The Medical Home Digest is a newsletter devoted to keeping you informed about medical home transformation in the safety net. This newsletter is brought to you by the Safety Net Medical Home Initiative, which is sponsored by The Commonwealth Fund. Each issue highlights critical aspects of patient-centered care and PCMH transformation.

From the Principal Investigator

The Safety Net Medical Home Initiative recently released two sets of materials that aim to support efforts to enhance the performance of leaders in safety net practices striving to become patient-centered medical homes. The first is a guide for members of health center boards of directors (Engaged Leadership: How Health Center Board Members Can Support Medical Home Transformation). The second is a compendium of tools, resources, and training programs to assist people leading PCMH transformation efforts (Engaged Leadership: Resources for Leaders).

One of the lessons we have learned (or actually, re-learned) during the course of the SNMHI is the extent to which successful transformation is tied to the presence of engaged leadership at all levels of an organization—from front office supervisors to board members. Indeed, “engaged leadership” is the first, foundational element of the eight change concepts that have guided the SNMHI. The earliest SNMHI practices to achieve NCQA PCMH Recognition began the initiative

continued
with higher assessment scores in the leadership domain (as measured by the PCMH-A instrument) than did other practices. Practices with high leadership scores have typically fared well in achieving progress in other PCMH implementation areas (e.g., empanelment or team-based care). Among practices that have struggled, staff often reported less engaged leaders, or significant turnover among leadership. Conversely, practices that made significant progress tended to have leaders who communicated a vision about the future, supported staff involvement in the redesign process, and devoted time and resources to making changes.

In a June 2012 article in the journal *Primary Care*, the SNHMI team reviewed the evidence supporting each of the 8 SNMHI change concepts. We found evidence that, while leadership support is important for any initiative, direct and meaningful involvement of top and middle-level leaders is often the most critical factor in successful clinical system redesign efforts. Clinical practices are complex, adaptive systems, and the changes required to become a PCMH often entail significant changes in practice culture and individual roles. Because of this, the challenges leaders face in PCMH transformation go far beyond the usual demands of incremental change in stable systems.

Among the topics addressed in this edition of Medical Home Digest are the role of measurement in supporting quality improvement, the importance of engaging patients and families, and methods of managing supply and demand in primary care practice. Success in all of these domains is contingent on strong leadership support, and we hope that the recently released SNMH-I resources are useful tools for PCMH transformation leaders.

The first thing an organization must do to establish a culture of quality improvement is choose a formal model or strategy for quality improvement. Measurement is a key component of any quality improvement strategy. This article provides ideas for how leaders can mobilize staff to measure their performance and use data to drive improvement in the context of Patient-centered Medical Home (PCMH) transformation.

Important performance measures for PCMH practices include: clinical quality, patient experience, provider/staff satisfaction, and office practice efficiency. These performance measures provide valuable information to leaders and staff about the way their practice organizes and delivers healthcare. This information can help leaders and care teams identify opportunities for improvement and implement solutions. Because PCMH practices organize and provide care for populations of patients, these data should be collected at the population level.

Yet many people who work in healthcare are accustomed to seeing and thinking about patients one at a time. The challenge becomes: how do we appropriately manage a group of patients, also known as population or panel management? One step is to study aggregate information. We may aggregate population data in the following ways:

- by patients with the same provider care team,
- by patients with a specific chronic condition,
- or by patients who are eligible for specific preventive services.

Organized in the above manner, population or panel management reports show performance measures by provider care team and/or all patients with a specific clinical condition or those patients who received preventive care services based on age-appropriate guidelines. Multi-disciplinary teams should discuss which measures are pertinent based on evidence-based clinical quality measures, practice transformation efforts, patient experience goals, and provider and staff expectations.

It is also important to think about the various audiences in your practice. Common audiences are board members, clinic leadership, providers, and staff. Each of these audiences will have different perspectives and will likely ask different questions about the measures. Table 1 is an example of a set of measures by audience.
Table 1: Examples of Types of Measures of Interest by Board or Staff

