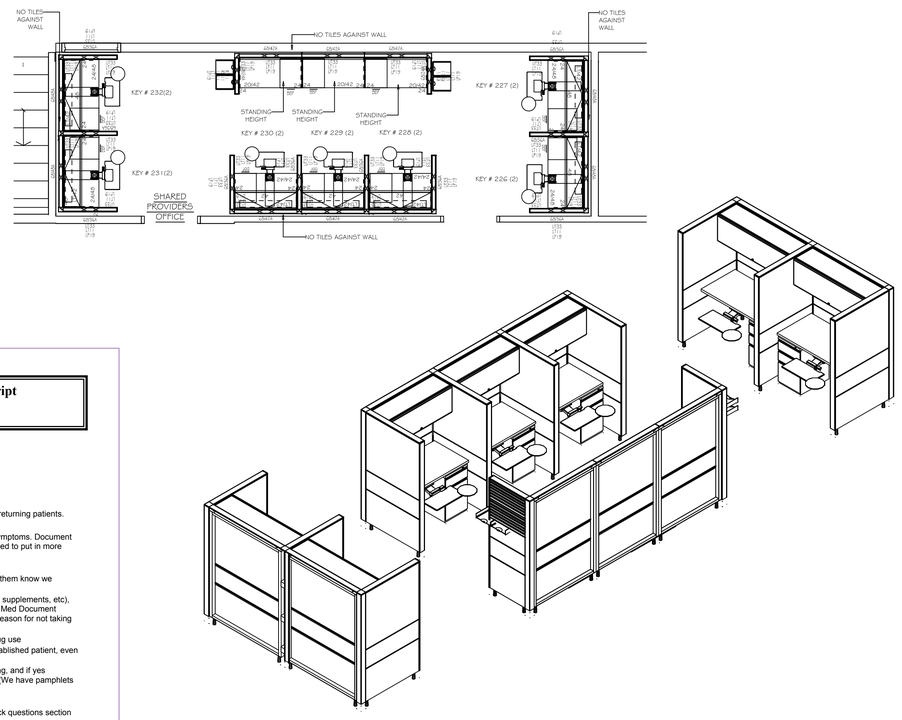
Benton County Health Services

We have four clinic sites in two counties—
- Benton County: Corvallis, South Corvallis, Monroe
- Linn County: Lebanon

Our main Corvallis Community Health Center is integrated with the local health department, "Benton County Health Services." We work on mental health, public health, health promotion, environmental health, and developmental disabilities.

We serve approximately 6,900 clients per year. Twenty one percent of our clients self-identified as Latino; 63% of our medical and mental health clients are uninsured.

Teams are easy to put together but need fostering to get to be a functioning unit. Remember to include the patient in the change process, so they know who their team is.



PARTICIPATION

What motivated your practice site to participate in this initiative?

We participated because it's the right thing to do. With a healthcare system in crisis it's evident that something needs to change and the underlying principles of the Patient-Centered Medical Home are the right ones for the future. Moving from responding to health problems to preventing them, engaging patients rather than treating them, relying on a team rather than one person being the 'provider,' makes perfect sense for a new model and is most likely to produce increases in patient and staff satisfaction.

CHANGES

Change One: Formation of Teams

What was the specific problem or issue being addressed?
We had a need for coverage due to the fact that many of our providers are part-time. With the development of teams, we created a system to provide the needed coverage for patients.

What did you hope to achieve by making the change?
We wanted to increase continuity of care for our patients, increase access to care when a provider is out, and provide a timely response to patient needs.

What was the plan for making the change?
Teams were formed by pairing part-time providers to provide full coverage throughout the week. They were also formed by specialty of care: primary care, pediatrics, women's health, etc.

What did you learn from the process of making the change?
Need to be organized from the very beginning and have management support. Teams are easy to put together but need fostering to get to be a functioning unit. Remember to include the patient in the change process, so they know who their team is.

What would you recommend to other sites trying to make a similar change?
Keep on the path. It may be rocky at times but hang in there. Have management's support be visible to staff all along. Encourage staff throughout the process.

Change Two: Empanelment

What was the specific problem or issue being addressed?
Our care was not patient-centered. Patients were being seen by whoever was available, and most patients did not know who to ask for when they called in with questions. Front desk receptionists were not sure whom to send a patient calls.

What did you hope to achieve by making the change?
We wanted patients to know who their team is and teams to know who their patients are. With identified patients, reports can be run through the Solutions program, so teams can work on improving healthcare outcomes for their patient panels.

