# Community Health Center (CHC)

Back Row Left to right: Lori (RN), Melissa (Medical Assistant), Rebeca (Medical Assistant), Karla (Family Nurse Practitioner); Front Row Left to right: Kelsi (Patient Care Coordinator), Trudy (Physician), and Brenda (Medical Assistant).

**Mission**
To promote the health of low-income, working, uninsured, and other vulnerable children and adults.

**Vision**
To be a leader in reducing health disparities and support for workforce development.

**Core Values**
Quality • Respect • Partnership
Compassion • Integrity

**Who Are We**
Community Health Center (CHC) began as a volunteer women's clinic above a sweet shop in Ashland, Oregon. We are now four clinic sites serving the communities of Jackson County, Oregon. One of our greatest strengths is partnership with our patients and with our community, and we serve two distinct patient populations:

- Those who live at or below 100% of the federal poverty index and who are enrolled in the publicly-funded Oregon Health Plan.
- Those who live between 101% and 200 % of the federal poverty index and do not have the benefits of employer-sponsored health care insurance.

We are committed to serving people of all ages and backgrounds, and we offer a wide-range of primary care, preventive, and chronic health care services provided by a dedicated team of physicians, family nurse practitioners, physician assistants, social workers, nurses, and support staff. We offer a generous sliding-fee schedule, based on the household income and family size, for persons who have high deductible health plans or no insurance.

In addition to primary care services, we also have a school-based health center including a children's dental program and provide support services including medication assistance program, behavioral health program, Oregon Health Plan enrollment assistance, and 24/7 telephone coverage.

## PARTICIPATION

**What motivated your practice site to participate in this initiative?**
The mission of Community Health Center motivated our practice to participate in this initiative. To effectively promote the health of our patients, we must engage them on our care teams, and respect them as partners in their care. The transformation to a Patient-centered Medical Home (PCMH) supports the work we do each day in the service of our mission.

Building and sustaining change is difficult, but participating in this initiative has provided us an opportunity to learn from and share with other like organizations working toward:

- Relationship-centered patient care.
- Whole person orientation.
- Integrated and coordinated care, including new information technology.
- Enhanced access.
- Quality and safety.
- Payment reform in recognition of improved care in a PCMH.

Each of the objectives we are working toward is supported by resources made available to us through this initiative, and our burden is lessened through this collaborative approach.

We have a vested interest in recruiting and retaining providers who are trained and motivated to offer coordinated, culturally competent, timely, and affordable quality care. We believe a PCMH will improve patient satisfaction, and will improve the satisfaction, and retention, of qualified staff.

## CHANGES

### Change One: Improved Delivery Model

Transformed delivery model to include a multidisciplinary team of individuals: provider, nurse, medical assistant, patient care coordinator, licensed clinical social worker, and health educator to better meet the needs of the patient.

**What was the specific problem or issue being addressed?**
Our patients were presenting with more complex health needs. Our providers felt overwhelmed. We were unable to recruit enough nurses, or afford the number of nurses, required to sustain our previous model. Despite best efforts, our staff felt unable to meet some of the most pressing needs of our patients, and staff burn-out was a constant threat.

**What did you hope to achieve by making the change?**
We hoped to:

- Create a culture where the patient is the focus of staff attention.
- Use all of our staff to their highest level of education and training.
- Maximize efficiency by preparing for scheduled patient visits.
- Offer care teams space to develop work flows to better meet the needs of their patients.
- Reduce barriers to care.
- Engage all staff and patients at CHC as care team members.

**What was the plan for making the change?**
Our change is still in process. To date we have:

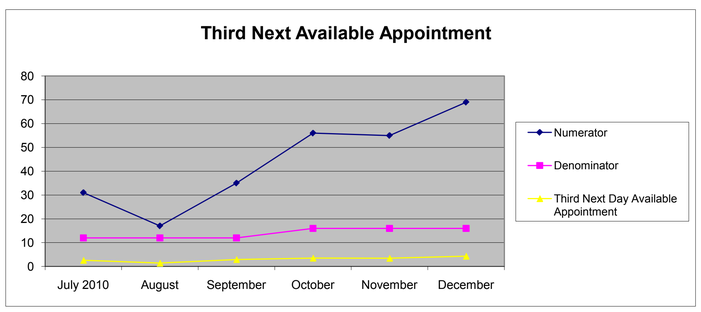
- Designated every team to have two providers, one RN, and three medical assistants – allowing for provision of translation services, completion of referrals or prior authorizations, administration of injections, or phone call response.
- Made the team RN the direct supervisor of the medical assistants on the team.
- Hired a Licensed Clinical Social Workers for each of our sites
- Trained our medical assistants to work with patients on setting self-management goals.
- Engaged our Continuous Quality Improvement committee to expand evidence-based practices by setting clinical benchmarks for the teams.
- Implemented an electronic health record and a reporting database for data extraction and analysis
- Asked each team to choose a clinical outcome to track.

