* 23(1), 446-459. The Johns Hopkins University Press. Retrieved March 21, 2012, from Project MUSE database.

METHODS FOR IDENTIFYING QUALITY LEADERS

This case study identified the top 10 quality leaders among all HCH grantees based upon 2010 UDS data on chronic disease management. HRSA's Clinical Measures were calculated for diabetes[11] and hypertension.[12] Those grantees scoring the lowest for poor diabetes control[13] and the highest for adequate hypertension control[14] were considered quality leaders. From the top 10 ranking grantees, two grantees with HCH-only funding (standalones) and two grantees with multiple funding streams (HCH plus other Health Center funding) were participants in the case study. The participating quality leaders included Community Health Care, Inc. (Davenport, IA), RiverStone Health (Billings, MT), Harbor Homes, Inc. (Nashua, NH), and Care for the Homeless (New York, NY).

This methodology for evaluating quality of performance is supported by an April 2012 study released by the Kaiser Family Foundation and *USA Today*, which evaluated the performance of community health centers by these chronic disease management measures, as well as others.[15]

To put the performance of the quality leaders in perspective with national public health goals, the 2010 UDS diabetes and hypertension control findings for the top 10 quality leaders were compared to Healthy People 2020's Leading Health Indicators.[16] Healthy People 2020 uses the same indicators for hypertension and diabetes control as HRSA's Clinical Measures specified above, making for a uniform evaluation. In comparison to Healthy People 2020's national goals, the top 10 quality leaders excelled in hypertension control (mean score of 76.9% of hypertensive patients with blood pressure adequately controlled), all surpassing the Healthy People 2020 baseline (43.7%) and Healthy People 2020 target (61.2%) measures. This is a particularly impressive feat considering that Healthy People 2020 is designed for the greater American public, not just special populations, and that grantees surpassed the target 10 years in advance. The quality leaders' outcomes for diabetes control were less substantial (mean score of 19% of diabetic patients with poor A1c control). The target of 16.1% indicates the goal of Healthy People 2020 to reduce the proportion of the population with diabetes with an A1c value GREATER than 9% (which shows poor diabetic control) from the baseline of 17.9%. Therefore, this measure should be low, not high. The goal is to have the number of people in the population with uncontrollable diabetes low, with a target of 16.1%. Presently, the mean score of the quality leaders is 19%, with three of the quality leaders surpassing the Healthy People 2020 baseline and target measures. However, this performance occurred 10 years in advance of Healthy People 2020's goal, leaving time for further quality improvement.

Interview Structure

To explore the organizational practices of the quality leaders, relevant staff persons (medical directors, providers, administrators, and quality/data managers) of the participating grantees were interviewed. In addition to obtaining an organizational overview (including funding, consumer demographics, number of

[11] Diabetes Measure: Percentage of patients aged 18 through 75 years with a diagnosis of type 1 or type 2 diabetes mellitus who had a most recent hemoglobin A1c greater than 9%.
[12] Hypertension Measure: Percentage of patients aged 18 through 85 years with a diagnosis of hypertension and whose blood pressure was adequately controlled [<140/90].
[13] Smallest percentage of patients aged 18 through 75 years with a diagnosis of type 1 or type 2 diabetes mellitus who had a most recent hemoglobin A1c greater than 9%.
[14] Largest percentage of patients aged 18 through 85 years with a diagnosis of hypertension and whose blood pressure was adequately controlled [<140/90].
[15] Galewitz, P. (2012). Community health centers under pressure to improve care. *USA Today*. Retrieved from http://www.usatoday.com/news/health/story/2012-04-17/community-health-centers-care-standards/54360638/1
[16] A comprehensive listing of Healthy People 2020's Leading Health Indicators can be found here: http://www.healthypeople.gov/2020/LHI/default.aspx

patients, setting), the interview structure also incorporated elements of the PCMH and HCH models to procure a comprehensive overview of health center practices. For each PCMH/HCH element, the quality leaders were asked to identify key practices that they believed contributed to their exceptional quality of care and outcomes. The practices identified in this case study are not statistically correlated with the hypertension and diabetes control outcomes used to select quality leaders. However, common themes did emerge among the four grantees, suggesting the importance of the identified practices in supporting quality of care.

The following section, Spotlight on HCH Quality Leaders, provides brief organizational overviews, a discussion of how setting affects health center performance, and finally a summary of the key practices purported to enhance quality of care. Final Lessons from the Field provides a synthesis of the major lessons the quality leaders opted to share with their fellow HCH grantees.