<table>
<thead>
<tr>
<th>Audience</th>
<th>Clinical Quality</th>
<th>Practice Transformation</th>
<th>Patient Experience</th>
<th>Provider/Staff Satisfaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Board Member</td>
<td>Diabetes Care Bundle¹</td>
<td>Reduction in Avoidable Emergency Dept Visits</td>
<td>Overall Patient Experience²</td>
<td>Retention Rates</td>
</tr>
<tr>
<td>Leader</td>
<td>Diabetes Care Dashboard</td>
<td>Call Management Dashboard</td>
<td>Patient Experience Survey Summary</td>
<td>Provider/Staff Satisfaction Survey Summary</td>
</tr>
<tr>
<td>Provider / Clinical Care Team</td>
<td>HbA1c control</td>
<td>% of Chronic Care Patients who have timely Planned Care Visits</td>
<td>Continuity</td>
<td></td>
</tr>
<tr>
<td></td>
<td>HbA1c testing</td>
<td></td>
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<tr>
<td></td>
<td>Foot Exams</td>
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<td></td>
<td>Eye Exams Etc.</td>
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<tr>
<td>Clinical Care Team and Other Staff</td>
<td>% of Patients with Diabetes invited to come for a Planned Care Visit</td>
<td>% of Patient Phone Calls resolved on first contact</td>
<td>% of Patients with Assigned Care Team</td>
<td></td>
</tr>
</tbody>
</table>

The reference to dashboards in the table above refers to a visual display of performance indicators that quickly communicate the “health” of the health center in terms of parameters which are critical for its success. Dashboards are like the instrumentation panel of your business, where various gauges indicate performance. This term is derived from the cockpit dashboard which not only enables pilots to monitor the flight, but also maneuver it.

Table 1 represents a mature, sophisticated set of measures. When health centers begin to establish measures, they should start small and build.

After considering which measures are most useful to the people in the organization, think carefully about how to display the data so that you communicate your message efficiently and effectively.

Dr. Scott Endsley³ provides a tool for building a healthcare instrument panel in his article "Putting Measurement into Practice with a Clinical Instrument Panel." You may download and modify this simple Excel tool to support the measures specific to your own organization. Dr. Endsley’s dashboard uses run charts to display clinical quality measures over time so all staff can see progress and opportunities for improvement. Run charts are a simple approach that allows staff to gauge whether the changes they’re making result in improvements. For this reason, run charts are a great tool for making data actionable! For more information on run charts, review the article by Perla et al.⁴
Next, carefully consider how to disseminate the dashboards in such a way that people across the organization are drawn into action. Many board members, leaders, and other healthcare employees receive data packets or have quality data on the agenda at monthly meetings. While these approaches are important, they are not sufficient at "mobilizing the troops" or engaging staff to make changes. Measurement walls are used at many healthcare organizations to post daily, weekly, and monthly measures for staff, patients, and families to see. Posting measures in high-traffic areas, lounge or break rooms, and even the back of bathroom stalls has been effective at communicating the importance of achieving the measurement goals of the organization. Additionally, some sites have offered trainings, for example, “Quality Data 101,” to train staff on the organization’s measurement strategy, how to read and understand run charts, and what their role is in improvement.

Again, data packets do not necessarily have to be a bad thing. Asking the following questions as the data are being reviewed can be very effective at engaging the staff:

- When will we feel good about the care we are delivering? What is our goal?
- What are the data telling us? What do these data say to you?

Further:

- How confident are we that the data accurately reflect care being provided?
- Do we care about this measure? If so, why?
- Are the data all over the map or bouncing around? If so, is the denominator size sufficient?
- Are we seeing a steady increase in performance over time? If so, what did we do that worked?
- Are we seeing a steady decrease over time? If so, what changed?
- How can we make these results better?
- Is the way we display the data helpful?

Having measurement systems, dashboards, and/or data packets are not enough. Using these tools to energize staff to engage in quality improvement is how change happens. Knowing your audience, visually displaying data in an efficient and effective way, and dialoguing with staff, patients, and families frequently will draw all to the common goal of improvement.

1. Diabetes Care Bundle measure: percentage of eligible patients with diabetes who received all recommended diabetes care; HbA1c testing, foot exams, eye exams, lipid profile, etc.
2. Overall Patient Experience measure: percentage of patients responding “My care team gives me exactly the help I want (and need) when I want (and need) it.”
Spotlight: Keeping the Patient Voice at the Center of Care

An interview with Juliette Schlucter

Juliette Schlucter is a nationally recognized consultant, trainer and speaker passionate about supporting the partnerships between healthcare professionals and the patients and families they serve. As the parent of two chronically-ill children, Juliette brings to her work a sensitive consumer voice coupled with a strong business and healthcare organization perspective. For more information, please see full biography at the end of the interview.

We all share a commitment to providing the best care possible and to keeping the patient at the center of our model, but are we actually engaging the patients and their families as partners?