What was the plan for making the change?
Members of our team stepped up to the plate and divided up the providers. Panels were cleaned-up to show active patients who were identified as anyone who has been seen in the last 18 months. If a patient had seen multiple providers, the provider seen most frequently was assigned as PCP. Patients that were under the heading of 'urgent visit,' and had been seen more than 2 times in last 18 months, were assigned to a PCP. We had to switch some patients. We had one 78-year-old assigned to a pediatrician; several patients that had always seen one doctor but were assigned to another.

Panel sizes were determined for providers using a formula that takes into account their FTE and practice type. All providers know what the maximum number of patients are for their panel, and panels are closed if they reach that number.

What did you learn from the process of making the change?
The upfront process was very time consuming and labor intensive, but the outcome was well worth it! This is also an ongoing process that has been added to the teams with no addition of hours or staff to do the work, so keeping the panels up-to-date will be challenging.

We currently have one team member running monthly reports on the unassigned patients seen at all the clinics; she is assigned as PCP in the EHR if missed by the front staff. Each team has the responsibility of dropping patients that have not been seen in 18 months. Pro-actively they can now call patients that are getting close to being dropped from panels and get them in to be seen.

Teams are taking the responsibility of running reports to improve healthcare outcomes for their panel. One team is focusing on getting young women that started the HPV series back in for next immunization. Another team is working with their diabetic patients to get them back in for diabetic lab work and visits with their PCP if patient has not been seen for over three months.

What would you recommend to other sites trying to make a similar change?
Stick with it; the benefits are worth it. What starts out looking like a 1,500 piece puzzle that has been dumped on the table, turns out looking like a beautiful seascape. Although pieces continually get knocked out, it is easier to see where the pieces fit the closer the puzzle is to being finished. It is exciting and rewarding seeing the teams taking ownership of their panels and starting to focus on proactive care. Ongoing support and training is always needed.

COMMUNITY HEALTH CENTERS OF BENTON AND LINN COUNTIES
POLICY-PROCEDURE MANUAL

SUBJECT: **HEALTH NAVIGATOR STANDING ORDERS:** Scheduling Lab and Provider Appointments for patients with Diabetes

SECTION: CLINICAL **PROGRAM: PC / WCH** **PAGE: 1 OF 1**

HEALTH CENTER DIRECTOR: Sherlyn Dahl **DATE: 8/26/10**

MEDICAL DIRECTOR: Charlene Clark, MD **DATE: 8/26/10**

REVIEWED BY & DATE:

PROGRAM DISTRIBUTION: Primary Care, Women and Children's Health

POLICY:
To support continuity of patient care through the use of a Health Navigator who will work with diabetic clients on finding their unmet needs to allow better management of their disease.

OBJECTIVES:
1. To establish a process for diabetic clients.
2. To better manage and track diabetic clients.
3. To offer a source for service information for diabetic clients

PROCEDURES:
A. Run solutions report to find identified diabetics
B. Determine last visit regarding diabetes diagnosis
   1. If last provider visit was greater than 6 months but less than 12 months, HN will:
      a.) Contact the patient to schedule appointment for the following labs:
         i. Diabetes Protocol A
            1) Hemoglobin A1c
      b.) Notify lab technician who will order labs
      c.) Schedule a Provider appointment for one week following the lab appointment.
   2. If last Provider visit was equal to or greater than 12 months, HN will:
      a.) Contact the patient to schedule appointment for the following labs:
         i. Fasting Diabetes Protocol B
            1) Hemoglobin A1c
            2) Lipid panel
            3) Microalbumin Screen
      b.) Notify lab technician who will order labs
      c.) Schedule a Provider appointment for one week following the lab appointment.

Attachment: Health Navigator Scheduling Algorithm

HEALTH NAVIGATOR STANDING ORDERS: Scheduling Lab and Provider Appointments for patients with Diabetes
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NEW PATIENT VISIT:
- Go over health history form, and document info in EMR using History Tab on left side EMR
- Medical history would be pulled from health history form positive answers for self
- Surgical history input use your best guess for the operation, the provider can correct
- Family medical history
- Family history and status
- Social History substance use as above for every visit
- Sexual history for men and women (as much specific information as possible)
- Spouse's name, occupation, number of children, etc. all go into social history
- ADL and other concerns: input "Personal concerns" results from health history
- Input "Year You Had Last" health maintenance info by adding to the problem list "Preventive Health Care" as a problem, and in the text box put in dot phrase: .HMM for males, and .HMF or .HMW. for females, and tab or hit F2 to get to each *** to fill in the info. If patient has not had these, indicate none in the table.
- Immunization (Pneumovax and tetanus), it should be put in as historical in the immunization section
- For Women Only enter in the MA progress note as dot phrase .FFO or .FWO

PENDING ORDERS:
- If patient is requesting an immunization, put the order in under order entry section and pend the order for the provider.
- If the patient is requesting a refill, pend the med refill order for the provider, and include the request in your nursing note.
- Eventually the MA will help pend health maintenance orders and labs as well.
- Go to Best Practice Alert Tab, and pend orders for recommended immunizations, etc.