SPOTLIGHT ON HCH QUALITY LEADERS

The following grantees – Harbor Homes, Care for the Homeless, RiverStone Health, and Community Health Care – established themselves as HCH quality leaders and participated in this case study. To provide a contextual understanding of these organizations, a brief description of each is provided below. The following figures were self-reported by the quality leaders during the interview process.

Harbor Homes – Nashua, NH

The Harbor Homes clinic is an HCH standalone that is embedded in Harbor Homes, which provides residential and supportive services to individuals, and their families, with mental illness and/or experiencing homelessness. First funded in June 2009, the clinic was a medical home for nearly 1,000 consumers in 2011, according to the staff persons interviewed. Its consumers are largely young Caucasian males living in shelters, doubling up, and occupants of transitional renting rooms, and are often referred to and from other Harbor Homes residential and support service programs. The housing programs provided by Harbor Homes are integral to supporting the clinic's services.

Care for the Homeless – New York, NY

Funded in 1985 by the National Health Care for the Homeless Program of the Robert Wood Johnson Foundation and Pew Memorial Trust, Care for the Homeless is an HCH standalone that serves persons experiencing homelessness in four of five New York City boroughs. In 2011, nearly 10,000 consumers received services at a total of 35 sites, 22 of which provide primary care. According to the HCH staff persons interviewed, consumers are 68% African American, 22% Hispanic/Latino, and the rest are Caucasian, Indian, East Asian, and other minority groups.

RiverStone Health – Billings, MT

The RiverStone HCH project is embedded within RiverStone Health, the public health department for Yellowstone County. RiverStone Health receives both 330(h) and 330(e) funding, and its HCH program operates at the RiverStone Health Clinic and three off-site shelter clinics (a men's shelter, women and family shelter, and mental health drop-in center). In 2011, nearly 1,500 homeless consumers were served, composed of mostly Caucasian males, with a minority population of Native Americans and Hispanics.

Community Health Care – Davenport, IA

Established over 30 years ago, Community Health Care is the largest Health Center Program grantee in the state of Iowa, having served 962 homeless consumers in 2011. It is a Health Center Program composed of nine sites spanning Iowa and Illinois, including one site specifically designated for homeless consumers. Persons experiencing homelessness can receive services at any site, but they are encouraged to visit the homeless outreach clinic due to the number of resources readily available beyond medical care. Its HCH program provides services to anyone who is homeless, living in a shelter or treatment center, or living on the streets for a period of 6 months at no cost. Minorities compose about 50 percent of the patient population, with the largest population segment falling in the 25 to 44 age bracket.

Setting Resources and Limitations

HCH projects operate in a multitude of settings as a Health Center Program grantee, including hospital districts, public health departments, shelters, mobile units, standalone clinics, and/or together with other health centers. The HCH quality leaders operate in a range of settings, which variedly affect their

performance expectations and capabilities. Major types of settings, and their resources and limitations, are described below.

Within a Parent Organization

Embedded within a larger organization, the Harbor Homes HCH project benefits from the breadth of services its parent organization offers. With permanent supportive housing for the persistently mentally ill, inpatient drug rehabilitation, an HIV taskforce, shelter, residency program for young mothers struggling with addiction, Healthy at Home, and other services, the HCH project can easily refer consumers within its own organization to supplement its health services. Additionally, Harbor Homes has experienced marked growth in total patients since opening just three years ago due to its notoriety and proximity to other in-house programs. One limitation is that the clinic is outgrowing the small office it occupies within its parent organization's administrative building. Additionally, it attracts a large volume of walk-in consumers, which it must sift through to identify those eligible for services.

Branch of Public Health Department

RiverStone Health's HCH project is embedded within Yellowstone County's public health department. This relationship provides a vital link between public health initiatives and hard-to-reach homeless consumers, mutually benefiting the public health department and HCH project. HCH providers are kept up-to-date regarding disease outbreaks and health education initiatives, while they conversely link the health department with shelter contacts and consumers who would otherwise be difficult to engage. Operating within a health center, as well as three shelter sites, allows RiverStone Health to engage a variety of consumers. The shelter clinics attract consumers who don't feel comfortable visiting a large clinic, while the other health center attracts the population segment that does not identify with shelter or street homeless settings, despite meeting eligibility requirements.

