Geiger Gibson Community Health Center

Geiger Gibson Community Health Center is located near Boston's harbor on what is called "Columbia Point" and serves over 6,000 unique patients. We give them access to a wide range of medical, dental, behavioral health, and social support services, including Family Medicine, Pediatrics, Podiatry, Dentistry, Behavioral Health, Optometry, Social Services, On-site Laboratory, and soon, an On-site Pharmacy.

SNMHI Team:

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Geiger Gibson serves a diverse patient population:

- 24% Hispanic, 29% Black, 45% White, 4% Asian
- 58% of patients are women and 20% are children
- 35% of our patients speak Spanish as their primary language; 5% speak Vietnamese
- 72% of our patients are below the 200% Federal Poverty Level

We were the first community health center in the country. In 2009, we began studying how to improve patient care – especially how to routinely do a better job of helping patients coordinate their care. In the past, care coordination and case management occurred primarily as a result of grant funding. When the funding ended, the intervention ended.

PARTICIPATION

What motivated your practice site to participate in this initiative?

Geiger Gibson was motivated to participate in this initiative to find ways to structurally and routinely provide care coordination and other 'between visit' services such as clinical pharmacy medication management consults and group classes on nutrition or other health education topics. Because of the high number of patients with type 2 diabetes, we decided to refocus our efforts on how to best and most quickly improve our delivery of care to these patients. Geiger Gibson's participation in the SNMHI is led by its Medical Director, Dr. Sam Ambewadikar, and occurs in partnership with the University of Massachusetts Boston School of Nursing, Northeastern University School of Pharmacy, and the American Diabetes Association.

> Our team-based approach helps us to better integrate support staff within the organization.
> —Diabetes Team Champion

CHANGES

Change One: Improved patient access to the clinic.

We experimented with an open access schedule in 2009. We sent postcards to patients explaining how we were switching to having more slots open each day for same day access. We wanted to accommodate the patients' needs more efficiently and to reduce no show rates. The concept was welcomed by many patients, and we did improve our same day access and scheduling, but we could never reduce the backlog to go to a full open access system. In addition, many patients just did not get the concept, and did not want to let go of having a scheduled appointment.

Therefore, we looked at other ways to improve access and found there was a bottleneck in our phone system. Our front desk staff had to register patients and take calls for scheduling while simultaneously play switchboard for the rest of the health center staff. We installed a new phone system (CISCO IP) that allowed us to quantify call volume by day and hour, and then we used this information to set up a "Call Center" to handle all incoming calls. The Call Center is staffed by two patient access representatives who triage calls without patients standing in front of them. This frees up the front desk staff. The Call Center is physically located next to the Triage Nurse who is able to answer many patient calls and questions and handle many of the prescription refill requests immediately. This reduces the number of messages for other clinical staff, and gives the patients better service.

The Call Center staff and nurse also make proactive outreach calls to our diabetic patients who need to schedule an appointment with their primary care provider or with Podiatry, Optometry, Clinical Pharmacy, or Dental.

> Diabetes is the perfect chronic illness to demonstrate how our practice is transforming the way we care for patients.—Medical Director

FUTURE WORK

We have reorganized and rejuvenated our Diabetes Team and are anticipating the need for a dedicated care coordinator for diabetic patients. The care coordinator, likely a medical assistant, will take the lead on proactive calls and outreach to the patients. Using data abstraction from the EMR to generate patient lists, we will better identify and stratify patients. It is estimated we have approximately 400 patients with a diagnosis of type 2 diabetes, and of these, only 140 are in an active relationship with their primary care provider. The care coordinator will use the resources of the Call Center to help with telephone outreach as needed.

We are rewriting some standing orders for diabetes care in order to do a better job of pre-visit planning and empowering the medical assistants (with training) to do more duties related to care coordination. We will also redirect some nursing expertise to help with complex cases.

Using our partnerships, the Diabetes Team is looking at various ways to improve patient education and empowerment such as introducing smart phone applications for self-management and how to use behavior modification theory to help patients set and reach goals.

SUCCESS SO FAR

- The Call Center has alleviated the pressures on the front desk staff who now report better customer service, and patients have indicated it is easier to get through the phone system to make appointments. It has also improved scheduling and follow-up for patients.
- The Diabetes Team (including partners) meets on a regular basis to review individual patient cases and analyze more change concepts of the PCMH and how they can be incorporated into our health center.
- Our providers and patients now have improved access to our clinical pharmacy team (via a relationship with Northeastern University) and have began construction of an on-site pharmacy. Providers welcome the additional expertise for medication therapy management and improved reports on patient compliance and fill rates for their medications.
- Geiger Gibson received NCQA PCMH™ Recognition (Level 3) in November 2010. We are glad to make the best use of our EMR investment, which enhances communication among providers and allows for electronic prescribing and referrals.

> PCMH has had a positive impact on our practice's ability to manage our diabetic patients. By providing support, resources, and funding, we are able to deploy needed resources to care for our patients. The Diabetes Medical Home Team at Gieger Gibson Community Health Center has been a great way to help involve all levels of our medical team, and involve them in helping to care for our patients
> —Medical Director

Safety Net Medical Home Initiative

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