Change Three: Medical Assistant Script

What was the specific problem or issue being addressed?
We have 12 medical assistants working at our four sites. Each had a unique way of putting information in the EHR and rooming patients. This made it very difficult for the providers to find information they needed, and it made filling in at other clinics or departments difficult. We needed a way to get everyone on the same page.

What did you hope to achieve by making this change?
We wanted uniformity among the medical assistants. We needed a way to find the information in the EHR that was necessary. We needed the medical assistants to feel comfortable filling in at other clinics or in other departments.

What was the plan for making the change?
Our plan was to come up with a way to make what the medical assistants do more effective and efficient. We wanted to give them the tools and resources to make what they do more uniform. We talked to several of the medical assistants and providers, and received good input on what was important and needed in the EHR. This was at least a three-month process. After gathering all the information, we sat down together and sketched our first draft of the medical assistant script.

What did you learn from the process of making the change?
The most important thing we learned was that there were a lot of people involved in this process who had good ideas. We also learned that there are a lot of different ways to do the same thing, which made doing this even more of a priority. There were many drafts after our first, and there is always going to be room for improvement. We also learned that the providers are trainable as well, so a provider script was created to guide them in process of closing a patient encounter.

What would you recommend to other sites trying to make a similar change?
Initially, we were getting information from many. We soon realized it was important to have a few key people in this process to gather the information and make sense of it. Plan for training. Follow-up is important to make sure that the script is being used correctly.

Primary Care Medical Assistant Script

Document Completed:
Document Implemented:

INTRODUCTIONS:
- Greet patient upon reception from the waiting room.
- Introduce self, title and provider working with.

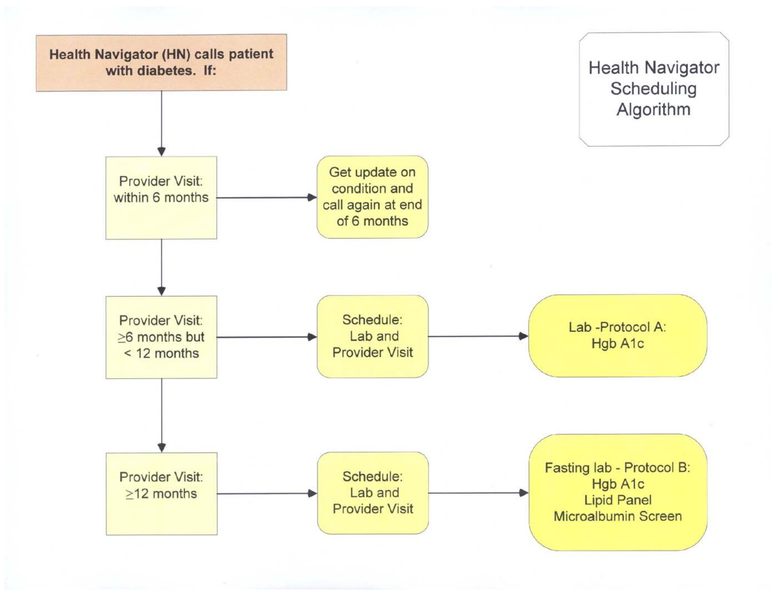
EACH VISIT:
- Measure height and weight on all new patients, and weights on all returning patients.
- Verify name, DOB, and allergies.
- Get chief complaint/reason for visit, and how long have they had symptoms. Document this in chief complaint section and in an MA progress note if you need to put in more information (not nursing note).
- Get vitals BP, pulse, RR and temperature.
- Thank them for bringing their meds in if they did. If they did not, let them know we request they bring their meds to each visit.
- Review all medications (prescription and over the counter vitamins, supplements, etc), and enter them into EMR if not already present. This is done in the Med Document section. Go over medication list and mark meds taking; document reason for not taking the meds they should be taking.
- Tobacco use, second hand tobacco exposure, alcohol use, and drug use
  - This needs to be done at every visit, even if they are an established patient, even if they are a non user of tobacco
  - If a user they need to be asked if they would like help quitting, and if yes document information given to patient in comment section. (We have pamphlets and info we can give to patient)
- Verify and document in EMR pharmacy of choice.
- Select patient area (7 - primary care, 1 - family planning) in the quick questions section in EMR.
- Document LMP for all premenopausal women
- If complaint includes shortness of breath, chest pain, asthma, or they have cardiac or pulmonary history, get SaO2 (there is a charge for this, so pend an order for this off

