Patient Centered Medical Home and Its Impact on HCH

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Objectives

- Demonstrate PCMH standards of Access to Care and Care Coordination
- Discuss the benefits of care coordination
- Demonstrate the model of a case management system that incorporates patient navigation and linkage to care strategies
- Discuss the model of improvement (PDSA cycle) as a quality improvement method for reducing barriers to care
- Demonstrate ways to utilize the electronic medical record for care coordination and other activities

Agency Overview

- Harlem United is a multi-service community-based organization providing healthcare, housing and prevention services for individuals and families living with HIV/AIDS and at risk for HIV transmission
- Founded in 1988 as Upper Room AIDS Ministry in response to increasing HIV/AIDS crisis
- Service provision located in Manhattan (Harlem), Bronx, and Brooklyn
- 10 facilities: 5 Housing, 2 Primary Medical Care/HIV specialty clinics and ADHC's (East/West), Prevention & Testing, Black Men's Initiative (BMI), Administration
- Opening a 3rd clinic and additional housing facilities in 2013
- "One-Stop-Shop" Model & Continuum of Care
- Over 12,000 individuals served in 2011
- 2,300 homeless individuals in clinics in 2011

Harlem United – Organizational Structure

Community Health Services

- Community Based HIV/ STI/HCV Screening
- Access to Care
- Drug User Health Services (Syringe Access, Harm Reduction, Recovery Readiness)
- Black Men's Initiative – integrated interventions for MSM of color

Integrated HIV Services

- Adult Day Health Centers
- Food & Nutrition
- Supportive Housing (Women's Housing, Transitional Housing, Congregate, etc.)
- COBRA Case Management
- Family Support

Holistic Provider-Led, Patient-Centered Primary Care and Dental Services

Behavioral Health Services

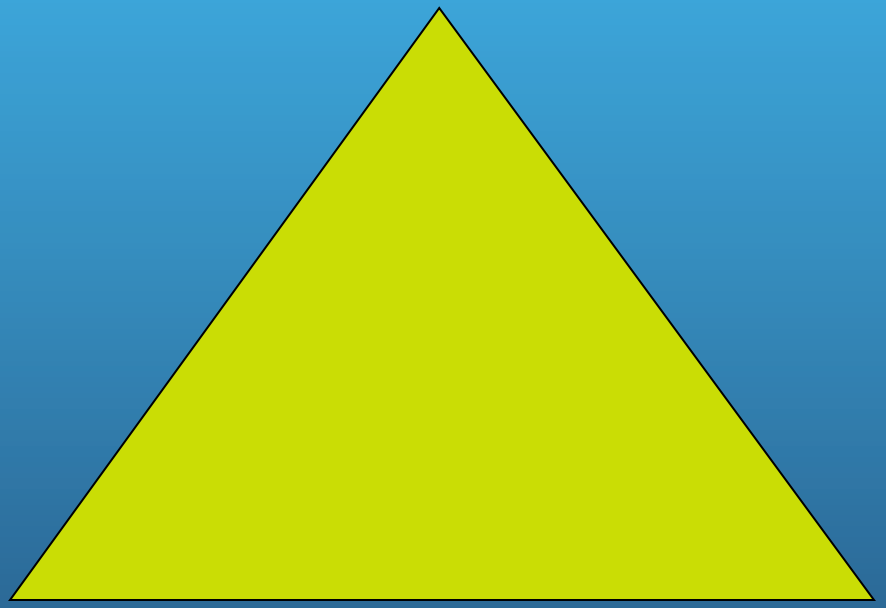
Patient Navigation/Case Management Support

Harlem United – Quality Management infrastructure

- Quality culture
  - Management Triad
  - Monthly Continuous Quality Improvement (CQI) meetings
- Primary Care & Dental QM reporting structure/ leadership
- Staff
  - Data & Evaluation team
- Equipment & Technology
  - Electronic health records

Harlem United – Management Triad

Continuous Quality Improvement (CQI):
Program-level assessment of service delivery



Administrative Data-driven supervision:

Staff-level assessment (broad) of service delivery

Clinical Supervision:

Staff-level assessment (focused), clinical skills building and trainings

Quality Improvement Activities - Example

- **Develop action plans:**
  Description of activities to be performed to test solutions, responsible parties, timeframes, and expected results.