**What did you learn from the process of making the change?**
We learned that:

- Expecting staff to work at their highest credentials or licensure is difficult without provider buy-in and leadership.
- Practice change requires data and benchmarks to show the progress made by the team.
- A data analyst is needed to ensure data validity, extraction, analysis, and reporting can be accomplished.
- Teams can feel divisive initially, but avoiding finger-pointing and navigating potentially difficult topics by framing issues around the question, "How could we have improved this patient's experience?" works.
- Protecting time for the teams to meet is critical.
- Highlighting PCMH as a clear priority for new employees is very important.

**What would you recommend to other sites trying to make a similar change?**

- Ensure the teams have way to track and extract data for analysis.
- Provide adequate staffing to ensure data validity and use the data to engage them in the process of improvement.
- Allow teams the time and space to make decisions, to hold team meetings to discuss and implement process improvement strategies, and celebrate successes.
- Have leadership, particularly provider champions, guide, direct, and support the process.




**Key:**
Denominator: The number of first days of the work week (4) times the number of providers
Numerator: The total number of days to the third next available appointment
Third next available appointment is numerator divided ( / ) by denominator

### Change Two: Implemented daily team huddles

What was the specific problem or issue being addressed?
Lack of efficiency on the part of the care team as seen by support staff running around trying to get an ED record on a patient the provider was already seeing, searching for translation support for a Spanish speaking patient ready to be roomed, or awaiting a lab fax on a roomed patient whose treatment plan cannot be completed without it. Also, we were missing opportunities to address preventative care, chronic care, or follow-up needs when patients came in for visits.

**What did you hope to achieve by making the change?**
We hoped to improve the patient experience with prepared and knowledgeable staff, and to increase staff engagement in the work of the care team.

**What was the plan for making the change?**

- We developed a Daily Team Huddle procedure by gathering information from other SNMHI sites and used team input to create our own.
- Care teams determined the roles of the team members and agreed on time and place for huddles.
- The care teams discussed clinical benchmarks selected for improvement, reviewed baseline, performance metrics, and developed strategies to achieve desired outcomes.
- Used Plan Do Study Act (PDSA) cycles to test implementation and posted on CHC's network.
- Altered staff work hours to ensure everyone's presence at the meetings.

**What did you learn from the process of making the change?**

- Co-location of team members is a huge advantage.
- Implementation is really challenged when not embraced by the providers. Some teams have benefitted tremendously from huddles, others not yet; we plan to have providers who have seen success share with others.
- Patient cycle time can be reduced when teams have taken the time to plan the visit.
- Our ability to support our patients and ensure continuity has the potential to be improved significantly through Daily Huddles.

**What would you recommend to other sites trying to make a similar change?**

- Co-locate teams to whatever degree is possible.
- Have provider champions talk this up with their colleagues prior to implementation
- Encourage teams to use this opportunity to recognize special efforts of teammates, and always end the huddle on a positive note.

### Change Three: Processes

Developed a process to assess supply and demand, determine panel size, and assign and transfer patients to a primary care provider.

**What was the specific problem or issue being addressed?**
We had no procedures or tracking mechanism to manage the provider panels to ensure a personal relationship between a patient and a provider and his/her care team.

**What did you hope to achieve by making the change?**

- A personal relationship between a patient and a provider and his/her care team.
- Manageable panel sizes that promote high quality care in a timely manner.

**What was the plan for making the change?**

- Met with the providers to discuss the empanelment procedures including the weighted panel components of age, gender, patient complexity, and language, though research was needed to determine how to weight each component, staffing level available to complete the task, and adequate data to support the measure.
- We set procedures to assign a new patient and unassigned patient to a primary care provider panels and how to reassign a patient based on patient request or primary care provider request.
- Set procedures for weighting provider panels using what we learned in a SNMHI learning session from other sites and documents that were shared to guide our staff in the 4 Cut Method, tracking TNA, and closing panels when full.

**What did you learn from the process of making the change?**
What we learned from the process of making the change was to implement the process in three steps:

- First, write procedures to support patient / provider empanelment.
- Second, track the third next available appointment to ensure PCP access which including retraining staff to assure data was being collected correctly.
- We learned that simple is sometimes better when implementing a change. Based on advice at the learning session, we chose to use TNA to determine access first and apply weighted measures later.
- Third, will implement use of the panel weight components of age and gender beginning in March 2011. We have learned through the Third Next Available Appointment we do not have an access concern. Our practice management system will have an adequate amount of information by then to weight the panels by age and gender providing a more comprehensive review of each provider panel.