Medical Assistant Script

Document Completed:
Document Implemented:

FAMILY PLANNING:
- Check immunization section to see if client has had HPV vaccine, if not provide information hand-out
- Choose appropriate dot phrase under BCFPMA to fill out:
  - BCFPMAAnn cc: Ann (350) – FP annual/initial exam needing contraception
  - BCFPMABirthContolMethod cc: birth(209) – Contraception including ECP, IUD insert, oral contraceptive pills, Nuva ring, OrthoEvra patch, diaphragm, depo, condoms and spermacide
  - BCFPMASurveillance cc: birth(210) – Contraceptive Management (evaluation) for pills, ring, patch, depo, or diaphragm
  - BCFPMAIUD cc: IUD – check management or removal
  - BCFPMAPGTest cc: preg –pregnancy test

- GYN Primary Care Visits seen in Family Planning
  - BCFPMAWell cc: An(418) – well woman exam not needing birth control examples: women with history of tubal ligation, hysterectomy, ovaries removed or are post menopausal
  - BCFPMASTI cc: sex(950) – STI screening
  - BCFPMAInfection any symptoms: abnormal vaginal discharge, irregular bleeding, or pelvic pain
  - BCFPMApPap cc: pap(16) – Abnormal pap. Repeat Pap due to history of abnormal pap
  - BCFPMABreast cc: (124) – lum; (125) – pain; (126) – breast problem



HEALTH NAVIGATOR STANDING ORDERS: Scheduling Lab and Provider Appointments for patients with Diabetes

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PATIENT IMPACT

"Since we have transitioned to the patient-centered medical home, I've noticed a huge increase in the preventive health issues that are being addressed. I've been here for two and a half years, and I've scheduled more mammograms in the past few months than ever before. Paps, flu and pneumonia shots, chronic disease follow-ups, and labs are now in the 'health maintenance' section of our EMR which brings it right to the provider's attention.

We now have a health navigator coming once a week to follow up on our diabetic patients who need labs or need to get reacquainted with their provider. It is making a huge impact on patient care. I don't know how family practice clinics function without them or a care coordinator. The care coordinator position is very important to the overall care of the patients. They are the ones that piece it all together!

Our patients now know who to ask for when they call the office which seems to make them feel more comfortable speaking with us." —Medical Assistant, Team Lead

"Having been involved in this process for a year, we are starting to see the benefits. I am the medical assistant for a very busy part-time provider, and I have been involved in work with the scripts, panels, and establishing teams. We spent quite a bit of time working out the wrinkles and finally putting this in to action. It was nice to get things organized. Having a way to make the information in the EHR easier to find is beneficial to both the patient and the provider. The most exciting part to me was establishing teams. There have been some really good ideas and a lot of work done inside the teams to show our patients what we really want for them. We have established key roles and some very basic responsibilities. It is interesting to see and hear how our patients are responding to this. After only a few months, I am hearing only positive comments. They say it is easier to get an appointment, they have more contact with the people on their team, they are getting return calls quicker, and they feel cared about here. This is a process that I see only getting better and more efficient." —Medical Assistant, Team Lead

PROVIDER OR STAFF IMPACT

"I'd like to comment on the positive impact that the team meetings have had on my work experience. I have attended many meetings where there's moaning and complaining about all of the things that go wrong and need to be fixed. Although the team meetings initially were off to a bumpy, lurching, awkward start, I feel like we are now on a roll. We have been identifying some challenges and then been able to problem-solve through sharing. Most exciting, we've tackled a 'panel management' goal, and it's been lovely to see some team members rise to the challenge both with enthusiasm and skill. Our first project is identifying all the girls who started HPV vaccines and getting them in to finish the series. This process is very rewarding. I think it demonstrates to all of us that we are able to provide really excellent service and follow-through. Our biggest challenge will be trying to meet our goals and visions with the limited number of staff and resources that are at our disposal."—Family Physician, Team Leader

"I'm very pleased with the transition I see with staff becoming more engaged in their work, motivated to try different things, and excitement in 'owning' their work. This model seems to help promote that better than the 'old rules' way. I also think the team model supports efficiency and enhances the likelihood of patients being successful in making meaningful changes in improving their health."— Health Center Director

"The guidelines and expectations are straightforward which has lead to a streamlined process for staff. The transformation—the formation of teams in particular—has made it easier regarding the coverage when a provider is out. As a supervisor, I have noticed the staff feel more empowered in their positions, and the patients are more empowered in their healthcare."—Manager of Patient Services

Safety Net Medical Home Initiative

QUALIS HEALTH

THE COMMONWEALTH FUND

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