

Primary Care Renewal 101

Background

Brief History

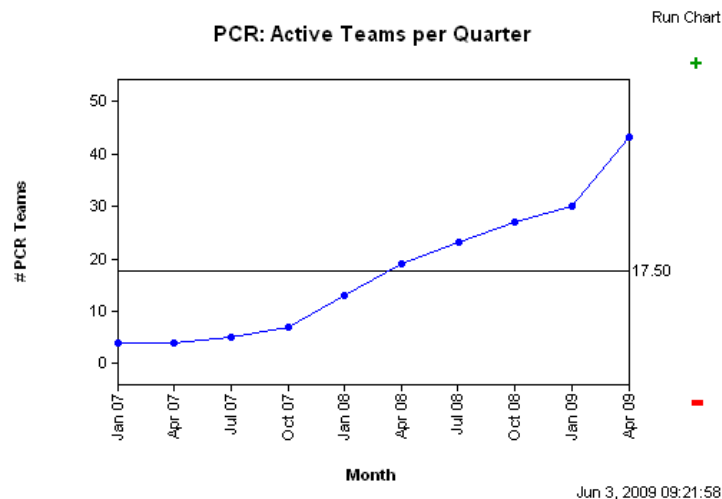
In August 2006, CareOregon led a group of delegates on a visit to the Southcentral Foundation in Alaska. The Southcentral Foundation is an Alaska Native-owned nonprofit that, over the past ten years, has implemented a very successful whole-system transformation based on the values and needs of its patients. The purpose of the visit was to learn about the Southcentral Foundation redesign, and to assess the feasibility of implementing the model with the CareOregon patient population.

The CareOregon delegation came back optimistic that the model could be replicated and developed a plan for implementing it. The redesign effort would be called Primary Care Renewal (PCR). Funding for it was provided through CareOregon's Care Support and System Innovation (CSSI) Program, which supports improvement projects at clinics and hospitals.

CareOregon requested PCR proposals from interested primary care clinic partners in November 2006, and funded projects at four clinics in January 2007: OHSU Family Medicine at Richmond, Legacy Clinic Emanuel Internal Medicine, Virginia Garcia Memorial Health Center- Cornelius, and Central City Concern's Old Town Clinic.

Each of the four clinics identified a pilot team that would be the first to implement the model at their site. Members of all the pilot teams came together at a Collaborative Learning Session in March 2007, where they learned about the Southcentral Foundation's model and received training in process improvement techniques. Soon afterwards, the pilot teams began identifying and testing improvements in their clinics.

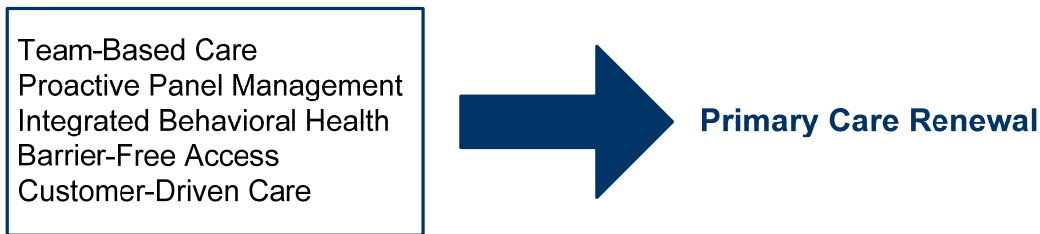
In August 2007, two more clinics joined the pilot project: Multnomah County Health Department's Mid-County and HIV Clinics. In January 2008 and January 2009 CareOregon renewed the funding for all clinics in the PCR Collaborative, and all sites continue to test improvements. Currently, the PCR clinics are working to spread the model beyond their pilot teams to other teams and clinics within their systems.



Charter

CareOregon and its partners will demonstrate that a new primary care delivery model will deliver higher quality health care with a more cost effective use of public funds. Pilot site providers will implement a new model of primary care based on the Southcentral Foundation paradigm, develop optimal new work flows, skills and technologies and explore new ways for CareOregon to support and spread this model.

Five Goals of Primary Care Renewal



Glossary of Terms

Team-Based Care

Patients are seen by high-functioning clinical care teams. Teams may differ from clinic to clinic, but usually consist of a PCP, a medical assistant, a case manager, a behavioral health practitioner, and sometimes a team assistant. The team approach allows more patients to be seen, and also allows patients to receive the care they need from the care team member who can most effectively deliver it.

