Outside In

Outside In is an FQHC in Portland, Oregon. We are both a community health clinic (CHC) and a healthcare for the homeless (HCH) site. We serve approximately 8,000 patients a year, totaling around 18,000 visits.

We provide primary care, complimentary alternative care, tattoo removal services, and outreach visits. Sixty percent of our patients are currently experiencing homelessness and 85% are uninsured. We focus on serving youth under 30 years of age and those who are experiencing homelessness. Our agency also houses a homeless youth services department, youth education and employment resources, transitional housing, intensive outpatient mental health, and alcohol and drug treatment for youth. We even have a doggie daycare.

SNMHI Team:

Dr. Tanya Page
Deb Shoemaker, RN
Ann Watterson, CMA
Angie Hurley , Clinic Manager
John Duke, Clinic Director
Zachary Goldman, Project Manager
Mandy Anderson, Data and Reporting Specialist
Lacey McCarley, Client Access Administrator

PARTICIPATION

What motivated your practice site to participate in this initiative?

We firmly believe that the patient-centered medical home model will provide better health outcomes for our patients and higher satisfaction for our staff. Due to the high need of our patient population and the unique challenges they face, we have traditionally provided a model of care which has incorporated pieces of the PCMH. Seeing the work done by other clinics who participated in the Primary Care Renewal project, we knew that this was the right path for us. The emphasis on relationships and teams already existed in our clinic, but we needed to become intentional and more effective. We anticipate and have already witnessed an increased drive for quality improvement, increased positive health and social outcomes for our patients, more efficient utilization of our current resources, and access to additional resources.

CHANGES

Change One: Patient Empanelment

Problem: Our patient population was only partially empanelled at the beginning of this project. We were not clear on the panel size that each provider was carrying and had no way to adjust their panels.

Goal: We wanted to gain control over our patient population, to set realistic expectations for provider panel size, increase continuity of care, evaluate health outcomes, and set provider-specific goals. We wanted to empanel 95% of our patients and to empanel all new patients within one week of their first visit.

Plan: We utilized our EMR to pull the names of every patient in our system that had been seen within the past two years. We deactivated any patient who had not been seen longer than that. We then pulled the names of the providers they had seen, narrowed down to the provider they saw the most, and who was most appropriate for their current health concerns. Our staff then spent countless hours adding primary care providers to each patient's chart.

Learnings: We learned that we had some providers who were over-paneled and others that were under-paneled. It was also a painfully long and tedious task, so we set in place weekly reports to avoid duplicating the effort in the future. We are still learning how to best manipulate and pull data that is useful to the providers and the healthcare teams.

Recommendations: The greatest recommendation we could have is to invest in a data and reporting staff position. Utilizing the skills of someone who knows how to extract and manipulate the data available is the only way to make this project successful.

Change Two: Team Co-Location

Problem: Our providers all sat in one office, our medical assistants shared an office with only two workspaces for five employees, and our referral and health access staff were located in separate offices that were in different areas of the clinic.

Goal: By moving the teams into the same office, we hoped to see the communication between team members increase and to become more effective in efforts to coordinate patient care. We anticipate lowered wait times for referrals and increases in preventative care delivery.

Plan: We remodeled the clinic which allowed us to plan spaces around the primary care home model. We built two large team offices to accommodate up to two teams in each office. We moved our first generation of teams—a provider, a medical assistant, and a referral coordinator—into the office. They also have an administrative assistant who is present for meetings and coordinates data sharing and addresses all logistical issues that arise.

Learnings: We learned that construction is only half the battle. We still had to identify what a team meant to us, who made sense to be on the team, and how we could make sure that the rest of the staff felt like important members of the entire clinic team. We learned that our teams may change and each team will develop a different workflow and strategy over time, even when started on the same path.

Recommendations: We recommend utilizing resources of those who have gone before you. In our area, there are many clinics that have rolled out similar teams. We had access to their skills and assistance, but due to time constraints and limited internal resources we never fully took advantage of this knowledge. It would be very helpful to identify another clinic to assist in the transition and learn best practices from them

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Change Three: Clinic Quality Improvement Project

Problem: Our clinic has not been very effective at utilizing data from our EMR. The EMR is the perfect tool to identify efficiency and outcome data, but we had no allocated resources toward doing so. With an upgrade to a newer version of our system, we lost access to our one effective data program.

Goal: We wanted to increase the amount and quality of data available to our providers and staff. We hoped to improve outcomes for our patients, and to give our staff solid data.

Plan: We set weekly half hour meetings to evaluate data points which we had all agreed were important. Our initial data points would evolve over time to include more panel and patient population specific areas, but initially we focused on productivity, continuity, and unassigned patients.

Learnings: We are continuing to learn and refine our meeting as time goes on. Very quickly we learned that we had to be very specific in the data that we pulled. Providers and staff had to agree that the data were important and relevant and that it fairly portrayed the work that was being done.

Recommendations: Make sure that the reports are either automated or that more than one person knows how to pull and manipulate the correct data. Prioritize the meeting time and keep it safe and efficient. We have very clear and concise agendas and try to be very punctual with the start and end time in an effort to keep everyone motivated and attending.

Data: Our data for this does not show clear improvement, however the improvement that was made was the continual pulling and refining of data to get to a place where it was useful information.

