Mid County Health Center

Mid County Health Center is part of the Multnomah County Health Department. We have staff from all over the world. We see a patient population with over 60 primary languages and serve as the Oregon Refugee Receiving Center. We serve 48,000 patients per year and have 11,751 active panel patients.

SNMHI Team:

- 6 PCP teams – four Family Practice, one Internal Medicine, and one Pediatrics
- Team composition: two PCPs, one RN, two support staff, one panel manager, and one team clerical assistant.

PARTICIPATION

What motivated your practice site to participate in this initiative?

We are participating in the SNMHI for several reasons:

- To learn from other Safety Net clinics in our region and across the country
- To continue development and implementation of the medical home model in our clinic
- To improve outcomes for our patients and staff

CHANGES

Change One: Streamline the process for call management in the clinic, including creating staff accountability for the process.

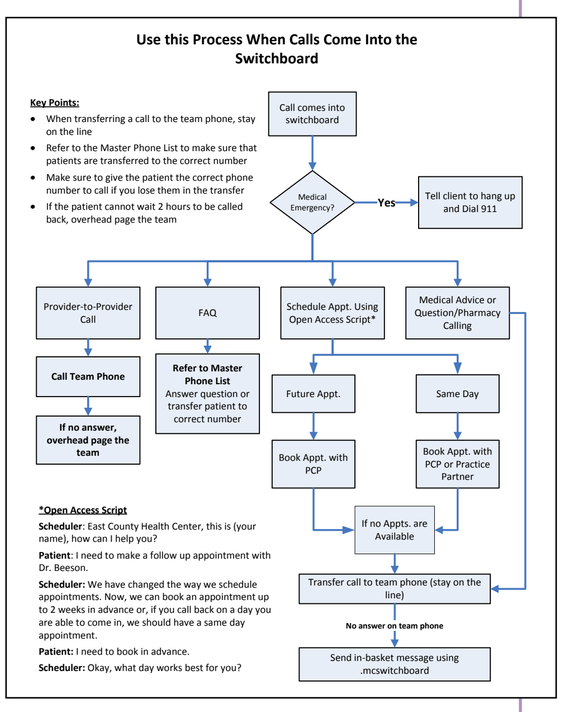
Problem: The abandonment rate—the number of times a patient hangs up before they talk to a person—was greater than 15%. Survey responses showed that only 44% patients felt they could "always reach" a member of their team by phone. Answering the phone was not any team member's primary responsibility.

Goal: We hoped to improve the patient experience of our call system and to take waste out of the call management process.

Plan: We held a five-day kaizen event with a cross-functional group of staff to map the process, develop improvements, and create an implementation plan.

Learning: Placing dedicated resources to identifying and solving a problem can lead to significant, sustainable improvements.

Recommendations: Take time to understand the root cause of the problem and a plan for implementation of the process. It will save time on the back-end of the improvement.



Change Two: Implement minimum provider-team staffing policies.

Problem: Providers and teams were operating in a team-based care environment but staffing ratios and policies were still part of the old model. We decided to update our staffing model to fit the new team-based environment.

Goal: We wanted to increase access for patients and to allow teams some decision-making autonomy for decisions regarding leaves.

Plan: Organizationally, MCHD adopted a provider minimum staffing policy where PCPs had to be in clinic four days per week over AM and PM sessions and teams had to have at least one PCP and one RN in clinic every day. Teams were allowed to adjust their schedules to fit the new policy.

Learning: We learned that to really achieve access and continuity for patients, the schedule has to prioritize access to the team rather than specific provider preferences.

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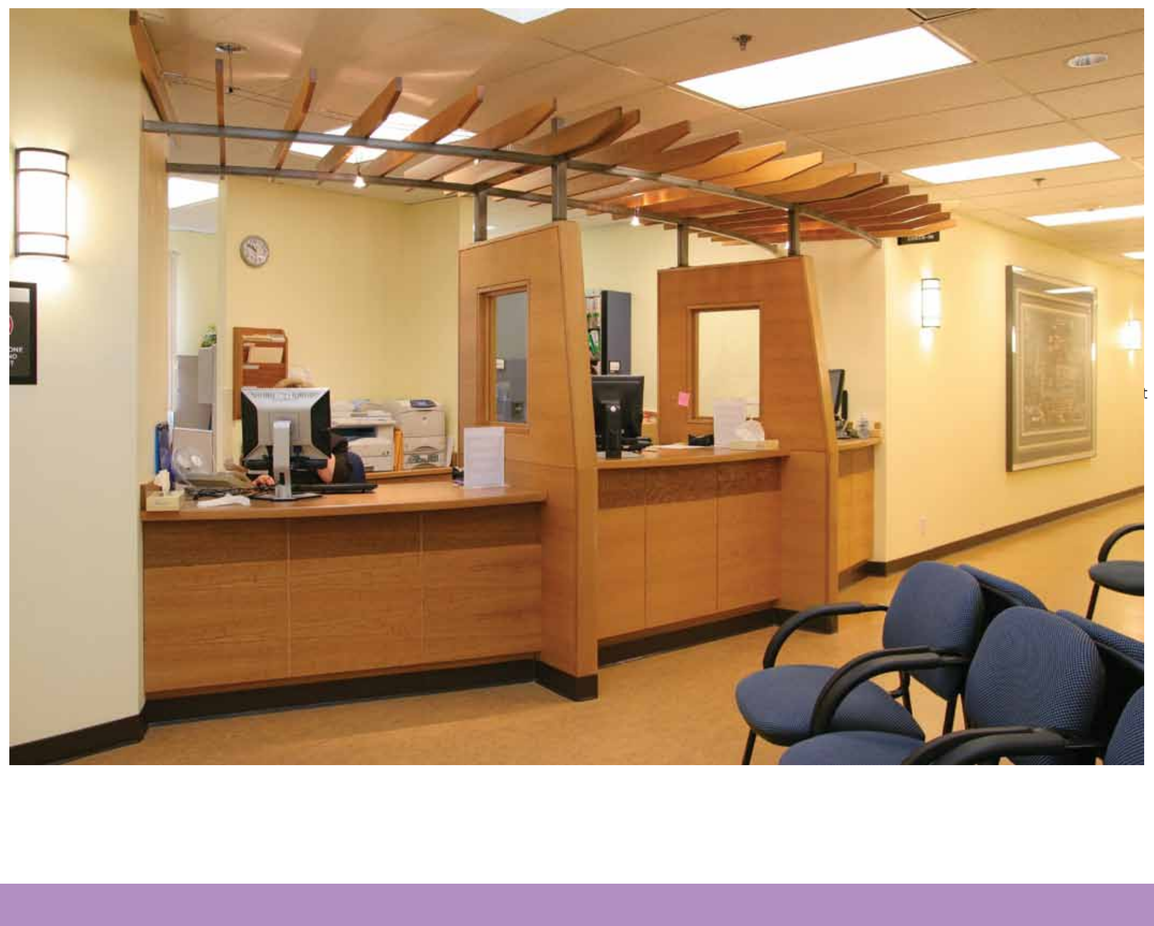