Multi-Site HCH Standalone

Care for the Homeless operates from a central model: bring care where persons experiencing homelessness congregate. This mission is reflected by the diversity of settings in which its 35 sites are located, including shelters, streets (mobile clinics), safe havens, drop-in centers, and single room occupancies. Operating where consumers reside encourages a closer patient-provider relationship and maximizes access. Throughout all its sites, a fixed weekly schedule provides consistency for patients and is well-publicized by site administrators and mobile outreach workers. In addition to its static sites, mobile clinics allow Care for the Homeless to reach mobile clients who might not otherwise be engaged. However, the transiency of its consumer population does hinder Care for the Homeless's ability to provide continuous, long-term care – a common limitation for many HCH grantees.

Health Center Program Grantee Network

Community Health Care's HCH project is part of a seven-site Health Center Program grantee network throughout the Davenport area, which includes the bi-state region of Iowa and Illinois. Most sites are not special population health centers, although one is co-located within a mental health clinic, the virology clinic is located in a hospital medical building, and the homeless clinic is located within the Salvation Army Family Service Center. Operating at seven different locations has encouraged Community Health Care to become more organized in its quality improvement program and processes. The clinics used to be more disjointed, but they are now much better connected due to deliberate efforts to share information and revise the operational management structure. It is still a struggle to make connections among providers given the large staff size, which can create a trust barrier for the Quality Department when it distributes its provider outcome evaluations.

Key Practices Promoting Quality of Care

The main objective for studying HCH quality leaders was to identify key operational practices that have contributed to quality of care successes and share them with other HCH grantees. The identified quality leaders have managed to surpass certain Healthy People 2020 targets nearly 10 years in advance. This case study will identify the means in which this high performance is thought to have been achieved, based upon the opinions of the staff interviewed. The content below identifies key practices the quality leaders have utilized to enhance access and continuity; identify, plan, and manage patient care; provide self-care support and community resources; and measure and improve performance.

Enhancing Access and Continuity

A hallmark of the HCH model is a focus on expanded access and inclusivity. This is achieved through a variety of means, including extended hours, walk-in appointments, diverse site locations, mobile clinics, and creative outreach strategies. In addition to their shared commitment to expanded access and outreach, the HCH quality leaders also ensure that their consumers experience provider continuity. Establishing consistent provider relationships has been paramount to building trust and consumer engagement.

Open Access and Responsiveness to Consumers Needs

The model of Care for the Homeless – bring care where persons experiencing homelessness congregate – exemplifies its commitment to expanded access. With 35 service sites, including mobile units, Care for the Homeless operates in convenient locations where consumers are already concentrated. Its consistent schedules are posted at all sites and shared by shelter administrators and outreach workers to ensure consumers' awareness. With an open-access scheduling system, Care for the Homeless tries to schedule appointments within a day.

RiverStone Health offers advanced access, including same-day appointments and walk-ins. Its shelter-based clinics have a walk-in-only policy, having found that consumers responded better to this flexibility than a structured appointment system. Its other health center is open until 7 p.m. and is considering adding Saturday hours to increase access.

Community Health Care increases access to its network of clinics by providing bus tokens to overcome transportation barriers, offering walk-in hours, and holding late night clinics from 5 to 8 p.m. As of June 2012, all of its sites adopted open access scheduling (with an 80:20 hybrid).

Invest in Outreach

Outreach plays a critical role in engaging hard-to-reach consumers in services, which is a fundamental goal of the HCH model. The quality leaders all noted the integral role of outreach in their operations.

At Care for the Homeless, the model of care ensures that all staff – not just outreach workers – participates in outreach efforts. By coming to its consumers, providers are able to engage a breadth of individuals at the places they reside. Care for the Homeless also does extensive outreach at encampments, bridges, and subways, publicizing its services through word of mouth and the help of its site administrators.

RiverStone Health places outreach workers in community shelters to refer consumers to its shelter clinics and other health center. Through a recent marketing campaign, it made special efforts to reach out to the community's newly homeless population, which often lives doubled up or in motels. The campaign publicized RiverStone Health's available resources to those who don't comfortably identify as homeless, but meet the eligibility requirements.

Harbor Homes has an outreach worker in the Harbor Homes shelter to bring new patients into the clinic. This consumer engagement is aided by the clinic's high visibility among the Harbor Homes network of homeless services. Similarly, Community Health Care operates its homeless clinic in the Salvation Army Family Service Center, giving its services greater exposure to those staying in the shelter. Mobile services are also provided to areas deemed "high-need," including a drug treatment facility, where Community Health Care provides complementary primary care services.

Build Continuity and Provider Relationships

The concept of provider continuity is new to many HCH consumers, who have not before experienced a long-term provider relationship. Maintaining consistency in these new relationships is integral in building trust and encouraging engagement.