Corrective Action Plan (CAP) template

Issues	Plans	Action Steps	Responsible Persons	Target Date	Status Update

- **Implement action steps outlined in CAP document:**
  - Make sure everyone is aware of which action steps are assigned to them
  - Identify a champion to make sure that action steps are executed

CQI Process- Continuous Quality Improvement

Continuing Quality Improvement (CQI) is a method of problem solving with three critical aspects:

- *Relies on input in the form of information from the environment. What is the problem? What evidence is there to address it? Has the solution attempted worked? Are stakeholders satisfied?*
- *Is circular: Problems are solved in small steps that successively add up to large gains.*
- *Is data driven. The problem must be quantified so that it is possible to measure the baseline level of the problem and to measure subsequent change from the baseline.*

CQI Process- Continuous Quality Improvement

At the core of CQI is a scientific method that involves experimental steps that can be applied to everyday work to meet the needs of stakeholders and improve the services we offer.

- *The purpose is to achieve performance goals that are sustainable over time.*
- *The PDSA cycle is a four-step process for quality improvement.*
- *In the first step (plan), a plan to effect improvement is developed.*
- *In the second step (do), the plan is carried out, preferably on a small scale.*
- *In the third step (study or check), the effects of the plan are observed.*
- *In the last step (act), the results are studied to determine what was learned and what can be predicted and feeds back into another Plan-Do-Study-Act cycle.*

Primary Care

- Started in 2001 as an extension clinic of a local hospital
- Response to patients in ADHC not receiving primary care
- In 2007, there were 158 patients in primary care
- In 2007, awarded FQHC(h) status
- In 2010 achieved NCQA PCMH Level 1 Recognition
- In 2011, we served 2900 patients between homeless (2338)and non homeless populations.
- In 2012 achieved PCMH Level 3 Recognition

