Denver Health Medical Center

Denver Health is an FQHC located in the Denver Metro area with 16,800 patient visits per year. The top two diagnoses are high blood pressure and diabetes. The Bernard F Gipson Sr. Eastside Family Health Center site has an Adult Clinic, Pediatrics Clinic, Women's Care Clinic, WIC, Dental Clinic, supporting Laboratory, and Pharmacy. It is the second oldest Community Health Center in the United States. The patients served are predominantly low income: 25% Medicaid, 30% Medicare, 42% uninsured/self-pay, and 2% commercial insurance.

SNMHI Team:

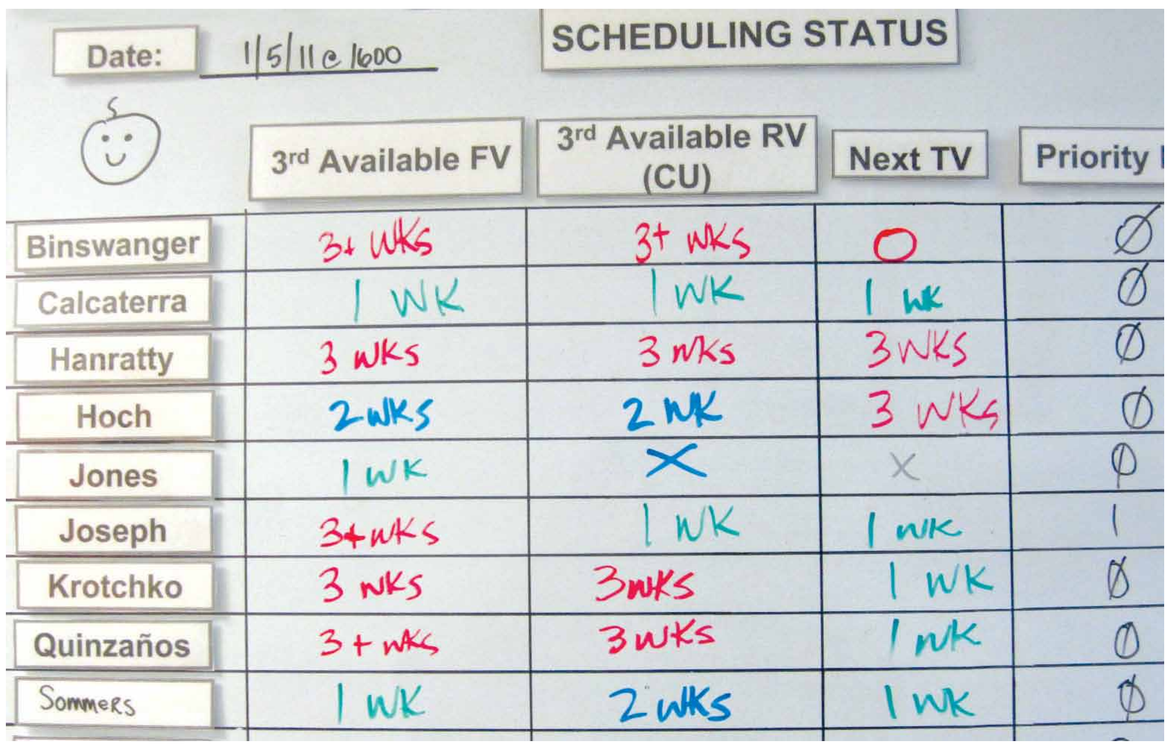
Nicole Joseph, MD
Felicia Hill Program, Manager, RN
Kathy Nelson, HCP
Beverly Benavidez, Clerk
Theresa Saiz, Clerical Supervisor

DENVER HEALTH
Level One Care for ALL

PARTICIPATION

What motivated your practice site to participate in this initiative?

