# Terry Reilly Health System (TRHS)

**Safety Net Medical Home Initiative**

QUALIS HEALTH · THE COMMONWEALTH FUND · MacColl Institute at Group Health Cooperative

Terry Reilly (TRHS) is a community-based non-profit corporation that is dedicated to providing quality, comprehensive health care. The services are provided in an accessible and affordable manner to all persons regardless of age, sex, ethnicity or economic situation. Particular attention is given to people who might have difficulty obtaining care elsewhere due to rural isolation, financial barriers, or cultural sensitivity. In June 2011, Terry Reilly will be moving its Boise Clinic to a new location near the city's largest homeless shelters. This clinic building is designed to facilitate full adoption of the PCMH model.

Terry Reilly operates:
- 6 medical clinics;
- 4 dental clinics;
- 5 behavioral health clinics that are integrated into the medical clinics;
- 4 treatment programs dedicated to assessing and healing the trauma experienced by victims of physical and sexual abuse; and
- and provides services to a detox and crisis mental health facility in Boise.

In 2009 TRHS served 30,756 patients living in southwest Idaho; of those:
- 2,148 where homeless
- 3,202 where migrant or seasonal farm workers
- 66% where uninsured
- 96% where 200% or below poverty level
- 42% identified themselves as Hispanic





## PARTICIPATION

**What motivated your practice site to participate in this initiative?**

The three main reasons Terry Reilly decided to participate in this initiative are:
1. **Continuity of Care** - Continuity of care has been a challenge at TRHS. By utilizing the principles within the PCMH initiative, we can now actively manage our patient volume (demand) and clinician appointments (supply).
2. **Holistic Care** - Focusing on the patient as a whole person rather than a series of problem-focused visits means better health outcomes due to coordinated and integrated care. Many of our patients have complex needs that require many services. By utilizing the tools and principles within the PCMH model, we are able to fully develop a holistic care environment for our patients
3. **Data Driven Model of Care** - Both the practice and the patient benefit from a data driven health system that focuses on outcomes and best practices.

## CHANGES

### Change One: Participation in the Treasure Valley Volunteer Physician Network (VPN)

**What was the specific problem or issue being addressed?**

The specific problem being addressed was lack of referral sources and a disjointed effort in finding and getting specialists to provide services to our patients who could not afford a specialist but needed one.

**What did you hope to achieve by making the change?**

A larger cadre of specialists who would see our patients pro bono and a specific referral and tracking process with the central idea of increased care coordination.

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

The plan was to work with Genesis World Mission and other local clinics that provide primary care to no, low and moderate income patients to create a network of specialists in the Treasure Valley who would be willing to provide specialty services to our patients pro bono. The Volunteer Physicians Network (VPN) is a web-based referral network that allows for the lower income, uninsured patients of four local safety-net clinics access to specialty physicians, labs, and hospitals.

VPN spreads out the opportunity to many more doctors, providing stable availability while also allowing the physician to control the parameters of the services they donate as some doctors experienced charity burnout by being the "charity doc" everybody called upon.

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

We have learned over time that banding together is far more powerful then going it alone. Specialty Physicians are much more likely to provide care when there is a standardized process among many entities and when the specialist is allowed to control the services he/she will provide. It is also much easier if one entity is doing all the recruiting of the specialists.

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

Band together with other FQHC's and/or free clinics in your area to create an overall program.

### Change Two: Increased integration of Behavioral Health

**What was the specific problem or issue being addressed?**

The issue that we are addressing is not having a just-in-time behavioral health staff at our Boise Clinic, which serves a large homeless population with complex medical and behavioral health issues. When a provider identifies a patient who would benefit from case management and/or behavioral health services, the patient must wait one to three weeks for an appointment.

**What did you hope to achieve by making the change?**

We hoped by making the change to a just-in-time model of case management and behavioral health we would increase positive outcomes for our patients and cut down on no-shows with our behavioral health staff

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

Our new Boise Clinic was built to facilitate the full integration of a just-in-time behavioral health model. Behavioral Health staff, including the case manager, will be stationed in the "bull-pen" with the medical members of the care team. Appointed care will be limited for behavioral health staff so that when they are needed, they can work with a patient immediately.

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

We have already learned many things about this change even though it will not be fully complete until June 1, 2011. This new model is a complete shift in the way that we have done business and thus it takes time for staff to assimilate. We have found that by taking the time needed – 6 months, to work through the changes, staff are getting excited about the new model.

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

Take the time to allow staff to express their opinions and concerns and if possible, act on requests made.

### Change Three: Increased positive clinical outcomes for patients

**What was the specific problem or issue being addressed?**

We were not meeting core clinical UDS measures established for 2010/2011 by the Terry Reilly Board of Directors. Underlying this issue was the fact that clinics did not have timely data on how they were doing in reaching the goals.