Community Health Care has recently moved into patient panels as providers go live with the newly acquired EHR. One provider has always been dedicated solely to homeless patients, so empanelment existed for homeless patients long before it was implemented throughout the entire patient population.

RiverStone Health's established provider teams provide great continuity of care for consumers. Upon intake, new patients are assigned to a provider team and primary care giver. In the event that a patient's primary care giver is unavailable, the patient sees a nurse or another member of his or her care team to maintain continuity. Additionally, its shelter sites have staff assigned solely to HCH care.

Care for the Homeless prioritizes continuity by enforcing set site schedules, bringing a high level of consistency and predictability to patients. In the event that a provider is out sick, a strong effort is made to notify site administrators in advance and maintain some sort of coverage at all sites, either by splitting a provider's shift or sending a nurse. In addition to a consistent staff presence, working at sites where consumers reside has allowed for providers to establish closer relationships with consumers. At a soup kitchen site, one Care for the Homeless provider eats lunch on a regular basis with patients, allowing for relationship-building outside of structured appointments.

Harbor Homes maintains such a welcoming environment that consumers often come in for a friendly check-in with staff, unrelated to an appointment. For many, this is the first time they've had a consistent primary care provider or enjoyed such a welcoming health center atmosphere.

Identifying, Planning, and Managing Patient Care

Across the board, the HCH quality leaders relayed the pivotal role their Electronic Health/Medical Records (EHR) played in their performances. From ensuring medical records are accessible across multiple sites to tracking referrals, this technology has proven invaluable to identifying, planning, and managing patient care. Other methods to support these aims include working in informal and formal provider teams, ensuring all visits provide holistic care, and integrating behavioral health care.

Electronic Health Record is Essential

EHRs are used by all of the HCH quality leaders for many purposes, including storing patient records, presenting best practice reminders, running reports to evaluate performance, and tracking referrals.

The EHR used by Care for the Homeless allows for coordinated and continuous care among its 35 sites. Consumers can be seen at any Care for the Homeless site without having to retrieve medical records from a previous provider, as the EHR system is consistent throughout. Additionally, Care for the Homeless utilizes best practice alerts in its EHR, which notify providers of various tasks that must be completed based upon

patient characteristics and medical history (i.e. a smoker is referred to a smoking cessation program, preventive care reminders, etc.). These notifications will not disappear from a patient's dashboard until the tasks are completed.

Harbor Homes staff said their GE Centricity EHR is key to the project's success in achieving quality outcomes. Monthly and quarterly reports are run to evaluate all aspects of performance, including missed appointments, items missing from the protocol for disease management, referral tracking, and HRSA clinical measures. Staff reads through reports and identifies ways to respond, including contacting patients who have missed appointments, following up on missed referrals, and other tasks.

Community Health Care has recently implemented a new EHR system, NextGen, to help facilitate patient management and information sharing and continuity among its 7 sites. The EHR allows labs to be ordered electronically and tracked with greater ease. To augment its EHR system, Community Health Care also uses the Interface to Information (i2i) software to track populations of patients with various diagnoses, including hypertension, diabetes, obesity, and asthma. The i2i software allows for searches based upon diagnostic codes, tracks key measures, and reminds providers when various tests or services are due.

RiverStone Health has used its EHR system, ECW, since January 2009. It has been key to managing its sizeable patient population, giving staff the quick capability of sorting patient data, running reports, and tracking progress on critical health outcomes.

Streamline Referral Tracking and Remain Accountable

Referral tracking is commonly managed through the EHR. Although quality leaders still reported difficulty managing the process – specifically obtaining a full 360 on referrals and collecting provider reports from specialty referrals – the EHR helps improve their effectiveness and accountability. Harbor Homes runs reports monthly to review referrals and follows up to make improvements, including facilitating better transportation to appointments.

At Care for the Homeless, using the EHR to track referrals has prompted providers to become more aggressive and proactive by reminding patients about appointments, providing transportation, and rescheduling missed appointments. RiverStone Health operates in a similar manner, using the EHR to see if patients followed through with their referral appointments, if reports were received following the referral visits, and to trigger follow up with patients and resolve any issues impeding the referral process.

Community Health Care employs a staff person specifically to make and track referrals using a Microsoft Access database. This staff person looks for letters from referral providers to document successful referrals and no-shows, notifying providers of incomplete referrals so that follow-up with consumers can be made.