Engaging patients and families in improving the quality of care ensures that system changes reflect the needs and priorities of patients and providers in the medical home. This engagement removes the burden of administrators and clinicians making assumptions about what the patient really experiences, values, and needs, and, in both formal and informal ways, is the key to ensuring that system changes reflect the needs and priorities of those who deliver and those who receive care in the medical home. It acknowledges that system demands, challenges, and priorities be transparent and validated as part of an overall solution.

Primary care practices in the Safety Net Medical Home Initiative (SNMHI) have been working on many fronts to implement the patient-centered medical home change concept, yet many still find it difficult to engage patients and families in making these changes truly patient centered. What factors engender a patient-centered culture?

The most important factor is to create opportunities to partner with patients and their families, not only in their own care, but also in the system design and implementation of care. This can be a challenge because the practices are embracing so many changes, and it becomes hard to prioritize where to place limited resources and energy. The key is to get started in small ways to create early success, and use those successes to build a sustained patient-centered culture.

It’s good to prioritize the many possible projects and early on choose some clear home runs that affect the patient experience directly. This gives clinicians an opportunity to become more comfortable working with patients and families as advisors. Working with visible successes and bouncing ideas off of patients and families not only gets the team comfortable with collaboration, but helps patients and families new to the advisory role.

As your patient advisor programs grow, it’s important to resist making assumptions about what affects patients. As a young mother receiving care for my two chronically-ill children 20 years ago, I had a birds-eye view of the healthcare system. From my point of view, everything had an impact on them as patients. Patients and families bring rich experience and input about what clinicians may think of as behind the scenes, so it’s vital not to assume or limit the areas in which you may think patients’ input will be valuable.
What are practical ways to keep the patient voice at the center of care delivery?

Much of the work in engaging patients and families in improving the quality of care has been developed in inpatient settings, where face-to-face contact is more frequent and sustained. There are real challenges to adapting this work for ambulatory care practices. The essence of this work, and our promise to patients and their families, is that their voice be at the center of our efforts. It is about always looking for ways to be informed by those who experience care in our settings. Whether it is in the waiting room, lab, or exam room, the following questions are simple, but rarely asked of patients:

- Is this working for you?
- Were there any difficulties in getting here; in finding us; in gaining access to your health information; do you have everything you need?
- Are there concerns or questions unasked?
- How could we make this process better?

Staff experience is also central. All of our staff—front line, office workers, managers, clinicians, housekeepers, and leaders—have a wealth of information, ideas and solutions. Staff witnesses the barriers and successes of the patient experience every day. But they too may rarely be asked, “How can we make this better for the patient? Is this system, form, policy, or program working?” Once asked, be prepared to really listen to the answer.

The reason effective partnering with patients and families is difficult often has little to do with good intentions, and more with how busy our days are. Since that is not likely to change soon, my hope is that as part of this paradigm shift leaders see the value in creating a culture where we are always asking, “How can we keep the patient voice at the center”? The Patient and Family Centered Care system-wide improvements implemented across the country illustrate that by asking these questions we remove barriers and improve outcomes.

Involving patients in quality improvement efforts means including them in discussions of care delivery challenges. What can teams do to begin sharing these difficult conversations with patient and family advisors? Will patients really trust us if we let them know what our problems are?

Administrators and clinicians should know that it is of great benefit to the organization to say, “Help us do this better.” This creates a culture of transparency where leaders and staff acknowledge that something’s not working perfectly. For many patient care experiences, the fact that something—a policy, program or care approach—is not working well is the elephant in the room. Patients and families see what is not working, sometimes long before we can see it. I would want everyone to have the faith to take the leap of opening the process respectfully, and saying, “Help us do this better.” Our experience has been that patients and families want to work with providers and staff to make improvements. It frees us from the pretense that all is working well.
Many patients and family members don’t have the time to attend meetings. How do teams work with this barrier?

This issue is especially true in safety net environments. Expecting patients to travel long distances for meetings or to meet during the workday may be unrealistic. This constraint forces us to think creatively. We have to be very sincere about wanting their help. Patients, when asked sincerely and when they feel their contributions are going to make a difference, do take part because they feel they are integral to the improvement.

Patients may resist involvement because we haven’t done a good job in explaining why we need their help, what they can do to help, and what we are going to do with their input. We need to be very clear about their time commitment, what the purpose is, and how they can help. These strategies help overcome some of the hurdles that may keep patients from participating. We can also use technology, conference calls or Skype, so that patients need not leave home to participate. We need to be flexible in our approach. It may be more practical to have a more ad hoc approach at the point of care in the medical home, so that we capture the unique and valuable perspective of patients and families.

Safety net clinics serve many patients with low-health literacy and from diverse languages and cultures. How have organizations assured that their voice is heard?