Example: a patient is scheduled to see his or her PCP, but while the care team is huddling they realize that the patient's concerns can actually be addressed by the case manager, which frees up the PCP to see other patients in the time slot.

Proactive Panel Management

A panel of patients is assigned to a care team, which provides an environment that allows development of deeper patient/team relationships and results in more personalized care. It also allows the care team to focus on maximizing the health of their entire defined patient population, rather than just focusing on their daily patient schedule.

Example: a care team decides to focus on managing the A1c results for its diabetic patients. Every time a diabetic patient is seen in the office, the team looks at the patient's most recent A1c results and discusses them with the patient if necessary. If the patient has not had an A1c test within 6 months, the team schedules one. If the patient hasn't been seen in the clinic in over a year, the team calls the patient to schedule an appointment and an A1c test.

Integrated Behavioral Health

A behavioral health practitioner is incorporated into the care team. This person offers solution-focused counseling and resources to patients, and provides both immediate and follow-up care when needed. Screening and treatment of mood and behavioral issues become integrated into the activities of the entire care team.

Example: a care team PCP is talking with a patient during an appointment, and the patient tells the PCP that she is having trouble keeping up with taking the right medication. The PCP calls the behavioral health practitioner into the exam room and introduces her as a trusted colleague. The behavioral health practitioner works with the patient to develop strategies for keeping up with her medication.

Barrier-Free Access

All barriers to patients receiving prompt, appropriate care are eliminated. Factors that might keep patients from receiving appropriate care can include time, place, language, culture, attitude, or facilities. Barrier-free access includes incorporating advanced or open access into the clinical structure.

Example: a patient is really frustrated because every time he tries to talk to his care team, he gets routed to seven different phone numbers, and sometimes he even gets disconnected entirely. In response to this complaint and others like it, the care team installs a phone line that patients can use to dial directly into the care team.

Customer-Driven Care

Patients, also known as clients or customers, are continuously involved in the design and evaluation of all elements of care provided to them. If patients' values, preferences and needs are taken into account, it will result in greater patient satisfaction and more effective use of the medical system.

Example: a newly-formed care team invites a patient to join their team meetings to help them figure out where they need to focus their improvement efforts.

Huddling

The care team meets daily (or more often if necessary) to go over the current patient schedule and to discuss the needs of the patients coming into the clinic. Team members share insights and concerns, and expectations for patient visits are clarified. This is also an opportunity to make sure that the appropriate materials, such as medical records or test results, are available prior to the visit.

Example: a care team huddles at 8:10 am for 20 minutes to go over the day's schedule. One of the patients on the schedule is coming in for a visit related to his diabetes. The case manager and behavioral health practitioner have each had a discussion with the patient about his diabetes within the past couple of days, and share what they know with the PCP so that she has all of the information she needs for a successful visit.

Max Packing

The care team works together to do as much as possible for a patient while he or she is in the clinic for a visit. This is a component of proactive panel management because it involves tracking patients' proactive care needs and taking care of those needs whenever possible.

Example: a patient comes in for a sore throat. During the huddle that morning, the care team noticed that the patient was overdue for a tetanus shot. During the visit, the team offers the patient the tetanus shot in addition to seeing her for the sore throat.

Scrubbing the Schedule

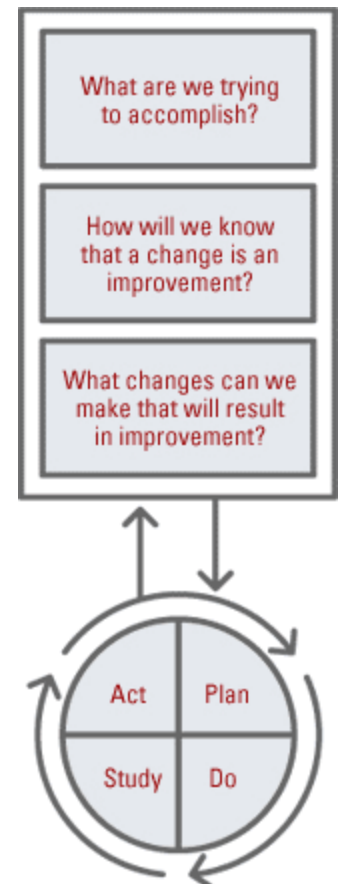
The care team determines that a visit is unnecessary and removes it from the provider's schedule. A visit might be scrubbed from the schedule if the patient's issue can be taken care of over the phone, if the issue can be addressed by another member of the care team, or if the appointment would be more appropriate on another day or time. Scrubbing the schedule usually happens during the care team huddle.