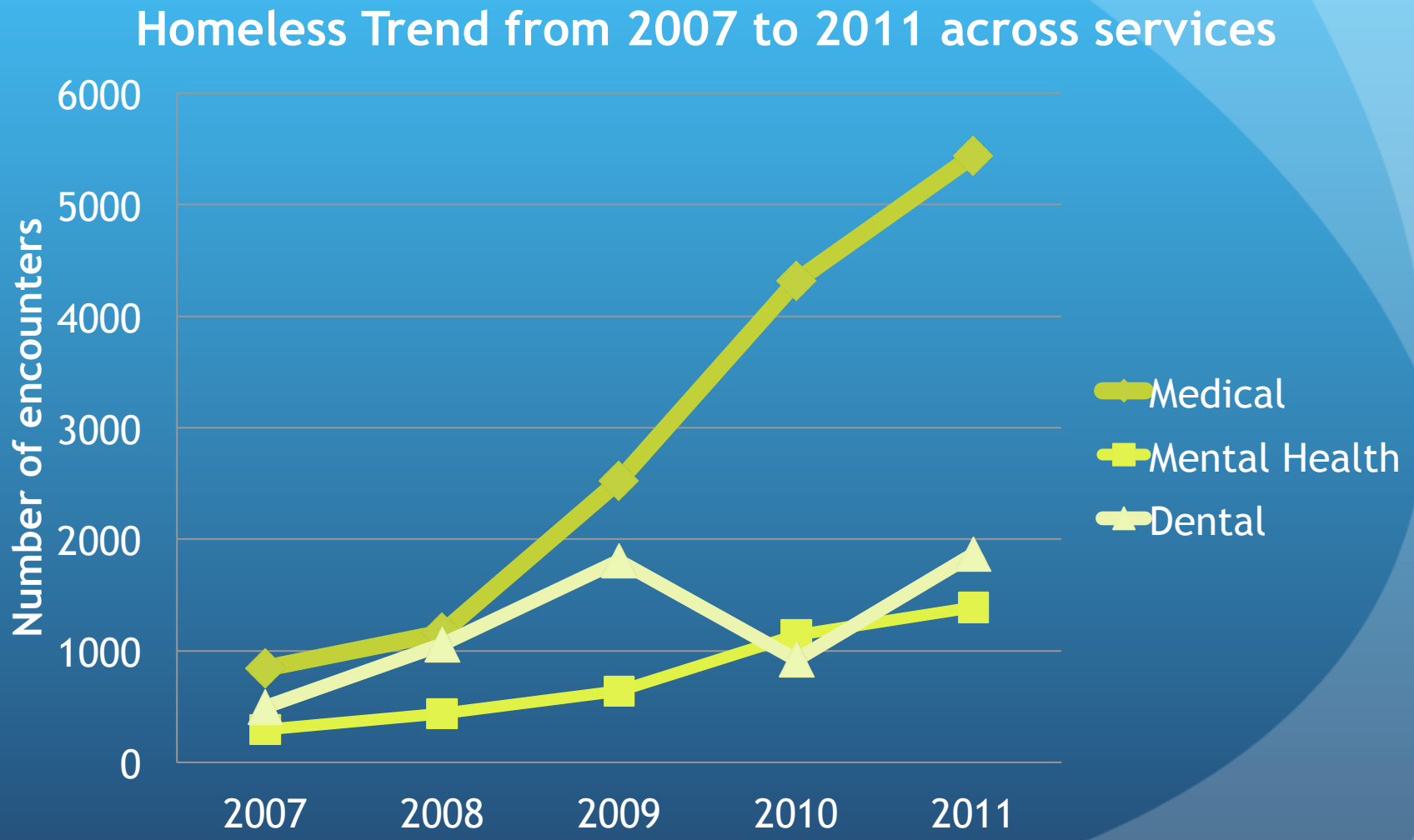
Primary Care Services

- Internal Medicine
- Comprehensive Integrated HIV primary care services
- Hepatitis C evaluation and treatment
- Mental Health (psychiatry and psychotherapy)
- Transgender care
- Suboxone
- GYN Services
- Dental Services
- Treatment Adherence

Top 12 Diagnosis

Top Diagnosis (Medical Home submission, 90 day period)				
ICD Ranking	ICD-9 Code	Description	Frequency -overall	Number of Clients with Diagnosis Code
1	*042	Human immunodeficiency virus [HIV] disease	1124	643
2	295	Mental Heath Disorders	737	593
3	296	Depression	372	78
4	401	Essential hypertension	319	54
5	250.00 - 250.92	Diabetes mellitus	260	180
6	305	Substance Abuse	231	38
7	493	Asthma	220	156
8	709	Skin Disorder	205	186
9	724	Low Back Pain	149	114
10	729	Pain in Limbs	149	114
11	272.4	Hyperlipidemia	108	159
12	070.41-573.3	Hepatitis	105	71

