North Side Christian Health Center (NSCHC)

- North Side Christian Health Center (NSCHC) has two offices (one in a residential/commercial area and the other at Northview Heights (NVH), a housing project community)
- NSCHC at NVH occupies the space on the ground floor of the senior high-rise apartment building. Most patients simply ride the elevator or walk to the clinic. The clinic is adjacent to the bus stop for those who are not residents of the public housing community. Patients frequently visit in person to make appointments, request refills, complete paperwork, or ask advice.
- The Northview Heights community is one of the oldest public housing communities in Pittsburgh, founded in 1962. The population of the community is approximately 968 residents, 99% of whom are of African American descent.
- NSCHC is the only community health center located within the public housing system in Pittsburgh. Patients receive treatment without regard for their ability to pay. NSCHC uses a sliding-fee scale for patients at or below 200% of the federal poverty line.
- As a faith-based health center, NSCHC recognizes that spirituality is a fundamental component of holistic health care.

PARTICIPATION

What motivated your practice site to participate in this initiative?

- The PCMH model offers us a framework for organizing care that is evidence-based and reflects best practices. As a small community, it is easier to make changes and implement new methods of engagement, and this Initiative offers us the opportunity to engage with similar health centers and regional and national experts who are striving to realize the same model of care as we are.
- Primary motivation emanates from the desire to improve the quality of care for our patients, who often times face significant barriers to fully engaging in their care and realizing optimal health. We desire to "raise the bar" higher for ourselves and our patients in an effort to improve their health and quality of life.

CHANGES

Change One: Diabetes

What was the specific problem or issue being addressed?

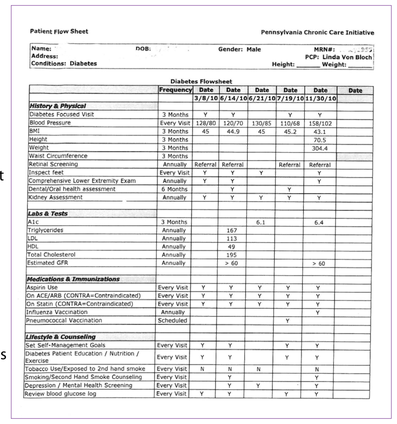
- We identified a trend of an increasing number of patients being diagnosed with Type II Diabetes.

What did you hope to achieve by making the change?

- We wanted patients to gain a greater understanding of diabetes, learn how to be involved with their care, and lower HgbA1C numbers.

What was the plan for making the change? How did you make the change?

- We implemented standardized, evidence-based treatment protocols, educated patients on the disease process, and provided support with identifying and monitoring self-management goals.
- Through our involvement in the Pennsylvania Governor's Office of Health Care Reform's Chronic Care Initiative, we used tools such as the Reach My Doctor (RMD) registry to track patient data, indicate trends, and identify opportunities for improvement. Through participating in learning collaborative with other practices in the region, we had the opportunity to learn more about best practices and effective strategies for improving diabetes care.
- We implemented of diabetes group visits and provided patient education materials.
- Care team members met monthly to plan strategies and huddled daily to discuss individual patients' needs.
- Using a diabetes flow sheet, we included at least one component of a diabetes in every visit (even sick visits).



Patient Flow Sheet — Pennsylvania Chronic Care Initiative

Name: DOB: Gender: Male MRN#:
Address: PCP: Linda Von Bloch
Conditions: Diabetes Height: Weight:

Diabetes Flowsheet

	Frequency	Date 9/8/10	Date 9/14/10	Date 6/21/10	Date 7/19/10	Date 11/30/10	Date
History & Physical							
Diabetes Focused Visit	3 Months	Y	Y		Y	Y	
Blood Pressure	Every Visit	128/80	120/70	130/85	110/68	158/102	
BMI	3 Months	45	44.9	45	45.2	43.1	
Height	3 Months					70.5	
Weight	3 Months					304.4	
Waist Circumference	3 Months						
Retinal Screening	Annually	Referral	Referral		Referral	Referral	
Inspect feet	Every Visit	Y	Y	Y		Y	
Comprehensive Lower Extremity Exam	Annually	Y	Y			Y	
Dental/Oral health assessment	6 Months		Y		Y		
Kidney Assessment	Annually	Y	Y	Y	Y	Y	
Labs & Tests							
A1c	3 Months			6.1		6.4	
Trighycerides	Annually		167				
LDL	Annually		113				
HDL	Annually		49				
Total Cholesterol	Annually		195				
Estimated GFR	Annually		> 60			> 60	
Medications & Immunizations							
Aspirin Use	Every Visit	Y	Y	Y	Y	Y	
On ACE/ARB (CONTRA=Contreindicated)	Every Visit	Y	Y	Y	Y	Y	
On Statin (CONTRA=Contraindicated)	Every Visit	Y	Y	Y	Y	Y	
Influenza Vaccination	Annually					Y	
Pneumococcal Vaccination	Scheduled				Y		
Lifestyle & Counseling							
Set Self-Management Goals	Every Visit	Y	Y		Y	Y	
Diabetes Patient Education / Nutrition / Exercise	Every Visit	Y	Y		Y	Y	
Tobacco Use/Exposed to 2nd hand smoke	Every Visit	N	N	N		N	
Smoking/Second Hand Smoke Counseling	Every Visit		Y			Y	
Depression / Mental Health Screening	Every Visit		Y	Y		Y	
Review blood glucose log	Every Visit	Y	Y		Y	Y	

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

- Many patients had limited knowledge of their disease and potential self-management strategies but were eager to learn how to live a healthy lifestyle.
- It is important to understand the patients' goals for managing their health, and to support and partner with them in achieving their goals.
- Using our electronic medical record, we identified operational and clinical areas of strength as well as opportunities for improvement, providing the team with new areas of focused change.