Independent of the busy, complicated lives of our patients and independent of their culture, literacy level, or socio-economic status, patients and families want some very basic things; they want to know that:

- they are respected and valued,
- we listen to their concerns,
- we validate their healthcare experience,
- we tell them the truth,
- we are providing the best care possible and are ready to openly share decision-making with them.

We can ask simple questions of patients to get to these answers for each of our patient populations. We can acknowledge that, for many, because of their time limitations, the distance they live from clinic, or other cultural and language challenges, the best way for them to participate as advisors is on an ad hoc basis when they come to the Medical Home for care. Patients appreciate that their opinion matters. To hear the diverse opinions of our many patients and families we might need to provide tools or translation services for them to contribute and share their thoughts.

When we openly share with patients whose voices have been underrepresented that we are making improvements, that we need to learn from them, we have had great experience with their desire to contribute. Once again we have to be creative, to strive for opportunities for meaningful dialogue. We are all familiar with patient satisfaction questions. The challenge with them is they are rather one-dimensional questions; they provide some much needed basic assessment data, but we need to begin a dialogue with patients to really move to excellence in patient- and family-centered care.
As an example, perhaps the patient satisfaction question challenging the clinic may be “I feel that my care is well coordinated”. One approach would be to openly, transparently share with patients and families that the Medical Home wants to improve intra-team communication and care coordination. You might put signs about this in the waiting rooms in the top languages you serve. You might ask two to three basic questions that get to the core of this satisfaction challenge. What would make it work better for you when members of your team have information to share with one another? What are your ideas to make your care more coordinated? You may, on the busiest of clinic days, when many patients and families are there, offer for them to stop by for coffee and fruit and snacks to talk with you about how to improve communication between the team to improve their care.

How can teams assure that they are doing more than giving lip service to patient input?

This is a real danger as Patient and Family-Centered Care has become a buzzword for healthcare marketing. I think the best way to keep honest on this is for everyone on the Medical Home team to ask this simple question: Have we asked the patients and families?

If we are making changes at the system level and we haven’t been informed directly by the patient and family experience, then we simply are not patient and family-centered. We get the patient and family perspective from asking, “Is this new care plan or new registration process working for you? What would you do differently?”

A good indicator that you are really valuing patient input is to share those change efforts and highlight them for the broader community. Outwardly sharing that the changes were made because you asked!

Imperative as it is that we make patient experience central to improving healthcare, the moral imperative is that, as leaders of change in the patient-centered medical home, we make clear the link between putting the patient voice at center and improvements in quality and safety. The nation is so poised to include the patient voice now, because of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) and other patient experience measurement. We need to ensure we connect the dots for our communities so they understand that their input is central not only to the improvement of their experience and satisfaction, but also to the quality and safety of their healthcare.

Juliette Schlucter Biography

For 19 years, Juliette served on staff and as a consultant to The Children’s Hospital of Philadelphia to advance patient and family-centered care. With professionals at The Children's Hospital of Philadelphia, Juliette created the Family Faculty, an award-winning program in which parents teach healthcare professionals about patient and family-centered care. She wrote and developed Partners for Excellence, a workbook and workshop to teach patients and families about using healthcare resources effectively. Juliette created and served as lead author of The Promise of Partnership, a toolkit used to teach healthcare professionals best practices for patient and family-centered care. The Institute for Healthcare Improvement chose The Promise of Partnership for its Open School module on patient and family-centered care. Among the honors she has received is the Gene Stanford “Power-of-One” Award from the Association of the Care of Children's Health, which recognizes the ability of one individual to bring about significant change in the field of children's healthcare. Since 1996, she has served as faculty and consultant for the Institute for Patient and Family-Centered Care; teaching and working with healthcare leaders and front-line staff across the United States and Canada.
Group Health Cooperative’s Patient-Centered Approach to Managing Phone Calls

An Interview with Erika Fox, Director of Lean Improvement and Promotion, Group Health Cooperative

Group Health Cooperative was an early leader in PCMH Transformation. One important part of Group Health Cooperative’s improvement process was finding a better way to respond to patient phone calls. The following interview describes Group Health Cooperative’s approach to handling patient phone calls and demonstrates the importance and benefit of being responsive to patient needs.

What is the name of the phone system you use? Why did you choose it?

We use Direct Connect, which we heard about from Kaiser Colorado. We like it because it allows the standard menu routing to making an appointment, but also then allows patients to directly reach their care team by typing in their member numbers.