Growth in our Homeless Population



Growth in Primary Care Staff

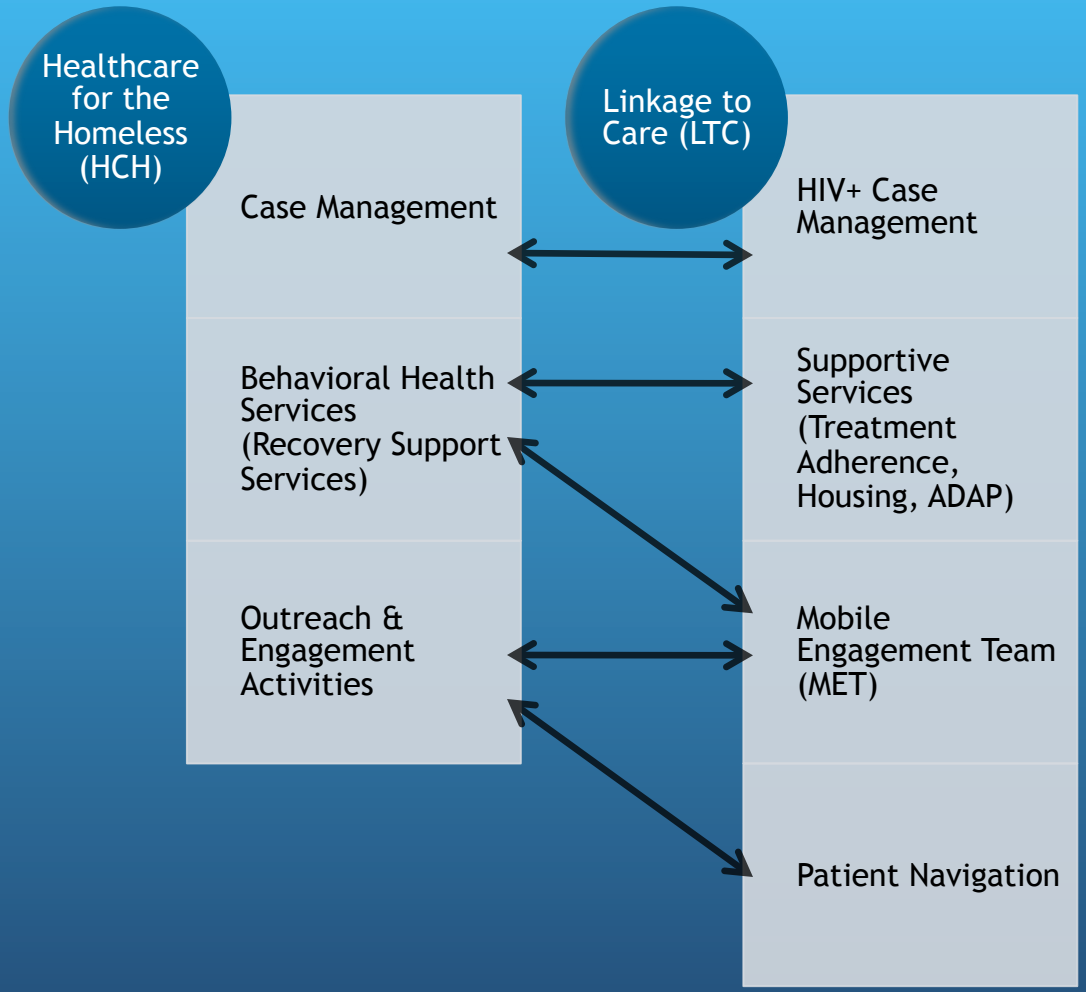
- In the last year increased staffing by:
  - 1 full-time Physician
  - 1 full-time Physician Assistant
  - 1 full-time Psychiatric Nurse Practitioner
  - 1 part-time Physician Assistant
  - 3 Medical Office Assistants

Increase Access to Care through expanded hours

- Early 2011 opened clinic every other Saturday
- Mid 2011 at 2 Late nights (til 7:30pm)
- January 2012 open every Saturday
- January 2012 open 4 late nights in one clinic and 2 late night in the other
- Increased Dental access to 2 late nights and 3 Saturdays per month

Access to Care Program

Parallel Programming



Integrated Programming

Access to Care (ATC) & Supportive Services			
Case Management Services (HCH & LTC CMs)	Patient Navigation Services (All PNs)	Supportive Services (Housing, Tx Adherence, ADAP)	Outreach & Engagement Activities

ATC Program Overview

GOALS:

- To locate and engage out-of-care individuals into care and support services
- To ensure access and retention to medical care and support services
- To provide support services needed to achieve optimal health outcomes
- To navigate through initial medical care and connect to comprehensive case management