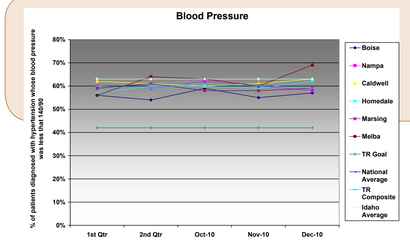
**What did you hope to achieve by making the change?**

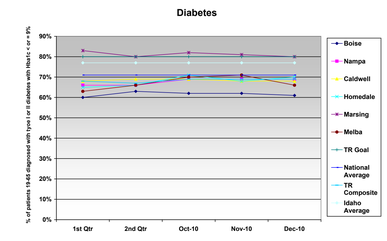
We hoped to empower and motivate sites to make changes by making transparent the goal for each core clinical measure was and how each clinic was doing, monthly, based on the goal.

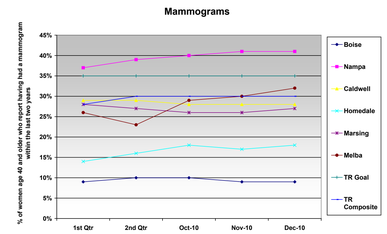
**What was the plan for making the change? How did you make the change?**

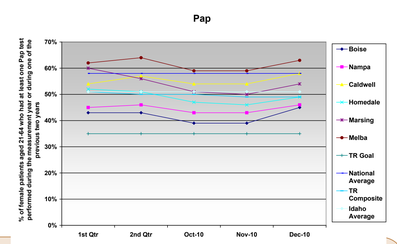
The plan was to create run charts, updated monthly, that would show how well each clinic was doing in regards to 5 core clinical outcome measures:
- HbA1c levels for our diabetic patients
- Blood pressure under 140/90 for our hypertensive patients
- Pap tests for women between the ages of 21 and 64
- Mammograms for women age 40 and older
- Immunizations for children

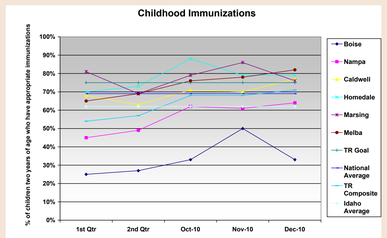
The data would be shared monthly at each clinics' care team meeting with brainstorming around how to increase the percentages.




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

We learned that you need to make sure your data is accurate when you are sharing it with staff; that data is a powerful motivator for coming up with unique answers to increasing positive patient outcomes; and that a little healthy competition is a good thing and can have positive results for our patients.

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

Make sure your data is good before you share it.

## PATIENT IMPACT

"We recently formed interdisciplinary care teams as part of our PCMH transformation. In our monthly care team meeting, we reviewed the quality data and noticed that our clinic was underperforming on our mammography rates. As a rural community, our patients would have to travel to nearby cities if they wantedto receive this screening. Every two months, we have arranged to have a mobile mammography service visit our community.

It had been some time since the last visit, so we scheduled to have the van come out. We brainstormed ways so we could ensure that we would fill up all the appointment slots. We use our patient huddle time to identify patients who are in need so we can invite them during their visit. We are offering a recognition prize to the care team member who signs up the most patients for their appointments. As a result, the current schedule is almost full and we will start a wait list to backfill for any cancellations."
—LPN and Clinic Coordinator – Homedale Clinic

"One of our patients who has benefited tremendously from the integration of Medical and Behavioral Health is "Diane" who suffers from bipolar disorder, which was initially misdiagnosed. Once diagnosed, her care for both the mental health and medical issues with her bipolar was not coordinated. She had a lot of guilt and shame about her depression for a very long time. She suffered from feelings of worthlessness and at one point thought about suicide. Diane's circumstances began to change at Terry Reilly, where her medical and behavioral health issues could be addressed in an integrated fashion."—Terry Reilly Behavioral Health Staff

"I had had to answer questions about my circumstance and my problems before and it was invasive and embarrassing. I didn't believe I would be treated with dignity and respect, but at Terry Reilly that is exactly the way I was treated. They were incredibly supportive and compassionate. I went from feeling like I was lost and alone to believing I could save my home, find a job, and finally have some structure in my life that would allow me to function. The staff at Terry Reilly partnered with me. They helped me get back a lot of what I had lost as a result of my bipolar disorder. The quality of my life has improved because of them. I don't know what I would have done if it had not been for the staff at Terry Reilly."
—Patient "Diane"

> The staff at Terry Reilly partnered with me. They helped me get back a lot of what I had lost as a result of my bipolar disorder. The quality of my life has improved because of them. I don't know what I would have done if it had not been for the staff at Terry Reilly.
> —Patient "Diane"

## PROVIDER OR STAFF IMPACT

"We recently had a 1.0 FTE clinician depart our medical clinic. Because of somewhat soft demand, we were not sure whether we needed to replace the clinician with a full- or part-time provider. Historically, we would not have taken any proactive steps to identify the patients impacted to manage a transition to a new primary care provider. We would have dealt with the issue when the patient requested an appointment with the provider who departed. We recognized that this approach was not very patient friendly. It also created significant uncertainty about our real capacity.

