ANNALS OF FAMILY MEDICINE

Online Supplementary Material

Rittenhouse DR, Schmidt L, Wu K, Wiley J. Contrasting trajectories of change in primary care clinics: lessons from New Orleans safety net. *Ann Fam Med*. 2013;11(Suppl 1):S60-S67.

http://www.annfammed.org/content/11/Suppl_1/S60

Supplemental Appendix 2. Reflections on the Context of Our Study of New Orleans Safety Net Clinics

The system that provided care to safety net populations in pre-Katrina New Orleans was almost totally destroyed by the hurricane. Within 2 years, the federal government invested in the rebuilding of medical care for poor and uninsured citizens through the Primary Care Access and Stabilization Grant. This grant provided core funding for safety net medical care and special incentives for rebuilding the system of primary care based on the patient-centered medical home (PCMH) model. A subsequent Beacon grant, ongoing as of this writing, funds the development of a health information network to link primary care to safety net providers of hospital and specialty care. When the Primary Care Access and Stabilization Grant ended, a Medicaid waiver created a mechanism for supporting some of the clinics that had been funded under that grant.

Our study focused on 5 organizations, 3 supporting multiple clinic sites that were among those farthest along in the implementation of PCMH. Leadership in some of those clinics had begun implementing PCMH processes before Katrina and before the federal funding. Although they varied in size, ownership, and structure, all 5 organizations had leadership fully committed to reconstructing primary care in New Orleans guided by a PCMH model. Two organizations were supported in part by private money that allowed them to make practice changes over and above what would have been possible with federal grant money alone. Two others are part of large academic medical centers that provided a steady supply of physicians in training as clinicians. Even with leadership committed to PCMH as a model for care, funds from private sources, and support from parent organizations, however, all 5 clinics faced common barriers to full implementation of the medical home paradigm. These barriers included (1) the difficulties of treating large numbers of uninsured persons in unstable living circumstances with multiple problems that complicate and sometimes overshadow needs for medical care; (2) the need to rebuild clinic sites that were damaged by Katrina; (3) inherent difficulties in implementing PCMH processes that would likely arise in situations far more advantaged than post-Katrina New Orleans, for example, creating a system of care management that integrates clinicians from several different disciplines; and (4) the uncertain sustainability of funds to support care of the uninsured.

Note: One author (J.W.) completed this appendix.