At the care team level, with the appropriate programming, the system allowed us to come up with a pretty sophisticated routing hierarchy. For example, when Nurse Suzy logs in to take phone calls, she gets calls from the patient panel with whom she works and has a relationship.

How did you set up the answering hierarchy? What was the rationale for the hierarchy?

Group Health set the answering hierarchy up so that the staff person most likely to be able to meet the patient’s need gets the call first. So if the doctor is logged on, he or she will get the call.

This hierarchy was a major change for us. We used to do all of our phone work through a batch and queue system. The front desk staff would take messages and then route them to the appropriate person. I think we did this because we thought it was helpful triage and that it protected doctors.

But in reality, when we asked patients, they said, “if I call, I want to talk to you and have you help me resolve my issues.” These patient specifications are a major part of the Lean journey and were a big turning point for us. When we started looking at first time call resolution, it was 0%. Patients could not possibly get a clinical question answered on the first call; they had to leave a message.

After hearing from patients, we started looking at the data, and found that not answering the calls and resolving them the first time actually resulted in a tremendous amount of downstream work. When they couldn’t get their question answered, we found that patients would call back and make an appointment, or call back four or five times and leave multiple messages, or go to urgent care. It added a tremendous amount of work into the system.

And we weren’t collecting any sort of standard data from the patients when they did call, so doctors or nurses wouldn’t have the capacity to answer the question when they returned the call. We found on average 2.8 hand-offs per message because it wasn’t clear who was needed to resolve the question. Now we’ve outlined key information that should be taken in the event that first time resolution isn’t possible.
But the doctor can’t staff the phones all day, right?

It was never our intent to have the doctors answer all the calls. The doctors are logged in for the least amount of time to the system; remember, they only get the calls routed to them when they’re logged on. But the point is, when they are logged on, the system will route incoming clinical calls to them first. Patients are always delightfully surprised and amazed when they reach their doctor and have never abused that.

So who staffs the phones?

This is really about the team taking accountability for the care of a panel of patients. The LPNs are logged in all day. They have the major responsibility for answering or finding answers to patient questions. But the RNs log on about an hour a day and provide coverage, and the Medical Assistants (MAs) are also a ring of defense, meaning that when call volume is high, they log on to provide support, too.

How did you come up with this way of organizing the system?

Are their scripts or tools that you used?

We follow a Lean methodology. So as part of that work, we do rapid process improvement workshops. That means that we collect patient input. In this case, that patients want to get their questions answered right away. We also collect data to see if there is a gap between what our patients want and what we’re doing. Obviously with a 0% first time call resolution, we had a lot of work to do. Then, we have an initiative sponsor who lays out the vision for this work. This is where the idea to have the person who is most likely to meet the patient’s need should be the preferred person to receive the call. After that, all the folks involved in the phone system get together to figure out how to do this work. As the front line staff, they know best how to operationalize it. That work included assigning roles, scripting, and so on.

This was a pretty major design and implementation. Leaders and facilitators did eight weeks of preparation before the Rapid Process Improvement Workshop (RPIW), and then we got 35 people in a room for a week from 8 am to 5 pm and asked them to figure out every detail. Once we had a standard process and method, the implementation wasn’t Herculean.

What were the biggest challenges you faced?

Without leadership, you’re sunk. It was important that leaders really held the patient perspective and were able to tell the story about the importance of getting questions answered. It was also very important to get as much frontline input on the how as possible. The sponsor sets expectations and lets teams figure out how they’ll do it.

Another big challenge was provider buy in—to get them to actually log in and take the calls. I think it was 10% early adopters, 40% majority, and 50% active resisters. In healthcare we have the idea that demand is infinite and we have no control over it. And that is just false—call management is a mechanism to shape demand. Patients were getting booked in appointments when they didn’t need to. After a while, folks started realizing, “If I actually resolve this call, I won’t get three other calls and two text messages and a patient who shows up in the Urgent Care.” It was part of the culture change—of practicing medicine differently, to realize that patient demand includes in person, on the phone, via e-mail, in the Urgent Care and ED.

It was also essential to have the ‘team-based’ care thing going on. We started the medical home by co-locating the nurses and pharmacists into the pods with the physicians. Having that line of sight was helpful so folks could just go ask the doctor, or say “I’ve got the pharmacist right here” who could answer a question. But it was more than co-location. We had to really stress that everyone was responsible for caring for the panel of patients however they came into contact with the team. So if you can resolve the issue on the phone, you must resolve it. It can’t be about taking a message and passing the buck. We really increased the level of collaboration. The idea now is the doctor and care team comes around the patient for their clinical care—and they all work together on behalf of the patient. This is true for calls and visits and everything else.
So where should a team start with the phone system?