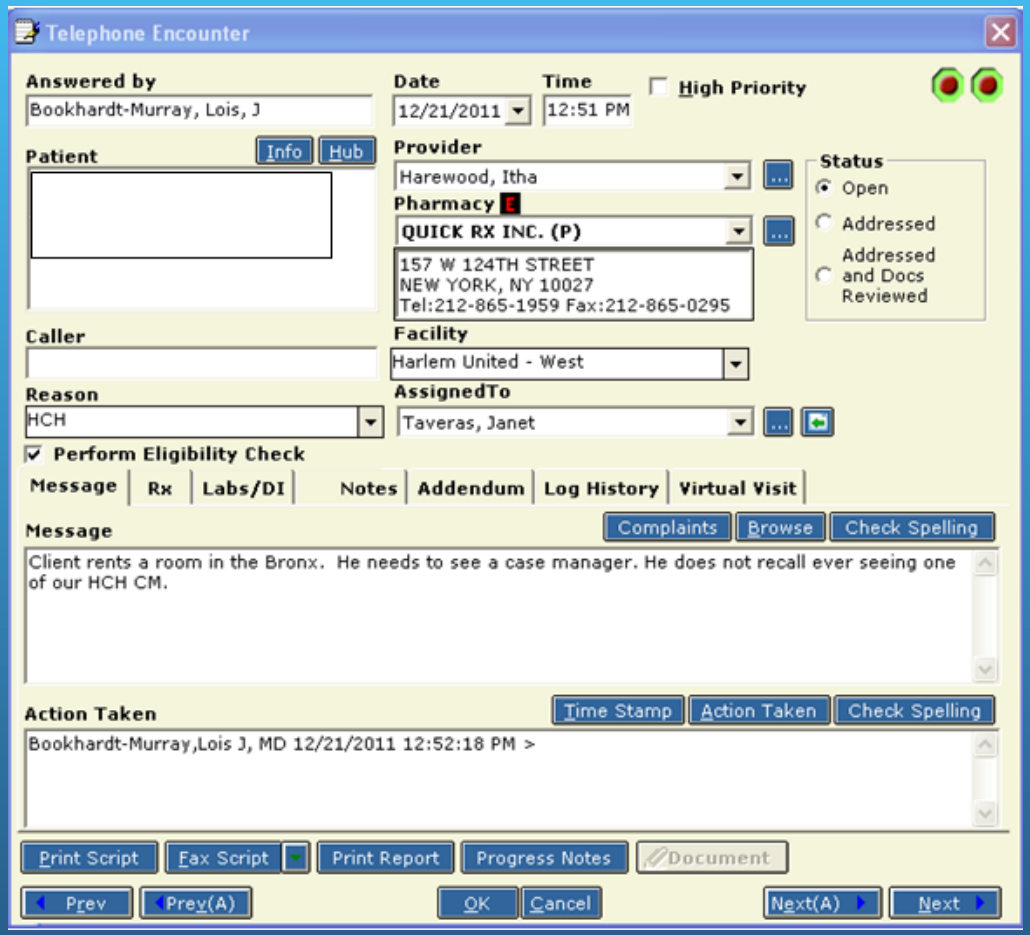
SERVICES:

- Supportive Case Management Services (service planning, counseling, referrals, escorts)
- Patient Navigation, Reengagement, and Outreach
- Support Groups (in English, Spanish & French)
- Connection to Medical Care & Support Services
- Psychosocial Assessments and Counseling
- Health Education/Risk Reduction Counseling
- Treatment Adherence Counseling (Individual & Group Services)
- Housing Placement Assistance (Individual & Group Services)
- Enrollment into ADAP/APIC/Health Coverage
- Entitlements Assistance

How Primary Care and ATC Care Coordinate

- Team meetings
- Electronic Reports
- Daily communication between outreach and office managers
- E-mails with daily reminders of appointment availability
- Patient Navigation /Escorts
- Case Management and Providers
- Communication via electronic health record

The "Telephone Encounter"



What is communicated?