Because of our efforts this past year with empanelment and establishing PCP assignment protocols and panel sizes, we were able to proactively manage the transition of the patient panel of the departing clinician. After determining the patients who need warm handoffs and a few other steps, we determined that we needed an additional .4 FTE to address the balance of the patients.
—Medical Operations Director

"As a front office manager, one of the fantastic side effects of implementing PCMH at our facilities has been the opportunities for my staff to develop new skills and interact as peers with providers, nurses and managers. Several of my employees have been invited to sit on the committees implementing PCMH. I've seen them go from shy, back-row-sitters afraid to speak up to vibrant contributors willing to tease or even politely disagree with providers and managers. The camaraderie in the meetings took some time to develop, but is really changing the way the staff interacts across the clinics. The Care Team meetings are also fostering more cooperation and interaction than we had before. Problem solving skills are being developed – we are looking forward to a LEAN workshop soon that will contribute to our ability to develop positive solutions and better processes. Change fatigue is a real challenge in health care, and good relationships and feeling heard as an employee go a long way toward preserving morale and helping with resiliency. The direct involvement of the employees in implementing the change concepts has benefitted us all." —Front Office Manager


## EMPANELMENT PROTOCOL: PCP ASSIGNMENTS AND CHANGES

Any time a patient calls in to the front desk or queue, confirm that their stated PCP matches the "doctor" field in PMIS.
- YES → Proceed as usual.
- NO → Schedule patient with provider they request (first incidence only) and note discrepancy in appt notes.
- NEW PT. → Schedule new pt. visit and assign that provider as PCP.

Any time a patient checks in at the front desk, confirm that their stated PCP matches the "doctor" field in PMIS.
- YES → Proceed with check-in as usual.
- NO → Has the patient established care with us?
  - YES → Is there an obvious, easy-to-correct error? For example, the patient has never seen the PCP listed and is clearly established with another provider – or the PCP no longer works at Terry Reilly.
    - YES → Make the correction and proceed with check in.
    - NO → Flag account to Care Team's Panel Administrator for follow up and correction.
  - NO → If only seen in express care, dental or behavioral health, no permanent PCP will be assigned yet. If establishing today, today's provider will be the PCP.

A PCP leaves Terry Reilly or transfers to another clinic.

PCP notifies Medical Director and Medical Operations Director.

Medical Director and Medical Operations Director develop a plan to care for the patients. They may do this in consultation with the Care Team(s) and/or Empanelment Committee.

- Option ONE: Transfer entire panel to new PCP.
  - Panel Admin requests reports for P1, P2 patients assigned to departing PCP. Front Office/Management team coordinate for bulk reassignment of patients in PM and sends form letters to affected patients. Panel reassignment patient form letter.doc
- Option TWO: Departing PCP reviews panel and individually recommends individual patients to specific providers, preferably on the current Care Team.
  - Upon approval of receiving PCP and Medical Director and Medical Operations Director, Front Office/Management team coordinate for bulk reassignment of patients in PM and sends letters to affected patients. Panel reassignment patient form letter.doc
- Option THREE: For a temporary leave, other Care Team PCP's see the patients without reassigning the PCP in PMIS.
- Option FOUR: Other solutions as developed by the Medical Director and the Medical Operations Director.

A patient or a provider wants to request a new or different PCP.

If the request is from a patient, explain the PCMH model and the importance of the continuity of care.

Give the patient a PCP Change Request by Patient Form and inform patient of 2 week turnaround time. Completed form is given to current Care Team Panel Administrator.

If the request is from a provider, give the provider a PCP Change Request by Provider Form. Completed form is given to current Care Team Panel Administrator.

Panel Manager reviews no show history, previous PCP changes, etc. and consults with current PCP. Does PCP agree to change?
- YES → Panel Manager consults with proposed PCP and proposed PCP's Panel Manager. Does new PCP agree?
  - YES → Previous and new PCP's consult directly for a smooth hand-off.
    - Panel Admin informs patient in writing within two weeks of their new PCP using PCP Change Request patient form letter.doc and updates assigned PCP in PMIS and notifies PCPs via EHR flag. All forms and letters are scanned into PM.
  - NO → The PCP or Panel Administrator informs patient of the denial verbally or in writing within two weeks using PCP Change Request patient form letter - denial.doc. Panel Administrator notifies both PCPs of decision via EHR flag. All forms and letters are scanned into PM.
- NO → Previous and new PCP's consult directly for a smooth hand-off. Current Panel Admin informs patient in writing within two weeks of their new PCP using PCP Change Request by provider form letter.doc and updates assigned PCP in PMIS and notifies PCPs via EHR flag. All forms and letters are scanned into PM.
- NO → Panel Administrator informs PCP within two weeks that request is denied. They discuss options including asking an alternate PCP, a behavior contract, or terminating services to the patient. The Care Team may be consulted in the discussion. Panel Admin. to document results in EHR.

Appeals process for a denied request to change primary care provider

Patient submits letter requesting an appeal of decision to deny request to change primary care provider.

Letter is routed to medical director for review.

Medical Director consults with current and proposed pcp's and panel administrator(s).

Medical Director may also consult directly with the patient.

Medical Director weighs needs of patient and providers, quality of care, provider schedules and provider panels in the decision.

Medical Director informs the patient of the final decision in writing within two weeks. Medical Director also informs the PCPs and Panel Administrator(s) of the outcome and scans all correspondence into pm.