We spent a tremendous amount of time talking about the menu options, ordering, and scripting. We visited sites and asked what other groups did. We collected data. We got so hung up on this first step—hashing and rehashing the menu and the wording—and honestly, it didn’t really matter. In the vast majority of cases, the menu options were not the problem. If I were to offer advice to others, I’d say, just set up a simple system that connects patients to their care team with the right routing hierarchy and get started.

If you want to think about menus and scripting, the most useful approaches we used were:

1.) Using data to set the menu order – 75% of calls were for appointments, so that was number one. You press 4 to access your care team with a clinical question, and then enter your member number. That was all based on understanding why people were calling.

2.) Ask patients for wording choices. Instead of spending time debating “doctor’s office” versus “provider” or “care team,” just asking the patients what made the most sense was the best.

3.) Finally, and I think this is a cultural thing, you all have to share the perspective that setting up the phone system is meant to facilitate patient access to the provider and care team. You have to assume good intent and work to facilitate the patients’ desires. It’s amazing how many folks assume that patients will try to manipulate the system or skirt the rules, and this just hasn’t been the case, nor is it a helpful perspective when trying to promote this kind of change.

What about providing service in multiple languages without causing menu fatigue (for callers) or misrouting calls to staff that don’t speak the patient’s language of choice?

We don’t have a great way to deal with this. I’m sure there are other organizations that have figured this out.

How do you balance patient access with provider time?

Striking the right balance involves figuring out the amount of time a given team member spends “logged on” to the phone system. We calculated the times of peak phone demand for the clinic and asked that most people be logged on then. Then we based the amount of time each person spends logged on to the size of the panel and their licensure. So, for example, a panel of 2,000 patients means the doctor needs to be logged into the phone system for 20 minutes per day and the peak hours are 8 to 10 am and 1 to 2 pm, so he or she logs in during those time periods. The LPN does have responsibility to log in and manage the phones and e-mails because that’s the core of his or her job. But an LPN can’t answer everything, so MAs are expected to log in as a second ring of defense. They get paged on the overhead if there are a lot of calls coming in and they need to get on the phone. I think the RNs have a standard of an hour a day. This all varies from clinic to clinic based on its size and complexity. Basically, I think the key is using the data to set these expectations. We first started by manually collecting data on volume and reason for calls. Now we use the Call Management System, which is a data system behind the phone system that captures the data. Managers can pull custom reports and it is their job to balance phone access with visit scheduling. It has to be a team effort where some roles are defined and others are more flexible, but everyone has a role.

If I actually resolve this call, I won’t get three other calls and two text messages and a patient who shows up in Urgent Care.
What about using patient identification to route calls to care teams (how often does that work? is it a barrier)?

We experimented a lot with this. Basically, if you don't know your member number, there is an 'opt-out,' so you press 0 and it takes you to the patient care representatives (PCRs), who mainly do appointment scheduling and other administrative duties, who can help route you to your doctor's office based on name and other characteristics. We also set it up so that if you didn't enter your member number within 2.5 or 3 seconds, the phone system automatically connected you with the PCRs on the premise that you didn't have or couldn't find your number. At the beginning our force out rate was about 25%. Then we did some patient education. We showed patients where their member numbers are on their cards and talked about how they could connect directly with their care team if they knew that number. Now that rate is much lower. The key, of course, is that you have to have patient panels so that the number actually takes you to the right physician's office. If you don't have a primary care doctor and enter your number, it routes you to the patient care reps who ask you what you need and, if appropriate, assign you a doctor.

Do you have dedicated provider and RN call-in hours for patients (for example, phone visits)?

We do have the ability to set up phone visits.

What about responding to voice prompts from callers?

Our system is based on the keypad. It doesn't take voice prompts; it's only number pushing. It's possible the system has that capacity, but we didn't use it.

How do you measure traffic and demand?

First of all, managing the phone isn't about avoiding in-person visits. It's about the elimination of re-work and inappropriate usage (such as urgent care) and reducing patient wait.

With that in mind, our best measures are:

1.) First Call resolution. When we started we were doing manual review to see how long patients waited to hear back. We had some calls that went up to 10 days without a response, which is just totally unacceptable. The original goal was call resolved within two hours. Now it's about first time call resolution.

2.) Percentage of calls answered. It's amazing, but there were times during business hours when the staff would turn off the phones. We really had to challenge that – when we're open, we should be available to patients. So now we make sure to measure how many of the calls get picked up. After all, the first thing you have to do is answer the phone.

