Beaver Falls Primary Care
Primary Health Network

Beaver Falls Primary Care is part of the Primary Health Network—the largest community health center in Pennsylvania.

The Primary Health Network, a federally qualified health center, provides quality primary care services and access to specialty care commensurate with the needs of the people in the communities we serve. We offer comprehensive primary health and subspecialty services that include complementary and integrative medicine programs. Behavioral health, obstetric, and dental services are co-located within our site.

SNMHI Team:

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Star Brown, MOA
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Melba King, FOA
Jessica Carmen, FOA

PARTICIPATION

What motivated your practice site to participate in this initiative?
Our site opened in 2009 and has one physician as the primary care provider seeing patients three days a week. Being able to track acute and chronic diseases, treat them effectively, and refer appropriately to a team provider, enhances the probability the patient will follow through with their care. The belief is that the practice of patient care and continuity will increase the level of treatment the patient receives and reduce costs across the board. The newness of the health center site provided an opportunity to implement the PCMH model. It was an ideal site to pilot the work of transforming into a patient-centered medical home and to transfer the learnings to other sites within the network.

SAFETY NET MEDICAL HOME INITIATIVE					
CLINICAL REPORTING Template					
SECTION B. TRIMESTER OF ENTRY INTO PRENATAL CARE					
		Number of women with first visit to center in each trimester	Number of women with first visit at another provider in each trimester	Total number of pregnant women	Percent of women entering prenatal care in each trimester
Line 7	First Trimester			0	#DIV/0!
Line 8	Second Trimester			0	#DIV/0!
Line 9	Third Trimester			0	#DIV/0!
SECTION C. CHILDHOOD IMMUNIZATION					
		Total Number of children with 2nd birthday during measurement year and at least one medical encounter during reporting period.	Number charts sampled or EHR Total	Number of children Immunized**	Percent of children immunized
Line 10	Children who have received required vax and who have had 2nd birthday during measurement year				#DIV/0!
SECTION D. PAP TESTS					
		Total number of female patients age 21-64 with at least one medical encounter during the reporting period	Number of Charts Sampled or EHR Total	Number of female patients tested	Percent of women receiving pap
Line 11	Number of female patients 21-64 with at least one Pap performed this year or in previous two years				#DIV/0!
Data taken from UDS Report Table 6B					

SMOKING ASSESSMENT					
		Number of patients age 18+ who had tobacco use status documented at the most recent visit or within the previous year	Number of Charts Sampled or EHR Total	Total number of patients 18+	Percent of patients receiving smoking assessment
	Smoking assessment				#DIV/0!

EFFICIENCY MEASURES				
		Number of appointments where patient did not show during the reporting period	Total number of appointments scheuduled during reporting period	No show rate
	No show patients			#DIV/0!
	Wait time until 3rd available appointment		Wait time (in days) until each provider's third available new patient appointment	

CHANGES

Change One: Supporting care delivery teams in improving operational efficiency and quality of care

We created a data-collection tool to enhance site-specific improvement opportunities. We knew that data collection is an important component of the work done by the SNMHI and can inform the team of valuable changes necessary to improve care. We had no process in place to support data collection at the Beaver Falls site. The team struggled with how to begin collecting the data in a more meaningful way.

One of the successes of the team was to develop a quality improvement strategy by creating a data tracking form which obtained healthcare measurements on all of our patients.

Plan: The goal of obtaining needed healthcare measurements data was identified at our site. Currently UDS tables and Centricity reports are used to identify this information throughout our network; however, being part of a large network spanning over several counties it is difficult to indentify data specific to our site. Therefore, our goal was to find a way to identify and collect these needed measurements specific to our site to better inform our care team.

Do: A data-collection form was developed to identify the needed measurement information in regards to the following: race, hypertension, smoking, diabetes, HgA1cs, Pap smear testing, mammograms, prenatal care, and immunizations. This form is placed on each patient's chart by front office staff and is completed by clinical staff and the provider.

Study: This form was easy to fill out and accepted by clinical staff and the provider. It allows us to collect the needed data on the identified health measurements. The data collected from these forms are placed into an organized Excel spreadsheet to allow for easy accessibility of the needed measurement information. It also gives the provider and team a snapshot of certain key data points that can better inform care during the visit.

Act: The data collection was adopted into our daily practice and is being used to gather the needed information on the identified health measurements. The form is color-coded to make the form stand out in the paper chart. Blue for last year, purple for 2011.