We believe it is important to leverage being a Patient-centered Medical Home (PCMH) site in order to invoke change and provide high quality patient care. We anticipate this initiative impacting our overall clinical practice and patient experience. Being part of this initiative has motivated our clinic team to increase clinic efficiency by creating care teams to manage our patient panels. This initiative has also catapulted our team to initiate advanced access scheduling to meet our patient needs in a variety of ways. For example, we now offer telephone visits, which allows our providers to increase capacity in an efficient manner.



CHANGES

Change One: Advanced Access

- We were unable to capture and visualize our unmet demand, and there was lack of PCP continuity.
- Ultimately, we wish to increase PCP/patient continuity by using a specific tool to capture the number of patients, their specific needs, and how we can best meet them.
- Our plan was to tabulate how many patients contacted the clinic and their specific needs on a daily basis so we could have an initial state of how much unmet demand we had per day. We made the change by creating a share point site for the Denver Health Appointment Center to message the clinic when the patient contacted our clinic and had an unmet need.
- We learned having a well prepared rollout plan bolsters long term success. We learned consistent PDSA cycles are important in order to sustain change.
- We recommend assessing your unmet demand prior to making changes and make sure each clinic role is actively involved in making the changes.

Change Two: Empanelment

- We didn't have a clearly identified PCP for patient panels or standard work to ensure PCP is populated in the PCP field in our computer information system.
- We hope to increase PCP/patient continuity and increase PCP ownership of patient panels.
- We created standard work to identify PCP for all team members. Clerical staff now consistently enters PCP information in the information system. We made the change by educating staff regarding standard work and changes, created consistent audits and feedback to staff via huddles, emails and meetings.
- We learned that consistent monitoring, feedback and reinforcement is important to sustain change.
- We recommend creating standard work for all team roles, educating, auditing, and providing feedback to staff on a regular basis.

Change Three: Created Care Teams

- There was a lack of clearly identified care teams and the roles/responsibilities were not well defined.
- We hope to achieve the right person doing the right job, and tighter communication and work flow between care team members.
- Our plan to make change was to evaluate the current roles/responsibilities for each team member. We made the change by having a rapid improvement event to implement lean concepts to create care teams, redesign clinic flow and evenly distribute workload for all team members.
- We learned that creating care teams has increased staff satisfaction and created a more cohesive team for front and back office staff. We learned even in the midst of staff turnover we have to keep moving because it's a continual process.
- We recommend having dedicated time to hold a lean event to make clinical overhaul changes and to evaluate current team roles/responsibilities to see where changes can be made to ensure workload is evenly distributed for all team members.

Some of the benefits of the Medical Home process for me have been a decrease in duplicate RN work, better ability to see patient progress by continuously having one RN see them, better provider/staff communication, and the ability to solve patient issues in a more rapid manner.—RN

PATIENT IMPACT

"PCMH concept has had a tremendous effect on how our patients access and receive care here at Eastside Clinic. Prior to Medical Home, a patient would call for an appointment, either for acute care or routine follow-up, and be appointed with whatever doctor was available. There was no thought given to whether or not the patient had seen this particular doctor before. Often when a patient came in, they would have to spend unnecessary time, while the doctor reviewed their medical history. This could be very frustrating for the patient, having to repeat the same information at every appointment. "

"With Medical Home, our whole scheduling concept has changed to better accommodate the needs of our patients which I feel is wonderful! Our patients are being taught to identify with a care team consisting of a clerk, a Medical Assistant, a nurse, and a doctor or nurse practitioner who work together to make sure the patient experience is efficient, effective and gratifying for all involved. The patients are much more satisfied because:

- They have a doctor that is familiar with their illnesses and is able to address their medical concerns on a continuous basis.
- They have a doctor who is available for them whenever they need an appointment.
- We now offer phone visits allowing the PCP to identify patients who may not necessarily need a face to face appointment, which allows them the opportunity to speak with their PCP, without the hassle of having to get dressed and come out to a clinic appointment.