3.) Percentage of calls answered within 30 seconds. This helps us know if we have peak times of demand when patients aren't able to get through in a timely way. If we see lots of people getting bumped back to the patient care representatives who wanted to talk to their care team, we know we need more team members logged in during those times.

What about using texts to respond to phone questions?

For us, it's always about first call resolution. Most of the calls that can't get resolved on the first pass are usually complex enough to need a call back. The way a patient contacts us is the we respond, though honestly, I think it is more important that the patient knows what is going to happen (for example, "we'll call you back in an hour, or we'll text you by the end of the day") than the mode used to communicate.
Matching Supply and Demand in a Primary Care Practice

Manage the Panel Size

Once a practice has empaneled all their patients and can track how many patients are being seen by each team, they can move on to managing the panel size. Murray and Tantau developed a simple formula for calculating ideal panel size that can be adapted to each practice based on the practice characteristics (visit expectations, standards of care for return visits, migrant vs. established population, etc).

Managing supply and demand for visits within a practice requires regular monitoring and adjustment as well as building the workflows and infrastructure to support the process. To successfully match supply and demand for visits, there are several key elements to consider.

After setting an ideal panel size, it is important to manage new patient volume to that panel size. Providers can take a different number of new patients depending on how full they are. This helps distribute new patients evenly, allows practices to know when they need to think about hiring new providers, and helps to even out the workload across teams.

Streamline the Schedule

Common wisdom used to be that if you wanted to make the ideal schedule, all you had to do was predict how many patients wanted to come in for which services and create space for all those types of appointments. This type of thinking is what led to schedules with well child checks on Thursday afternoons, well woman exams on Friday mornings, and one urgent slot every day at 10 am.

Don’t worry about getting too precise here... you will always have variation between new providers (no vacation) and very established providers (lots of vacation). Know that this equation will be right for the majority of providers and adjust separately for those special cases. PS. Many practices use 210.

Can be average per provider, team, clinic, or practice type – whatever makes the most sense in your setting

Solve for panel size

Days in Clinic per year x Visits per day (productivity) = Average patient visits x Panel Size per year

Total visits available in a year

Total visits patients create

Murray and Tantau equation with graphic from CareOregon’s Patient and Population Centered Primary Care Curriculum
While these rigid types of systems make it easier for some patients to get in (and can make provider days more predictable), it makes it access more difficult for the average patient and more frustrating for schedulers. Instead, limiting the types of appointments available frees up the schedulers to put patients in where it is most convenient for them, taking them less time (so they can help other patients in the queue!). It also provides more flexibility for patients and their families.

When looking at schedules, it is also helpful to make sure that there are enough appointments on the schedule to get to needed productivity goals while still compensating for the no-show rate. So, if a provider needs to see 18 patients per day and their no-show rate is 10%, 20 patients will need to be scheduled in order to achieve the target.

Use Data to Monitor and Adjust

Measures that help a practice understand supply and demand – productivity, panel size, average patient visits per year, no-show rate, continuity, and access – change regularly. They change with seasons, staffing, with implementation of the medical home and need to be monitored regularly. Consider including these types of measurements in dashboards or other regular reporting mechanisms and teach clinical teams and leaders what to do when they see the numbers changing.

Here’s an example:

<table>
<thead>
<tr>
<th>Data Change</th>
<th>Actions to Consider</th>
</tr>
</thead>
</table>
| % no show increasing | • Are reminder calls/letters/texts being made? Can someone on the team take on that activity?  
• Are appointments being scheduled out further than normal? Identify the cause of the access issue and work with leadership to correct. |
| % time patient sees own PCP decreasing | • Review scheduling policy with scheduling staff – that appointments are always offered on the PCP/practice partner schedule.  
• Consider working with scheduling staff to develop scripts for patient phone call scenarios and post at each work station.  
• Check to make sure provider wasn’t on vacation during the reporting time.  
• Review provider panel size – are they over paneled? Consider slowing the number of new patients on the provider’s schedule. |
| % time PCP sees own patients decreasing | • Review scheduling policy with scheduling staff – that appointments are always offered on the PCP/practice partner schedule.  
• Review provider panel size – are they under paneled? Consider ramping up the number of new patients so that the panel fills and can stabilize. |

Conclusion

Managing supply and demand requires regular monitoring and adjustment. Practices need to build workflows and invest in infrastructure to support the process of scheduling patient appointment. To successfully match supply and demand for visits, remember the three key elements: manage the panel size, streamline the schedule, and use data to monitor and adjust.
The Role of the RN in Direct Patient Care

In most health centers, the role of an RN is often limited to immunizations, triage, and secretarial tasks. Getting RNs "off the floor" and into direct patient care, either acute visits or patient education, has been a challenge.