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

- The team approach to care and quality improvement is essential, and the patient is a member of the care team. Know your patients so the entire care team may offer personalized, individualized care.
- Leverage technology to provide point-of-care reminders, and share data regarding patient outcomes with the care team to overcome clinical inertia.

Change Two: High Blood Pressure

What was the specific problem or issue being addressed?

Health Department data shows that hypertension is a significant problem. It is under-diagnosed and sub-optimally treated. Some patients are at particularly high risk for hypertension and encountering barriers that impact their ability to manage their health.

What did you hope to achieve by making the change?

Increased awareness of hypertension and an increased percentage of patients with a BP lower than 140/90.

What was the plan for making the change? How did you make the change?

- Provided strategies for patients to control their blood pressure, and educated patients on the value of exercise, dietary modification, and medications.
- Used the 340B pharmacy to provide medications at a low cost to patients
- Utilized evidence-based approach to medication management.
- Leveraged technology to provide point-of-care reminders of blood pressure targets.

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

- Intervention strategies and care plans must be individualized, and patients must understand the seriousness of their condition and be willing to make changes to their lifestyle.
- The care team and patients must partner to ensure patients' success in managing their health.

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

- Involve the entire care team for each patient, understand the patient's barriers to achieving optimal health, and individualize patient education and care.

Change Three: Immunizations

What was the specific problem or issue being addressed?

- Immunization rates for children 0-2 years were lower than national standards and our health center's goals.

What did you hope to achieve by making the change?

- Increased rates of fully immunized 0-2 year-old patients.

What was the plan for making the change? How did you make the change?

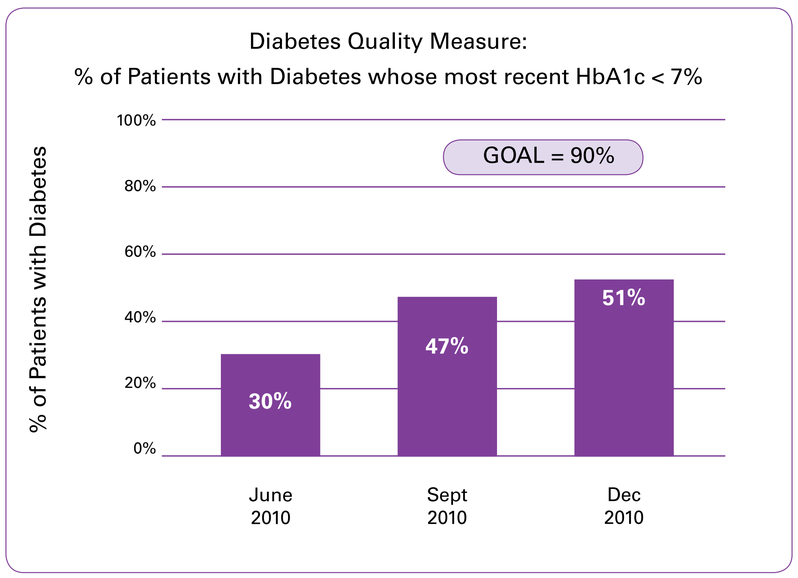
- Rearranged schedules to ensure that a pediatrician was available more frequently and during hours most convenient for families, and conducted all visits as well-child visits whenever possible.
- Held immunization clinics at the elementary school and community fair.
- Held "Ask the Doctor" sessions at the local elementary school.

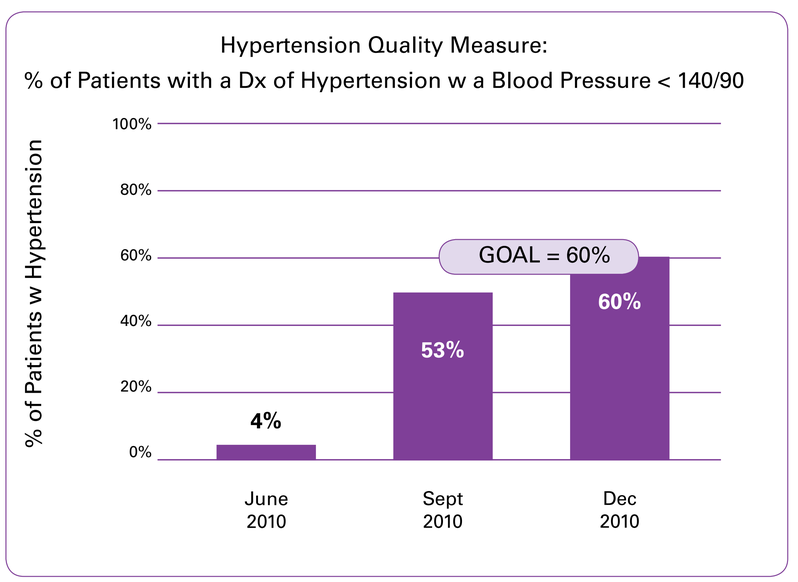
What did you learn from the process of making the change?