These are just a few of the examples of how the Medical Home initiative has impacted our clinic and made it easier for our patients to receive the highest quality of care."—Health Care Partner

"As a clerk here at Eastside, I believe the changes we have made are better for the patient because I see the patient's surprise when they can get a appointment the first time they contact the clinic. The phone call volume has decreased allowing clerical staff to be available to assist patients face to face in a timely manner. Since making changes, I see the patients and the clerical staff making a connection with a care team. I personally tell patients to see me when they come to clinic for forms, messages, etc. because I am the clerk working with their PCP."
—Clerical staff

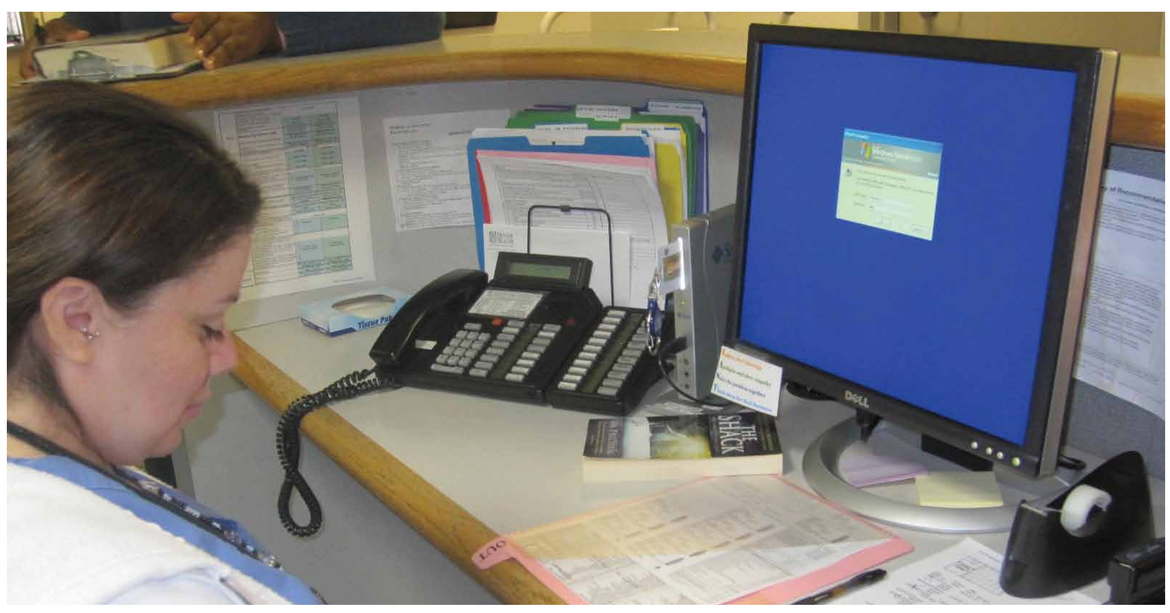
	Initial State (3/2010)	Current State (11/2010)	Target State
PCP-Pt concordance (Pt perspective)*	79%	86%	85%
PCP-Pt concordance (PCP perspective)*	66%	76%	85%
Visits at the Medical Home**	78%	82%	90%

*Excluding providers that have recently left or other extended provider absence.
** Percent of visits to Medical Home out of possible medical home visits (Medical Home, Emergent Care, Urgent Care, Other Community Health Services).

PROVIDER OR STAFF IMPACT

"Before the creation of our care teams, because I didn't have a team to lean on, I ended up doing everything myself which led to inefficiencies and burn out. Now that I have a care team, I know exactly who I can delegate tasks to and the responsibilities of each team member are clearly outlined."

"Before we transitioned to advanced access scheduling, I would have to talk to each patient (for 5 minutes of a 20 minute appointment) about how difficult it was for them to get an appointment with me, and my colleagues had to see my patients frequently. Now, we have improved continuity and the patients seem to have an easier time scheduling an appointment, such that it is much less often a topic of conversation."—Team Leader



Safety Net Medical Home Initiative

QUALIS HEALTH
THE COMMONWEALTH FUND
MacColl Institute at Group Health Cooperative