Work in Collaborative Provider Teams

The HCH quality leaders typically operate in collaborative provider teams, although they do not always meet the formal definition of a care team. RiverStone Health does have the capacity to operate in formal provider teams. Its 36 providers are organized into teams, and upon intake, patients are assigned to a team. At the beginning of each session, the provider and nursing support staff huddle to discuss the needs of the patients coming in, although open communication is encouraged all day. Collaboration is especially prominent at the shelter clinics due to the small staff size and intimate space. In addition to daily huddles, the HCH-only team meets weekly to discuss any concerns or needs for their patients. As a teaching health center with medical residents, provider teams also serve as a means of mentorship, training health professionals for a field that critically needs more health professionals.

For Harbor Homes, having a small staff and facility allows for natural teamwork among providers. Staff has end of week meetings, plus providers discuss patients and plan for visits on an ongoing basis. Similarly, Care for the Homeless does not have formal care teams, but the staff works very collaboratively through weekly team meetings and with the assistance of the EHR, which coordinates communication and the exchange of information throughout the 35 sites. All team members possess high levels of cultural competence and experience with the homeless population, enhancing their abilities to understand and treat patients with complex co-morbidities. Providers use a team-based approach, wherein each team member reinforces care plan goals with each patient. This has been especially effective for chronic disease management. For example, a medical assistant teaches a consumer about how to treat a particular health condition, the health educator reinforces with informative materials on diet and lifestyle modifications, and the provider follows up to see if progress is made. The reinforcement through provider continuity encourages better health outcomes.

Community Health Care recently implemented patient empanelment, so providers are now working in care teams. It plans to implement formal team huddles in the near future as they move to an open access structure, but these meetings are already done informally to discuss the previous day and address what tasks are outstanding. The efforts of care team members are coordinated through the sharing of the provider's daily tasks, allowing for coordination to complete these objectives. The nursing staff is also being restructured to include an RN on each care team to provide patient assessment and teaching components.

Integrate Behavioral Health to Your Best Ability

HCH quality leaders recognized the importance of integrating behavioral health care into their health centers as opposed to reliance on outside referrals. However, most are constrained by limited financial resources, so integration is done to the best of their abilities. At Harbor Homes, patient demand is so great that it cannot be fully met. Even as a new and relatively small health center, Harbor Homes employs a part-time psychiatrist and part-time therapist to provide in-house behavioral health care. These services have proven so popular with consumers that weekly hours have been expanded and still providers cannot take on additional client case loads. As it is, eligibility to see a behavioral health care provider hinges upon already being an active patient with a Harbor Homes primary care physician.

RiverStone Health has full behavioral health integration at all four sites, employing a licensed addiction counselor, case manager, and social worker. Care for the Homeless also ensures that behavioral health staff is available at all 35 sites in congruence with primary care schedules, allowing for mental health referrals to be handled within the provider team.

Behavioral health is available at one Community Health Care site. This site has a counselor on hand to perform pre-assessments and refer consumers to an off-site mental health facility. Behavioral health care is of great need in the community, but these providers are scarcely available. To overcome this, Community Health Care is considering the implementation of behavioral health telemedicine to link patients with these essential services.

Promote Holistic, Whole-Person Care

HCH quality leaders noted their commitment to treating the whole patient and educating clients on healthy lifestyle choices. Care for the Homeless focuses on providing comprehensive care at every visit, going beyond the acute concerns presented. Although their productivity numbers are lessened, their appointments provide more thorough care. A high level of cultural competence and experience –imparted by effective mentorship – allows for providers to treat the whole person and understand a multitude of situational factors and social determinants, which may be impacting health status. For example, many

patients at Care for the Homeless struggle with depression, which providers treat first, in hopes of increasing their motivation to treat other issues.

At Harbor Homes, providers ensure that visits go beyond acute concerns. Although the HCH project cannot currently fund a health educator, its providers are diligent about discussing healthy lifestyle choices every time patients are seen to instill this knowledge. Similar values are imparted by providers at RiverStone Health and Community Health Care.

Self-Care Support and Community Resources

The quality leaders noted the importance of providing self-care support to consumers. Through health education and meaningful consumer engagement in health center governance, these grantees encouraged their consumers to acquire the health literacy skills needed to self-manage their health and become powerful community advocates. Additionally, the quality leaders emphasized the importance of building community partnerships in order to provide more comprehensive care and resources to their patients.

Improve Health Literacy

The quality leaders all stressed the importance of health education in improving the long-term health outcomes of their consumers. To achieve this objective, most of these grantees employ health educators while also ensuring that all providers incorporate health education into each visit.

Care for the Homeless provides much of its health education through interactive group events. One example, Paps for Pocketbooks, is a women's workshop that addresses reproductive health questions in an informal roundtable discussion. These events are held throughout its large network of sites. Care for the Homeless hosts other public health events, including flu shot and Pap smear campaigns, to get consumers engaged and provide incentives for involvement.