Change Three: Implement open access scheduling system.

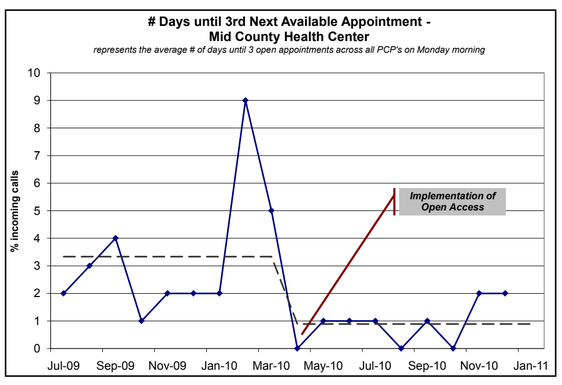
Problem: The third next available appointment was 5-14 days for each provider in the clinic. There was a lot of waste in the process of triage, and patients could not get an appointment as soon as they wanted one.

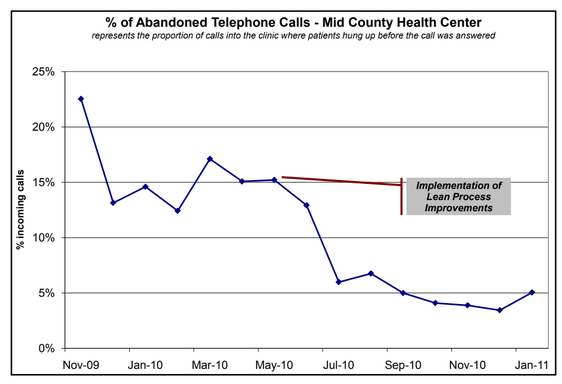
Goal: We wanted to increase same and next day access for patients, decrease the no-show rate, and improve patients' perception of being able to get an appointment as soon as they need one.

Plan: Implementing an open-access model post flu season in 2009 allowed us to take advantage of the reduction in backlog created by holding same-day appointments for flu. We implemented a 40% same-day, 60% future schedule for family practice, 30%:70% for internal medicine, and 50%:50% for pediatrics—and decreased the time to schedule future visits to two weeks.

Learnings: We learned that it is possible to take advantage of "crisis" situations to create space for improvements. We also learned that

1. The more detail we put into training materials and trainings, the easier the implementation process goes, and
2. It is always necessary to re-visit and improve the process post-implementation. (You don't always get everything right the first time.)





PATIENT IMPACT

"Being part of a team means that help for the patients is more readily available. They're not just calling and relaying a message to their provider. Patients have more people that can help them with what they need. That means that they can get their problems addressed faster and more efficiently."—Primary Care Provider

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"As a team, we're closer because we have to rely on each other. There's more work, and we have to use all of our skills. We're also more focused on the patient needs – each person brings their skills, and can help meet patients' needs, whether it's the panel manager outreaching or a team clerical assistant reminding a patient of their visit. Patients know that there are more people taking care of them than just the provider." —Nurse

PROVIDER OR STAFF IMPACT

"I think that the transformation to the medical home has positively impacted the way I interact with the clinic managers and the way that clinic managers interact with the care teams. Because our systems are more standard and there is more accountability and transparency in the work, it is easier to empower managers and staff to try new ideas. The best part is that now we can understand if an idea is working and we have a process to spread it to other sites!" —Operations Director

"I feel like since we started in the medical home model, we are overall providing more comprehensive care and a lot more primary prevention which is what primary care is all about. As a provider, having a team lets me focus on my goals to provide care. I can do more of my job and do it better. With each team member doing their specific role and functioning better together, I can be a better provider." —Primary Care Provider

Safety Net Medical Home Initiative

QUALIS HEALTH

THE COMMONWEALTH FUND

MacColl Institute at Group Health Cooperative