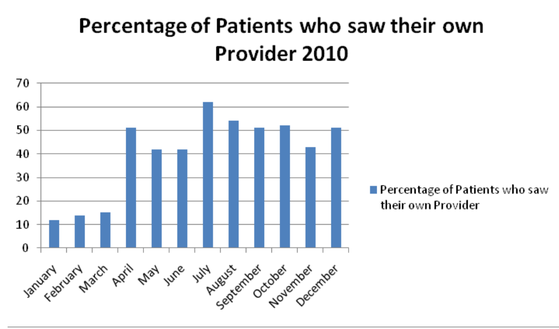
PATIENT IMPACT

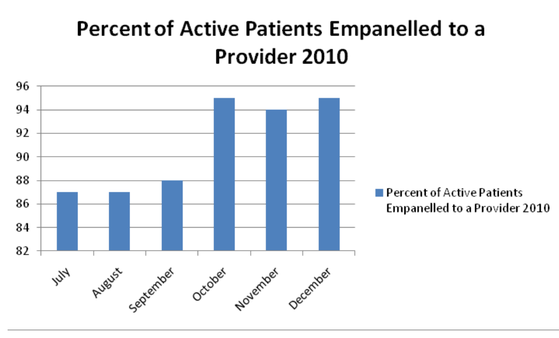
"Pretty much since I started on referrals at Outside In, there has been one patient who has been the poster patient for the PCMH. This patient has a rare movement disorder and was undocumented when we first started seeing him. Even prior to PCMH, a team formed around his care consisting of a referral coordinator, his medical provider, the medical assistant, our nurse, a social worker, an interpreter, and an administrative staff. We've all worked together to do some pretty amazing things! We've secured the patient a citizenship visa and helped him to get Social Security Disability. With that, he was able to get Medicaid. The Medicaid coverage has changed everything for him. Things were looking pretty dark for awhile, but we are steadily working toward a day when he will finally get the surgery that we're hoping will drastically change his current situation. Without the willingness of Dr. Page to work side-by-side with me and everyone else, we never could have made it this far. We share each success, and we brainstorm how to recover after each setback. I always feel supported and trusted by the team around me to do the work I need to do to help this patient. I can't imagine how we would have made it this far without working together."— Referral Coordinator

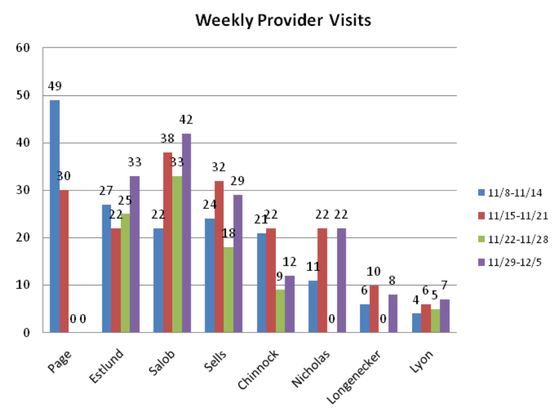
"We only recently moved into our co-located offices, but I've immediately noticed a change in our delivery of patient care. My care team consists of me, my medical assistant, and a referral coordinator. Many times in the past I would put in a referral for a specialty visit and send the patient out the door not knowing if they were going to be able to follow-up with our referral staff. The patient may have a disconnected phone, no mailing address, or they may assume that specialty care is out of reach for them. With my referral coordinator sitting in the same space, I know that I can call on her to speak with the patient in the moment. One of the measurements our team has chosen to track over time is our referral completion. I know that we will see a steady increase in this number as our patients get to know the new team structure and as our team continues to improve communication and workflow."— Primary Care Provider

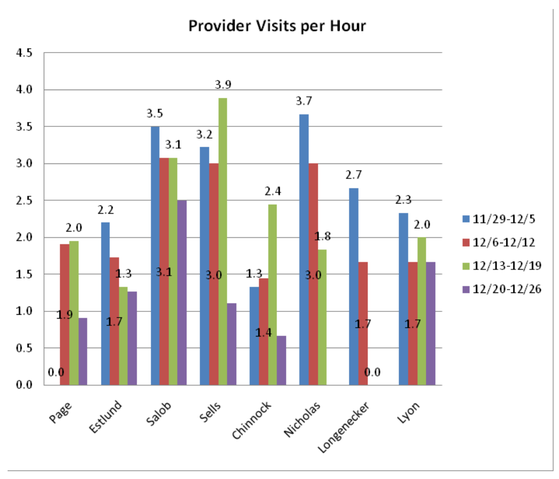
PROVIDER OR STAFF IMPACT

"Having a Patient-Centered Medical Home has positively impacted my work experience at Outside In. Our PCMH care team is composed of a provider, an RN, a medical assistant and a bilingual referral coordinator. This "one stop shop" facilitates the accessibility to medical care and creates a more pleasurable patient experience. Our clients see medical professionals who are thoroughly familiar with their health history. In an underserved community, the continuity of care our clinic provides is essential. As the Outside In Front Desk Coordinator, I can easily funnel medical questions/concerns to the specific PCMH team. In turn, this prevents patients from "falling through the cracks" of healthcare. It gives me great satisfaction to know that our clients receive excellent care." — Front Desk Coordinator









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"Our work with the PCMH model has allowed our clinic to fully embrace the work we've been trying to do for many years. Our work with a vulnerable population who lack so many resources cries out for a model such as this. The patients we work with have complicated medical and social conditions, and our staff often collaborates in order to provide the best outcome possible. As an example, an older gentleman who entered our clinic during a snowstorm in 2008 was very obviously experiencing homelessness and had a variety of ailments common to that population. Through extraordinary communication and teamwork, this patient received medical care, temporary housing to address medical conditions, enrollment in Social Security Disability and Medicare coverage, and assistance finding and maintaining long-term housing. He continues to access our clinic on a regular basis and during a recent hospitalization had visits from multiple members of his team. I am honored to be a member of the Outside In team. The work that is done each day, the energy and caring, the enthusiasm and the advocacy, motivate and inspire our patients and our staff."— Client Access Administrator

Safety Net Medical Home Initiative

QUALIS HEALTH
THE COMMONWEALTH FUND
MacColl Institute at Group Health Cooperative