In addition to employing a nutrition educator and a diabetes educator, RiverStone Health is also using a similar group approach by creating self-care groups for peer support. A diabetes peer support group is currently in the works to facilitate a dialogue and camaraderie among consumers dealing with diabetes.

Community Health Care employs one health educator, who is shared among the seven sites. The health educator counsels on diabetes, pre-natal care, smoking cessation, and other topics. This education is augmented by provider teaching, which is incorporated into visits. Providers assess patients for any special learning needs and identify preferred learning methods so health education is presented in the most effective manner. As a staff, Community Health Care aims to change the culture of its patient to shift from a pre-occupation with acute health concerns to a more preventive mindset.

Engage Community Partners and Resources

All the quality leaders noted their strong connections to community organizations and resources – an essential way to supplement their services. Having a broad awareness of available resources and the staff to build linkage allows these grantees to provide the necessary connections for consumers, compensating for any in-house limitations.

For Harbor Homes, many valuable resources are available within its parent organization, providing for streamlined referrals to housing and supportive services. Others like Community Health Care look outside for these resources. The outreach staff of Community Health Care is well-versed in the community resources available and tries to connect patients with all relevant benefits, including the Patient Assistance Medication Program, which provides low- to no-cost medications. Community Health Care leads an

outreach meeting twice a month to partner with local social service agencies, develop a synergy among the programs, and identify areas of need and available resources for homeless populations.

To help consumers engage its community partners, RiverStone Health employs a Community Resource Advocate, as well as case managers, to help consumers identify available resources, complete paperwork, and overcome other barriers to referrals and benefits. Strong community partnerships exist with local hospitals, as well as specialty providers, which help facilitate referrals.

Care for the Homeless possesses a number of community partnerships, including those with the Department of Homeless Services, churches, safe havens, Department of Health, local hospitals, and private foundations.

Give Consumers a Strong, Meaningful Voice

Consumers play an integral role in the HCH model, a tenet which is strongly upheld by the quality leaders. These grantees often go beyond the minimum Section 330 federal guideline, which requires that consumers compose a majority (at least 51%) of an HCH project's Board of Directors.

In addition to consumer representation on its board, Community Health Care also places consumers in all of its committees to further their engagement and influence. To obtain consumer feedback, patient satisfaction surveys are done by a third party company and patient satisfaction focus groups are also held to discuss patient experience. Additional focus groups are held to address the experiences of patients with certain chronic diseases, such as diabetes.

Care for the Homeless has two consumer groups, a Consumer Advisory Board and a group for HIV-positive consumers. These consumer groups participate in and coordinate important events, including voter registration drives, lobbying in Albany with HCH staff, peer outreach, World Health Day, and Homeless Persons' Memorial Day. Additionally, consumers participate in annual focus groups to evaluate patient satisfaction, which can often result in substantive changes. Following consumer feedback requesting later hours, this suggestion was honored and resulted in a policy change.

Measuring and Improving Performance

For the quality leaders, data collection and analysis is foundational to their successes. Reviewing process and outcome data, often through provider and organization-wide report cards, allows these health centers to document their strengths and successful practices while triggering policy and operational changes to overcome existing shortfalls. Using an EHR is indispensable to facilitating all aspects of this process. Although each quality leader expressed a unique quality improvement strategy of its own, five major objectives were shared among them: achieving staff buy-in, setting appropriate data measures, helping providers gauge their performance, letting data drive quality improvement decisions, and pursuing national quality recognition.

Encourage Staff Buy-in for Quality Improvement

Community Health Care has experienced a major culture change regarding its quality assessment and improvement by making these processes more transparent and interactive. Its staff has gone from avoiding discussions about what doesn't work to identifying an overwhelming number of areas to evaluate for quality improvement. The Director of Quality has focused on involving all levels of staff in quality improvement projects, helping them understand the purpose of their data collection and evaluation activities. All new hires meet with the Director of Quality to discuss the quality improvement process and orient them to this organizational culture. Buy-in has been achieved on several levels, including its committed, active

leadership; a medical director focused on improving provider performance; policies basing providers' long-term employment on their performance with critical health outcomes; offering provider productivity and quality incentive bonuses; and hiring sufficient staff dedicated to quality improvement activities. Operating seven sites, it is still challenging to achieve buy-in and trust among all staff, but increased transparency and engagement has made this more attainable.