What would you recommend to other sites trying to make a similar change?
Proactive data collection leads to more effective reporting. It adds greater real-time meaning for the care team in utilizing the data to look at all aspects of providing care to our patients. We developed an Excel file to input data from the paper document. This makes it easier to pull and track data. We learned that by using a team approach, it was easy to identify a need, implement a process, measure the success and barriers, and act upon the findings.

Change Two: Improve patients' healthcare experiences and reduce disparities in access to care and quality of care

The care team became concerned over a dramatic increase of new patient appointments for chronic pain management due to a local pain clinic closure. The provider and MOA staff discussed the complexity of providing effective and safe care to this patient population. With the provider's guidance, the care team developed a process map and implemented an action plan within weeks of identifying this problem. Staff and the provider communicated on how to handle the phone calls and requests. It was decided that the physician will see the patient once whose chief complaint is in the form of pain. If the physician deems necessary, a prescription will be given in addition to a referral to another pain clinic for chronic pain treatment, thus ensuring that the proper medical management is maintained.

As a result of implementing this policy and procedure, there was a decrease in the number of appointments requested. Our daily schedule displays the office visit reason (like chronic pain) and a referral log indicates where, when, and the outcome of such referrals.

Providing the patients and staff continuity of care also increased productivity and satisfaction:
- Quicker response time to phone calls
- Partnering with patients to be actively involved in chronic pain management

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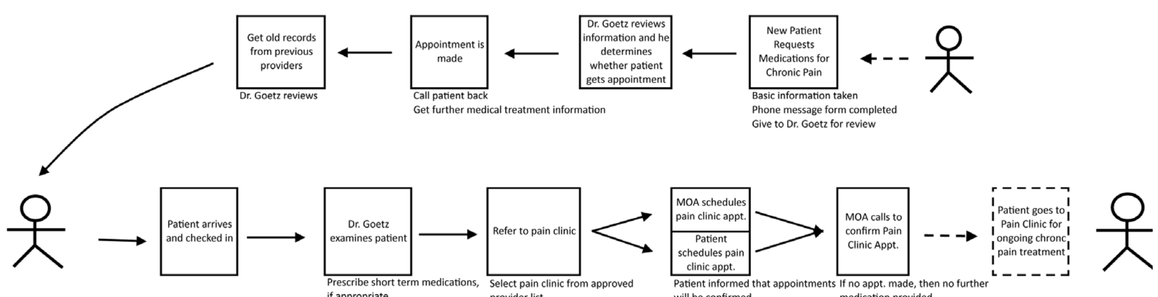
Change Three: Improve patients' healthcare experiences and enhance continuity

The number of calls being addressed in a timely fashion was less than efficient, thus causing a low level of contact for the patient. We did two things to improve this situation. We introduced new answering machines for calls, and we created a procedure for calls 'in line' to roll over to other FOAs for pick-up.

Our learnings from this include:
- The faster patient response time increased their satisfaction and decreased their stress level. The immediate access to communicating with a staff member or rapid response to the patients' calls is vital to the practice's census.
- Patient hold time decreased, thus increasing their satisfaction due to response time. The patient is often able to been seen on the same day of call or the very next office day.

Recommendations to others:
- Enabling the patient to leave a message if needed increases productivity because the patient's chart may be pulled and information reviewed prior to returning phone call. Clinical improvement is that the patient's chief complaint is addressed on first communication; therefore the ability to schedule or refer is addressed as soon as possible



PATIENT IMPACT

"As an MOA, I have found that this has impacted the patients by making them more aware of this being a medical office and not a pain clinic. Also, I feel that the patients will receive the proper care if chronic pain is the issue, by receiving treatment at a facility that deals with chronic pain." — MOA

"Working in multiple areas of the offices, the new process of addressing the phone issues has proved to make the patients happier—and the quality of care, in terms of time, has certainly been improved." —FOA

"The patients' stress level is low, and they tend to communicate with the staff more effectively in their needs when they are taken care of in a timely fashion."—FOA

PROVIDER OR STAFF IMPACT

"The quality of work has improved. The steady pursuit of excellence in patient care has increased and the anticipation of this form of patient care being spread to the entire network is exciting. The product we deliver to our patients will surely increase our quality and commitment to obtaining future goals." —MOA

Safety Net Medical Home Initiative

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THE COMMONWEALTH FUND
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