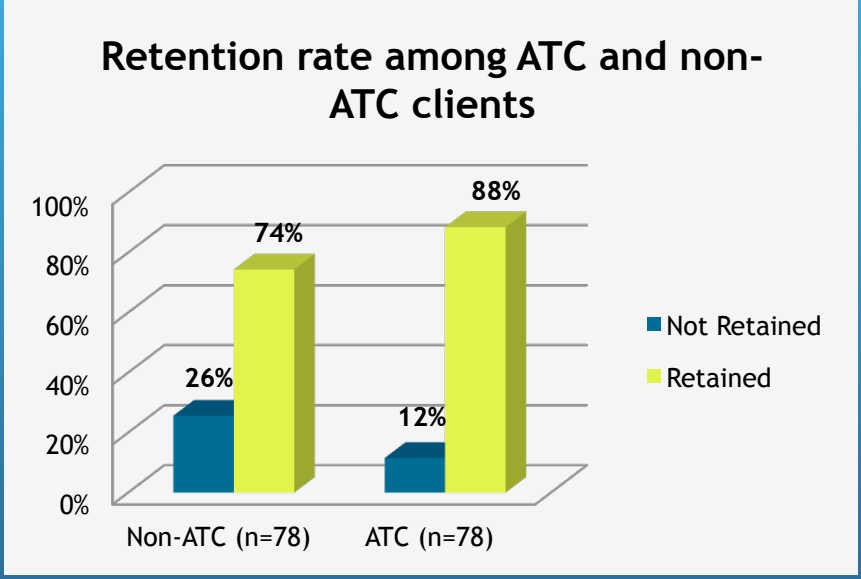
- Medication Renewals
- Referrals
- Forms
- Needs that provider or Medical Assistant has identified

Care Coordination improves outcomes

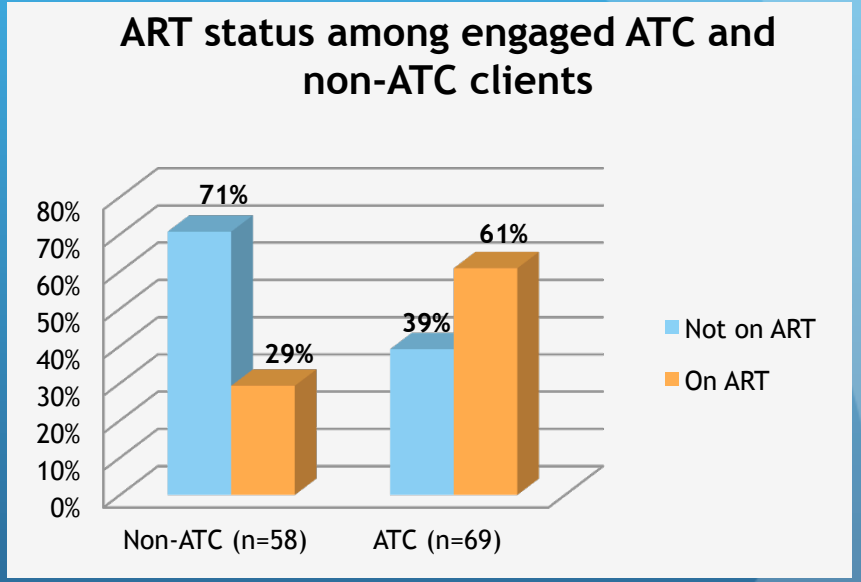
- To measure the success of strategies implemented, data on 1192 homeless clients who had at least 1 primary care (PC) visit between January-September 2011 was reviewed.
- Of those, **88%** were retained in care (i.e. had 2 or more PC visits through September 2011).