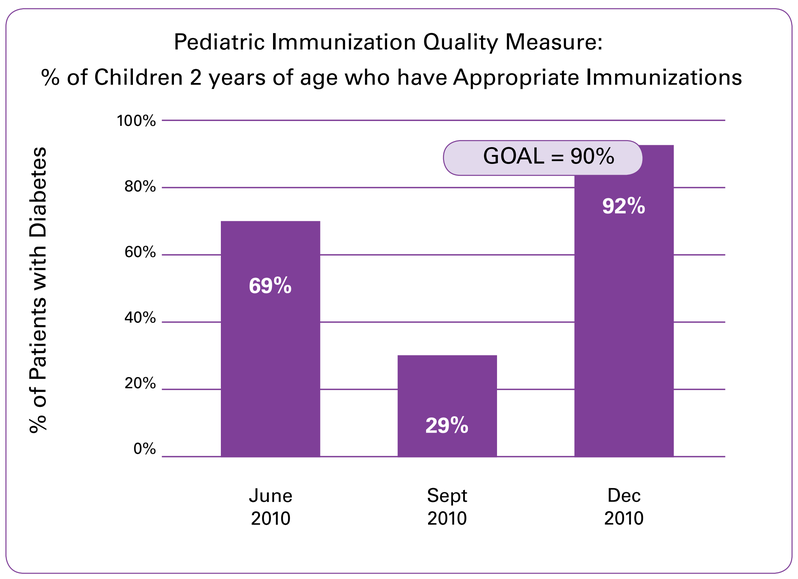
- Increasing the availability of pediatricians has allowed us to see more patients, creating the opportunity to make sure children are up to date on their immunizations.
- Understanding of the socio-economic conditions of the family and community has provided more opportunities for outreach, education and enabling services.

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

- Leverage technology to track each child's immunization schedule.
- Increase the availability of staff and be flexible to meet the needs of the patients.
- Share a visual depiction of data with the care team to demonstrate improvement.







PATIENT IMPACT

"NVH has brought a sense of care to the community. While it is a small medical office, it's more intimate than others, reminding me of the Cheers song: "A Place Where Everybody Knows Your Name". It's great to work in a place where patients and staff know one another well. The location is within a public housing community which cuts down on traveling expenses for those who would have to leave their community for health care and increases availability for the community residents. NVH residents know that when they have health concerns they can come to us. NVH is there and ready to provide both routine and urgent care for children and adults.

The inclusion of prayer as a part of our daily practice is greatly appreciated in the NVH community. Recently, we began offering a prayer service from 12 to 1 pm born out of a tragedy that involved the death of a teenager. The day after the event, a patient came in and suggested that a group get together to pray for the community. Our staff person took the idea and ran with it. So when our office was normally closed for lunch, we now take the time to stop and pray." —Medical Assistant

PROVIDER OR STAFF IMPACT

""Though we are located in the community, there was much misinformation about our services such as whether or not we see only children or people with insurance. We began to look at every interaction as an opportunity to educate patients and the community about our services including participating in the NVH Community Day event. This provided an informal opportunity to interact with both patients and potential patients, building relationships, and the trust.

A majority of our patients extend their trust in us outside our doors. Our scheduling referrals to specialists solidifies our being their medical home, builds the relationship and coordinates a much higher level of care than many of our patients have ever received. It is a great day at work when a patient calls to report that they simply made it to the specialist appointment as often times this takes great effort.

The relationships are also improving between staff. As a small staff, we depend very heavily on one another. Often patients will walk-in without a scheduled appointment and we are often able to successfully integrate such requests, no matter how full the schedule. This requires flexibility from every team member, but the sense of satisfaction is well worth the minor inconveniences.

Many opportunities remain at NVH. Further development utilizing the Empanelment, Quality Improvement and Care Coordination guidelines will be a tremendous resource to us. We look forward to meeting and exceeding higher and higher standards." —Front Office Staff

Engaged leadership is imperative in order to implement a planned strategy of quality improvement, through administrators, physicians, and front/back office staff leaders. Teamwork is important from the start of the day and facilitates communication and efficiency. Follow through is an important safety net for our patients. When these elements function in an optimal fashion, the system is effective. My work experience has been positively impacted through this process when I have seen patients achieve an "Aha" moment and take charge of their health. They realize that I am not their judge but their advocate on their journey to better health. Participating in the SNMHI has been a great experience, propelling us forward in order to provide greater quality care for our patients. It is exciting to think of what the future holds! —Provider

Safety Net Medical Home Initiative

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