Care for the Homeless said that one of its greatest quality improvement successes is the buy-in that has been achieved among its patients, Consumer Advisory Board, and providers. All these parties are engaged in and supportive of quality improvement activities.

Strategically Set Data Measures

Data collection and evaluation require extensive time and staff resources, so measures should be selected strategically. The quality leaders typically limit these measures to UDS requirements, nationally standardized measures from sources like Healthy People 2020 and Meaningful Use, and carefully identified needs and characteristics within a health center's patient population.

To ensure that the most appropriate data is being evaluated, Community Health Care revisits its measures on an annual basis. Its staff frequently suggests new areas for data tracking, but to be implemented, these must be connected to existing measures used by reputable organizations (e.g. Healthy People 2020) or identified as a critical outcome for patients.

Care for the Homeless has a Quality Management Plan that contains key indicators with goals that are revisited periodically throughout the year. A Quality Initiative Team meets quarterly to ensure that Care for the Homeless is en route to meeting these quality goals. The measures are drawn from UDS requirements, Ryan White requirements, and internal indicators based on their population (some examples include HIV testing, depression screening, and mammogram referrals). Many of their longstanding internal indicators – such as smoking cessation, asthma screenings, and weight control –have since been adopted as UDS requirements, validating that their quality goals have been well ahead of the curve.

Help Providers Gauge Performance through Report Cards and Peer Reviews

A key to Community Health Care's quality improvement process is making outcome data readily available to providers. Providers are given reports on a quarterly basis documenting their own outcomes with patients based on Healthy People 2020, UDS, and Meaningful Use measures, as well as a comparison with peers and a summary of organization-wide performance. They hold provider meetings to discuss where they're at, how they can improve on areas of low performance, set annual goals for critical measures, and decide if they need to start a formal performance improvement project to address shortfalls.

RiverStone Health uses a similar approach with Provider Dashboards, which report on each provider's patient population, including a list of patients with various chronic diseases, their most recent vital statistics, and when they were last seen. Dashboards allow provider teams, especially nurses, to start working their lists strategically to follow up with patients and re-engage them in care. Likewise, this allows for RiverStone Health leadership to know how individual providers are managing their patient populations. RiverStone Health also uses peer reviews as another perspective to assess provider performance.

Care for the Homeless publishes Performance Report Cards for its providers every three to six months, which assess quality measures, productivity, chart reviews, patient satisfaction surveys, peer reviews, and meaningful use criteria. Comprehensive tables are also developed to evaluate organization-wide performance.

Let Data Drive Quality Improvement Decisions

With strong staff buy-in, the quality leaders are sometimes overwhelmed by the number of quality improvement ideas suggested. However, taking on a manageable number of performance improvement projects is vital. To prioritize and organize their quality improvement processes, the quality leaders take varied approaches.

At Community Health Care, all proposed performance improvement projects and new data indicators are prioritized on a matrix by several criteria, including how critical it is to patient care, how critical it is to staff satisfaction, financial implications, and connection to the strategic plan. Those scoring 15 or higher are approved for implementation. Each year, a report is published evaluating the outcomes of the performance improvement projects. One major limitation in this quality improvement process is the high amount of staff turnover, which is common at health centers, where providers go for initial experience. These disruptions in provider continuity can adversely affect the outcome data.

Care for the Homeless uses the Plan-Do-Study-Act model to guide its continuous quality improvement. This model encourages them to stay focused on goals, review the results often, and work together as a group to review patient feedback and make changes.

RiverStone Health employs a continuous quality improvement strategy. Having determined that only basing quality improvement projects on annual UDS reports was too long to wait, staff now meets monthly to evaluate UDS data and identify problem areas. When a shortfall is identified, staff puts a plan of improvement in place to initiate a quality improvement project.

Harbor Homes has a quality improvement board, as well as policies written for its disease management process to guide patient care and ensure quality goals are being achieved. Harbor Homes credits its EHR's reporting capabilities in facilitating continuous quality improvement. Reports are developed with great ease, in comparison to manually collecting data through chart reviews. Comprehensive reports are run and reviewed on a monthly and quarterly basis for all patients, evaluating various chronic disease populations, missed appointments, preventive services, lab and diagnostic results, referrals, and other areas which require action or consideration. The Program Manager follows up with any red flags and shares findings with clinical staff.

Pursue National Quality Recognition

All four quality leaders are in the process of pursuing or have achieved PCMH recognition. The reasons for doing so vary, from wanting to remain on the cutting edge of health care to demonstrating to their patients the high level of care they are receiving.