Example: a patient is scheduled to come in to discuss the results of a lab test. During the huddle that morning, it becomes clear that the patient hasn't yet had the lab test, and isn't scheduled to have it for another three days. The care team reschedules the patient for a date after his lab test has been completed.

Model for Improvement

The Model for Improvement is an improvement tool developed by Associates in Process Improvement. The tool consists of three questions: What are we trying to accomplish? How will we know that change is an improvement? What changes can we make that will result in an improvement? After the team has answered these questions, it will use PDSA cycles to test whether its proposed changes really will result in improvement.

Example: a care team wants to make a change to the way they room patients. They define what they are trying to accomplish: a better system for rooming patients that lets all team members know what room each patient is in. They talk about how they'll know that their change is an improvement: they will track the number of times a team member can't find a patient, and hope that the number decreases. They discuss what changes they could make that might result in an improvement, and decide to try one PDSA cycle using a white board that lists room assignments, and one PDSA cycle using colored flags outside of the rooms that are occupied.



PDSA Cycle

PDSA stands for Plan, Do, Study, Act. The purpose of PDSA cycles is to test small changes in real work settings to see whether they will result in improvements. A PDSA cycle will help the team **plan** a specific test of change, **do** the change to see whether it works, **study** the results of the test, and **act** based on what the results of the test were. PDSA cycles are meant to be short, data-driven tests of change. They are a component of the Model for Improvement.

Example: a care team isn't sure whether huddling in the morning or the afternoon makes the most sense for them. **Plan:** they decide to try huddling in the morning for one week, and huddling in the afternoon for one week. **Do:** they carry through with their plan, and track how many team members were able to join each huddle. **Study:** they discover that only three team members were able to join the morning huddles on a regular basis, but that all five team members usually made it to the afternoon huddles. **Act:** the team decides to stick with huddling in the afternoon to discuss the next day's schedule.

Role Definitions

Each care team is made up of team members who fulfill different roles. At the Southcentral Foundation, care team roles are defined as follows.

Primary Care Provider (MD, NP, MA)

Heads care team (teams identified & patients assigned by PCP); makes major medical decisions; responsible for patient panel outcomes; spends majority of time seeing patients; responds to work defined by MA (scheduling) and case manager (calls and panel management activities).

Case Manager (RN)

Actively manages the patient panel; constantly reviews the visit schedule with (and without) the PCP; heads chronic disease tracking; answers panel member calls; identifies preventive care needs with every patient contact; coordinates follow-up procedures, labs, visit reminders, case management and care coordination issues, patient teaching opportunities, and refills; manages pain contracts; occasionally has patient visit.

Medical Assistant (MA)

Focuses on clinic visits; reviews daily schedules for patient care needs with case manager; reviews health maintenance form prior to rooming patient; does vitals, depression, substance abuse and tobacco screening; orders labs; gives immunizations; completes orders per clinician & draws labs; keeps clinician on schedule; ensures visit closure; covers other MAs as needed.

Behavioral Health Practitioner (LCSW)

Focuses on decreasing division between mental health and physical health; provides solution-focused therapy in handoff from PCP on issues such as depression, anxiety, substance abuse, personal or social emergencies, and coaching for behavior changes; does limited follow-up calls and visits; refers patients to specialty mental health as necessary.

Team Assistant

Helps with anything that does not require an RN; makes appointments and referrals; orders tests; communicates negative lab results to patients; arranges transportation for patients; communicates refills to patients; does data entry (for PHQ9 scores, etc); helps with office management (faxing, letters, filing, etc); assists with daily schedule review.



Sources:

"About Southcentral Foundation." Southcentral Foundation. 20 May 2008
<<http://www.southcentralfoundation.com>>.

Gottlieb, Katherine, Ileen Sylvester, and Douglas Eby. "Transforming Your Practice: What Matters Most." American Academy of Family Physicians (2008). 20 May 2008
<<http://www.aafp.org/fpm/20080100/32tran.pdf>>.

"How to Improve." Institute for Healthcare Improvement. 20 May 2008 <<http://www.ihl.org/ihl>>.