Union Square Family Health Center, part of the Cambridge Health Alliance in Somerville MA, is one year into a new initiative designed to allow registered nurses (RNs) to work at the top of their license. This initiative has moved the RN role to that of care manager, tasking them with the chronic disease management of their team's patients through direct patient visits and patient education. Most floor duties, including immunizations, pharmacy, and medication requests, are now accomplished by a licensed practical nurse (LPN).

As care managers, RNs spend most of their time doing direct patient care with a focus on their scheduled team's high-risk care management patients. RNs have been trained in patient activation techniques and track patient goals using flow sheets available to the care teams through the Electronic Medical Record. In contrast to their previous focus on immunizations, RN visits focus on disease management, such as teaching patients about glucometer use, when to take which medications and how to refill them. Increasingly, RNs have found themselves able to begin to address the root causes of patients' poor health—often poverty, literacy, and housing—with close collaboration with onsite social work. All RNs have attended motivational interviewing trainings and continue participation in additional educational programs, such as hypertension management.

The care management work is supported by site and organization leadership with bi-weekly multi-disciplinary case conferences. Bi-weekly RN educational meetings are regular events featuring topics like depression or diabetes management and include guest participants drawn from the local pool of specialists at Cambridge Health Alliance. Regular care team meetings with special attention to the highest risk patients ensure that communication flows across the patient care teams.

The addition of direct patient education by the care teams, led by the RN care manager, has supported patients in their chronic disease self-care. This innovative and patient-centered program has resulted in immediate improvements among our diabetic patients: an increase in the number of patients with completed diabetic RN visits (42%), a decrease in HgbA1C for patients who completed RN visits (from an average of 8.5 to 8.0) as well as a decrease in LDL (average 108 to 100mg/dl).

No significant change in these metrics was observed in the general diabetic population at our site during the same time period. Process measures for our patients have improved to goal levels during this time however, including annual screening ophthalmologic visits and routine diabetic laboratory tests.

<table>
<thead>
<tr>
<th>HgbA1C Average</th>
<th>LDL Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.0</td>
<td>110</td>
</tr>
<tr>
<td>8.5</td>
<td>105</td>
</tr>
<tr>
<td>8</td>
<td>100</td>
</tr>
<tr>
<td>7.5</td>
<td>95</td>
</tr>
<tr>
<td>2011</td>
<td>2012</td>
</tr>
</tbody>
</table>
This reorganization of duties reinforced existing care management successes as the increased patient contact with RNs strengthened patients’ connections to the teams. RNs were able to maintain previous care management successes in depression outreach using workflows inspired by the IMPACT model, with 42% optimal patient contacts and 37% of patients with at least a 50% decrease in PHQ9.

The shifting of RN time from typical floor duties, like triage and refills, to direct patient care with a focus on chronic disease management, has shown early promise as a model for team-based intervention. Improved glycemic and lipid control in diabetic patients who attended at least one RN teaching visit, and process measure improvement for the entire diabetic population are likely to yield benefits for years. RNs have embraced their new roles, enhancing their skills and competencies in chronic disease management while maintaining previous gains in depression management.

<table>
<thead>
<tr>
<th>LDL Average</th>
<th>60%</th>
<th>50%</th>
<th>40%</th>
<th>30%</th>
<th>20%</th>
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<tr>
<td>2010</td>
<td>30%</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>2011</td>
<td>40%</td>
<td>30%</td>
<td>20%</td>
<td>10%</td>
<td>0%</td>
<td></td>
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</tr>
<tr>
<td>2012</td>
<td>50%</td>
<td>40%</td>
<td>30%</td>
<td>20%</td>
<td>10%</td>
<td>0%</td>
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</tr>
</tbody>
</table>

Optimal Contacts 50% Reduction in PHQ-9

The objective of the Safety Net Medical Home Initiative is to develop and demonstrate a replicable and sustainable implementation model to transform primary care safety net practices into patient-centered medical homes with benchmark performance in quality, efficiency, and patient experience. The Initiative is administered by Qualis Health and conducted in partnership with the MacColl Institute for Healthcare Innovation at the Group Health Research Institute. Five regions were selected for participation (Colorado, Idaho, Massachusetts, Oregon and Pittsburgh), representing 65 safety net practices across the U.S. For more information about the Safety Net Medical Home Initiative, refer to: www.safetynetmedicalhome.org.