Care for the Homeless is currently recognized as PCMH Level 1 and hopes to achieve Level 3 recognition by the end of the year. Its first recognition came in 2009. Care for the Homeless pursued recognition because it wanted to demonstrate to its patients that they are receiving the highest level of care, in the context of HCH grantees and beyond.

Community Health Care plans to achieve PCMH recognition by December 2012 to remain on the cutting edge of health centers. With HRSA's encouragement, including funds for the survey, pursuing this recognition was deemed financially attainable. Having Joint Commission accreditation since 1999, Community Health Care foresees an easier recognition process as many PCMH elements are already in place. Some anticipated barriers will be the continuity of care and referral elements.

Currently in the preparation stages, RiverStone Health has chosen to pursue PCMH recognition because its staff believes it is a well-proven model and simply the right thing to do. They want to ensure that all decisions are made for best interests of the patients, not the providers or organization. RiverStone Health plans to apply for recognition in the fall of 2012. Likewise, Harbor Homes has submitted its letter of intent and is making preparations for recognition, including changing provider workflow to meet certain PCMH requirements.

FINAL LESSONS FROM THE FIELD

The HCH quality leaders highlighted in this case study achieved exceptional chronic disease management outcomes in comparison to their peers and even Healthy People 2020 targets. Coming from a range of settings, geographies, and patient populations, these grantees shared diverse perspectives and lessons learned. Based upon their years of experience in the field, they offered the following advice:

- **Ensure that all levels of staff have a good understanding of their patient population.** Care for the Homeless recommends that staff possess a high level of cultural competency and knowledge of persons experiencing homelessness, including the great diversity within the homeless population (such as differences among sheltered, street, and safe haven homeless). Awareness of social determinants of health and employing effective communication strategies are some ways in which cultural competency can augment quality of care.
- **Be open-minded in their outreach efforts, looking beyond the more visible segments of the homeless population.** RiverStone Health stresses that not all consumers eligible for HCH services are comfortable identifying as homeless or even realize their eligibility. This has been the case for the newly homeless in the Billings, Montana area, who are commonly doubled up or staying in motels. In addition to typical outreach efforts, RiverStone Health recommends targeting less visible segments of the homeless population with specially designed strategies. Their targeted marketing campaign, which utilized graffiti-style posters that clearly stated eligibility requirements for HCH services, helped increase awareness in this under-engaged community.
- **Based upon a key tenet of the HCH model, approach each patient as a whole person through the consideration of medical, behavioral, and social service needs.** The quality leaders recommend looking beyond acute concerns, integrating health education that covers preventive and lifestyle changes into each visit. Although this comprehensive approach may lower productivity, the returns in quality of care are well worth it.
- **Invest in building strong relationships with their patients.** Many HCH consumers have never experienced provider consistency at a medical home and respond well to this newfound trust and support. According to Harbor Homes staff, its focus on building provider relationships has yielded exceptional patient engagement in treatment.
- **Encourage staff to work in integrated provider teams.** These do not have to meet the formal definition of a care team, but utilizing a team approach can improve staff satisfaction, efficiency, and quality of care. Each team member serves an important, complementary role, providing advice and support to fellow providers. This arrangement can also facilitate reinforcement through provider continuity, according to Care for the Homeless. Providers should have their goals and messaging aligned so that consumers receive consistent guidance on how to manage their health. From medical assistants to physicians to health educators, all parties should be on board with a care plan.
- **When treating patients with complex needs – a common issue for HCH grantees – address the most significant problem first.** Treating patients with complex co-morbidities can be overwhelming, but Harbor Homes recommends that providers gradually "chisel away" at a patient's most prevailing problem first, and then gauge the patient's level of engagement from there. Without sufficient effort and interest on behalf of the patient, his or her outcome will be hindered, regardless of a provider's efforts.
- **Be very persistent in reviewing their data.** With the aid of technology like EHRs, evaluating process and outcome data can be done with greater ease. Harbor Homes recommends that grantees take advantage of these capabilities, running reports on at least a monthly basis to see good results. Of course, also act on these reports, investing in practices that are yielding strong results and altering areas that are falling short.

- **Strive to obtain staff buy-in to encourage their ownership of the quality improvement process.** This was especially essential for Community Health Care given its multiple sites and large staff. By opening the process to all levels of staff, explaining the why and how, and welcoming any suggestions for new data indicators or performance improvement projects, staff became more engaged and trusting in the quality improvement process. Providers should also be continuously informed of their own performances so they can improve on an individual level, supplementing the organization-wide improvement activities. This requires grantees to invest in quality infrastructure, ensuring their improvement efforts are properly supported by designated staff.