Dorchester House

Dorchester House serves approximately 15,000 primary care patients annually and 94% of our patient population lives at or below 200 % of the Federal Poverty Line. Our patient population is 30% Asian (predominantly Vietnamese), 29% African American, 18% White, and 14% Hispanic/Latino. Roughly 40% of our patients speak a language other than English.

SNMHI Team:

Patrick Egan, MD, Chief Medical Officer
Carol Bradlee, Analyst
Elizabeth Frutiger, MD, Family Practitioner
Mary Irwin, Director of Human Resources
Diane Picard, Director of Operations
Patricia Wheeler, RN, Director of Clinical Services
Patrick Ziemnik, Development & Communications Associate

PARTICIPATION

What motivated your practice site to participate in this initiative?

The staff and board at Dorchester House are immensely proud of our health center's history. We have been providing high-quality, comprehensive primary care since the 1970s; before that, we were a settlement house. Our clinical culture reflects that tradition with our partnership approach to improving a patient's health by touching on all aspects of his/her life. This made the SNMHI a natural fit for us—with the emphasis on providing patient-centered care that yields better health outcomes, we realized we already had the right mentality and commitment in place. We simply needed a road map to help us finish the transformation.

The following aspects particularly appeal to us:

- Emphasis on the patient.
- Relentless focus on outcomes.
- Commitment to access, quality, and satisfaction.
- SNMHI's formalized plan (or road map) to pragmatically implement change.
- Defining and improving the roles that staff, patients, and the community have in working toward a healthier, happier neighborhood.

CHANGES

Change One: Appointment Confirmation Process—New Phone Script

- To address the long-standing problem of high no-show rates for patient appointments, the Dorchester House team examined the appointment confirmation process with three goals in mind. 1) Improve patient satisfaction with a more personal process, 2) increase clinic efficiency by reducing no-show rates, and 3) improve "teamness" by coordinating appointment staff, registration, and nurses to ensure patients arrive at their visit prepared with medications and paperwork.
- We planned to watch staff make confirmation calls and develop ideas for improvement. By watching staff, we learned that they lacked a consistent script, seldom gave their name to patients, and left out important information about the visit.
- Therefore, for all confirmation calls (about 500 per day), we implemented a standard script designed to be patient-friendly, personal, informative, and efficient. Anecdotal evidence suggests that providers are more satisfied with the appointment process because their sessions are running more smoothly due to the confirmation calls and better preparedness of patients (i.e., they arrive with proper medication and paperwork). Patients seem to appreciate the more personal touch that the script encourages.

Change Two: Patient-Provider Communication Form

- The Dorchester House team identified patient-provider communication as a key patient-centered process that could be improved during the clinical encounter, which is historically difficult due to time constraints, diverse populations, and differing levels of patient education, among other reasons. The goal was to find a way for both the patient and medical team to plan and direct the visit collaboratively and efficiently. We created a pre-visit questionnaire to solicit information about patient expectations to be filled out while the patient was in the waiting room.
- The first form did not meet expectations and garnered little useful information for our providers. Therefore, we cut it from five questions to two simpler questions: 1) What do you want your provider to do today? 2) What do you want to tell your provider? This immediately resulted in more thoroughly written answers from patients, and our doctors have been able to review the form ahead of the clinical encounter to create a more patient-centered visit.
- This form is not part of the medical record, which led to the unexpected innovation of providers writing notes on the form and returning it to the patient, who can then use it for reference. We recommend this method for other medical homes, as it has been a tremendous interactive tool for on-going communication and patient compliance. This has also been another example of cross-team collaboration, as registration and provider teams work together to hand out, collect, and use the form.