**What would you recommend to other sites trying to make a similar change?**

- Define the goals and objectives of empanelment.
- Engage the providers in empanelment decisions.
- Keep it simple, learn from others, and use available resources.
- Document and train the teams on the empanelment procedures.
- Ensure the team understands his or her role in the process.
- Ensure the data is valid and set benchmarks to track progress.

## PATIENT IMPACT

"As part of our journey toward a PCMH, we have begun "scrubbing". Having an assigned team member previews the schedule and charts for the next day, we are able to identify medical records that need to be called for in advance, remind patients of yearly physicals or follow-up for chronic conditions, and advise them of programs and services that may benefit them. In addition, we look patients under 18 to assure they are fully vaccinated and patients over 65 years to assure they have received their pneumonia vaccination. These are two clinical benchmarks our team has committed to improve. This work has been supported by our ability to print rosters out of the Solutions data base, of children or adults who fall outside of these guidelines.

A recent example is of a 2-year-old who hadn't received any vaccines since the Hepatitis B vaccine given at birth. We initiated routine vaccines and requested a follow-up visit in two months. On our last printed roster, we saw her name come up again. Going into the record, we noted the follow-up visit was not kept. We contacted the parents, and found out their house had burned down in the interim; they were displaced and living in chaos. They were tremendously appreciative of our outreach, brought their daughter in for her needed care, and confirmed for us that our proactive work can definitely make a difference in the lives of our patients!" — Nurse Case Manager

"A 62-year-old patient with COPD, bipolar depression, chronic pain, hypertension, adult failure to thrive, and angina was taking approximately 30 OTC and prescription medications ordered by several different providers. Frequently in the ED with multiple diagnostic studies each visit, he was admitted for accidental drug overdose and secondary aspiration pneumonia last July. This patient was in need of Care Management! Our medical assistants offered lots of social support, checking in with him whenever he came to the office and calling him at regular intervals when he did not. With the help of the team RN and LSCW, we have verified and maintained an accurate medication list, offered ongoing education and support, engaged him on the care team, and have seen this patient move out of crisis management to care management. He has not been to the E.D. for 3 weeks. This one patient's story has convinced me our multidisciplinary team can work miracles!" — DO, Doctor of Osteopathy

## PROVIDER OR STAFF IMPACT

"As Executive Director for Community Health Center, I have seen our participation in the PCMH transformation collaborative bring focus to the work we need to accomplish to achieve our mission. As a direct result of the patient-centered focus, I have witnessed board and staff become more engaged and passionate regarding their work.

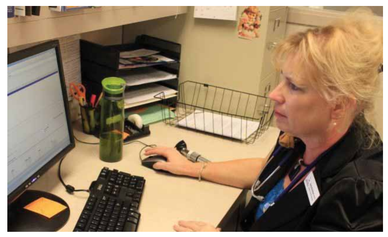
For example, as our Leadership Team discussed a need to change assignments in the face of diminishing resources, our Director of Nurses passionately and with data in hand defended the need not to make reductions that might divert the staff's focus on the patient's engagement as part of the care team. Also, in our board meetings, the consumer members of the board have become more engaged and vocal regarding decisions, often beginning their comments with the statement 'It would be patient centered to …" — Executive Director

As Executive Director for Community Health Center, I have seen our participation in the PCMH transformation collaborative bring focus to the work we need to accomplish to achieve our mission. As a direct result of the patient-centered focus, I have witnessed board and staff become more engaged and passionate regarding their work.

"I fully expected patient-centeredness to improve the care we offer to our patients, but what has impressed me is the impact I see on the staff. Patient-centeredness as a constant theme has the power to change our culture. In implementing the EHR, we have had to revise every clinical work flow. This has afforded us the opportunity to ask, at every juncture, "How will this change impact the patient's experience?" When we successfully keep this consideration at the forefront, there is a palpable change in the way we evaluate alternative work flows. It seems to bring out the best in all of us.

When the inevitable happens, and something goes wrong, instead of the defensive position, we are better able to put ourselves in the place of the patient, and freely share what we would have wanted or needed. Team members seem to feel safe in sharing. When everyone feels he or she is part of the care team, charged with improving the patient experience, the traditional divisions between front and back office team members lose all relevance.

We are only in the beginning stages of this transformation, but we see glimmers of what awaits us as we progress toward our goals, and it reaffirms our commitment to the work we have undertaken." — Director of Nursing



Community HEALTH CENTER

**Safety Net Medical Home Initiative**

QUALIS HEALTH
THE COMMONWEALTH FUND
MacColl Institute at Group Health Cooperative