Valley-Wide Health Systems

We began providing health services in a small southern Colorado clinic in 1976 and are now one of the US' s largest Rural Community Health and Migrant Health Center organizations—with 40,000 users and 162,000 encounters each year.

We serve 17 Colorado counties with:
- 13 health clinics
- 5 dental clinics
- 1 medical/dental mobile health unit

PARTICIPATION

What motivated your practice site to participate in this initiative?
This project dovetailed very nicely into the work we had already begun to support a "Convenient Care" model in our region. Ensuring that patients are linked to a medical home provides our population with better care and lowers the utilization of ED services.

CHANGES

Change 1: Use Case Managers to Guide Patients to Appropriate Resources
Change 2: Open an After-Hours "Convenient Care" Clinic

What was the specific problem or issue being addressed?
Both of the change tactics were designed to tackle three interrelated issues:
- Many of our patients did not have a regular source of care and indicated that healthcare was generally inaccessible.
- Acute-care patients were crowding out patients seeking chronic and preventive services from our clinics.
- The ED was our patients' only resort for care during evenings, weekends, and holidays.

What did you hope to achieve by making the change?
An after-hours clinic directly addressed our patients' need for care that better fit their schedules.

By using case managers, we intended to help our patients better navigate the healthcare system, get connected with appropriate healthcare resources, and become part of a medical home. In addition, our case managers could provide basic health education as well as counseling regarding psychosocial needs (i.e. transportation, language, etc.).

We were confident that caring for high volume, low complexity problems up front would keep people out of the ED later.

What was the plan for making the change?
A marketing campaign was launched to publicize the benefits of this new approach.

In addition, the local hospital and private practice providers were enlisted to educate patients about the unique aspects of this initiative.

The scope of services and operational hours would be subject to change, as the needs of our patients changed and/or became more clear.

Results
- There was an immediate 20% reduction in level III, IV, and V visits to the ED
- 672 patients have been connected to medical homes
- A sample of 100 of these patients revealed that 87% attended at least one medical visit for a chronic care condition or preventive health care service
- More than half of the patients who completed mroe than one visit had utilization rates approximately equal to Valley-Wide's overall rates—demonstrating their general acceptance of the medical home model
- Patient & community response has been overwhelmingly positive
- There is optimal information exchange with the ED and local providers
- A community cross-coverage call system has developed

"Thank you for your caring medical attention on Christmas Eve afternoon when I came into the office with severe abdominal pain. I appreciated your patience and skill in determining that my condition was truly serious…. Your timely and intuitive attention truly made a difference!"

—Patient of the Convenient Care Community Clinic

PROVIDER OR STAFF IMPACT

"[The PCMH model] actually improves the quality of patient care. We ensured that patients were linked to appropriate community resources, and that they did develop a medical home—and were seen and followed up in that medical home." —Director of Clinical Support Services

Safety Net Medical Home Initiative

QUALIS HEALTH

THE COMMONWEALTH FUND

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