Change Three: Access Facilitator

- Communication between registration and clinical staff, and among clinical teams and translators, is always challenging in a busy clinic. Breakdowns in such communication hamper patient flow and negatively impact the patient experience. To address this, we created a trial position in the Adult/Family Medicine Departments, called the Access Facilitator (AF). For the AF role, we identified two experienced, high-performing medical assistants who coordinate cross-team activity by:
  1. Meeting with registration staff and specialty services prior to each shift and incorporating them into the primary clinic flow.
  2. Prepping rooms and patients prior to the start of sessions.
  3. Allocating translators and medical assistants and arranging alternative coverage when a medical assistant must translate for a provider.
  4. Assisting each team when necessary and overseeing the general flow of the clinic.
  5. Communicating with patients and registration staff when providers are running behind.
- This has been our most successful change! Registration staff members love having a "go to" person to communicate with clinical staff. Providers have noticed more efficient sessions. Medical Assistants like the additional resource. Most of all, patients are benefiting from a quicker, smoother process and better communication.
- Finally, we realized that our two AFs are training other medical assistants to perform at a higher level. There is a coaching component to the role that we did not recognize when we developed the operational activities of the AF. We hope to provide opportunities for these emerging leaders to develop this interpersonal skill set so they can more effectively oversee the other medical assistants.

(left to right) Mary Irwin, Director of Human Resources; Carol Bradlee, Analyst; Joel Abrams, President & CEO; Kathryn McGovern, Practice Coach; Patrick Egan, MD, Chief Medical Officer; Diane Picard, Director of Operations; Patrick Ziemnik, Development & Communications Associate; Patricia Wheeler, RN, Director of Clinical Services; Elizabeth Frutiger, MD, Family Practitioner.

PATIENT IMPACT

"I have found the new team structure between providers and medical assistants to be tremendously helpful for patients in ensuring that they have all of their needs taken care of. This has been most noticeable for me in the process of scheduling labs and referrals. Every session, my medical assistant and I go over the schedule for the day and look at any issues we might encounter. We particularly focus on diabetic patients to determine who is due for an eye exam. We also look at who is due for a mammogram. Since we now work together all the time, my medical assistant knows all of my patients and scheduls tests and does related patient education as soon as she gets the patient into the room. Before, it wasn't always clear these things would happen, and patients sometimes fell through the cracks. I also love that I have more time to talk with the patient about the issues that matter to them." —MD, Adult Medicine

"Working on a team with one provider has been great for serving our patients better. We meet every day to go over the schedule and flag any patient who needs specific labs and tests, so I can schedule those things as soon as I get the patient in the room. One specific example of how our team-based method helped a lot occurred when the provider was running behind one afternoon, and a complicated patient came in. The patient also had an appointment with Behavioral Health right after his appointment with us, and we did not want him to miss that! Since I knew that problem was going to happen, I pulled the patient out of the waiting room and took him to Behavioral Health. He made that appointment on time, and when he was done and came back down to us, we were able to take him pretty quickly. What could have been a bad situation wound up working really well, and the patient was happy with how we handled it." —Medical Assistant

Our cross-trained teams have been able to build bridges of communication and resources between specialized departments resulting in higher quality care.

PROVIDER OR STAFF IMPACT

"Our Patient-Provider Communication Form, for soliciting patient expectations prior to the visit, continues to yield highly useful information that helps our providers structure the visit smoothly and in a way that is most helpful to the patient. We had to try the form twice, as the first version had too many questions and was therefore more difficult to fill out. Our second version has been highly successful in helping us create a more productive, patient-centered visit, and it has also taken on additional meaning as an interactive tool between the patient and provider. On a broader level, the process of implementing this form has also been a valuable learning tool. We had a good idea and we had to watch it fail, which forced us to decide whether to give up on the idea or try to change it. We opted to change the implementation, and found immediate success – this has increased our confidence as a team to experiment with new and innovative changes, and I expect that to help carry us forward as we continue to transform our practice into a Patient-Centered Medical Home." —Chief Medical Officer

"One of our improvements has included better cross-training of nurses and medical assistants. Being a cross-trained nurse has given me a broader range of skills and resources to offer our patients. For example, I am part of our Pediatric and Women's Health Department teams. I have been able to coordinate continuing care for our pregnant patients as they transition from their prenatal visits with our midwives to pediatric visits with our pediatricians, as well in the opposite direction for our adolescent patients who become mothers early in their lives. Patient needs are vast. I believe we are able to provide better care because our teams partially consist of staff who follow the patients and their children through every life transition and can pass full knowledge of their vulnerabilities and strengths to the next care team efficiently and accurately. Our cross-trained teams have been able to build bridges of communication and resources between specialized departments resulting in higher quality care."
—Registered Nurse

Safety Net Medical Home Initiative

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