Program Outcomes

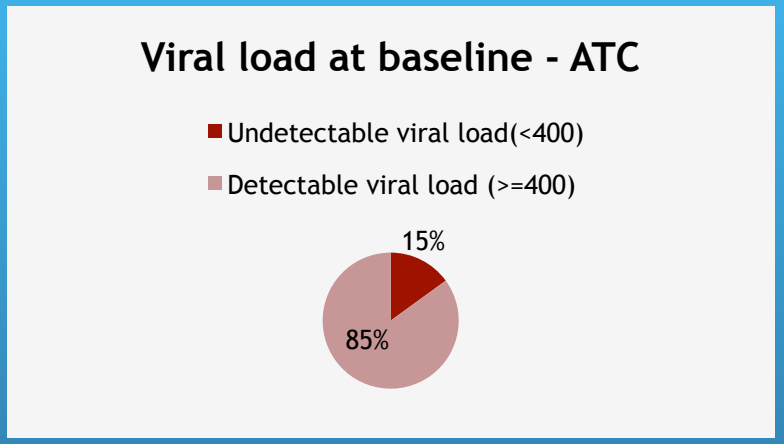
- Retention in care

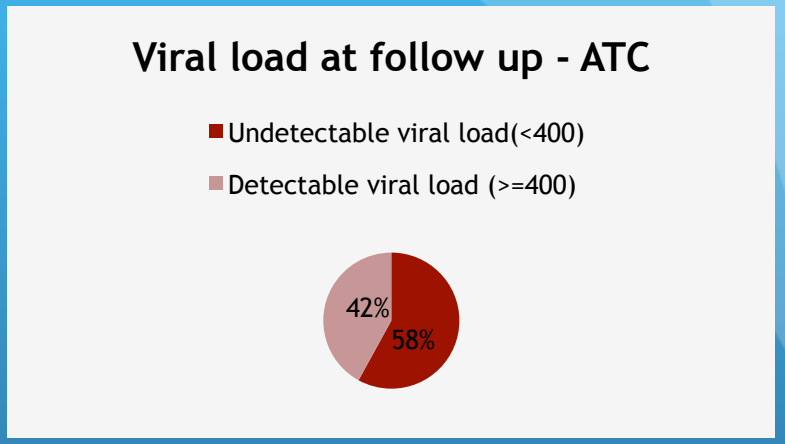


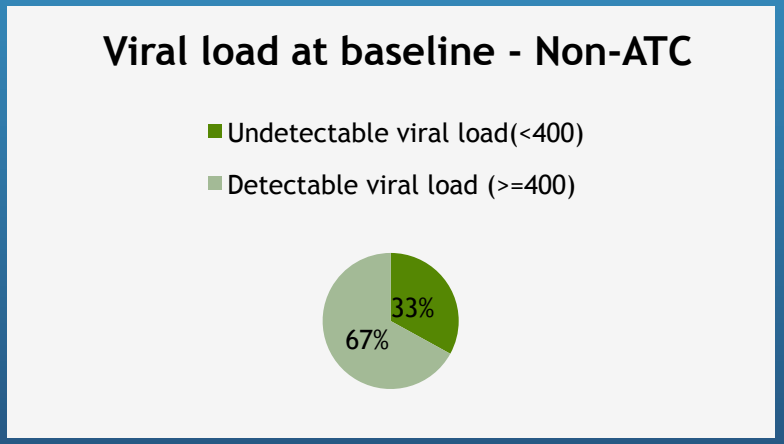
- ART Status

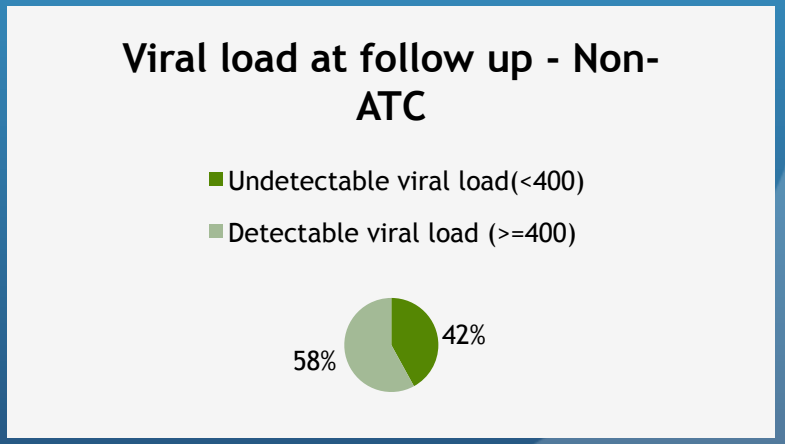


Program Outcomes

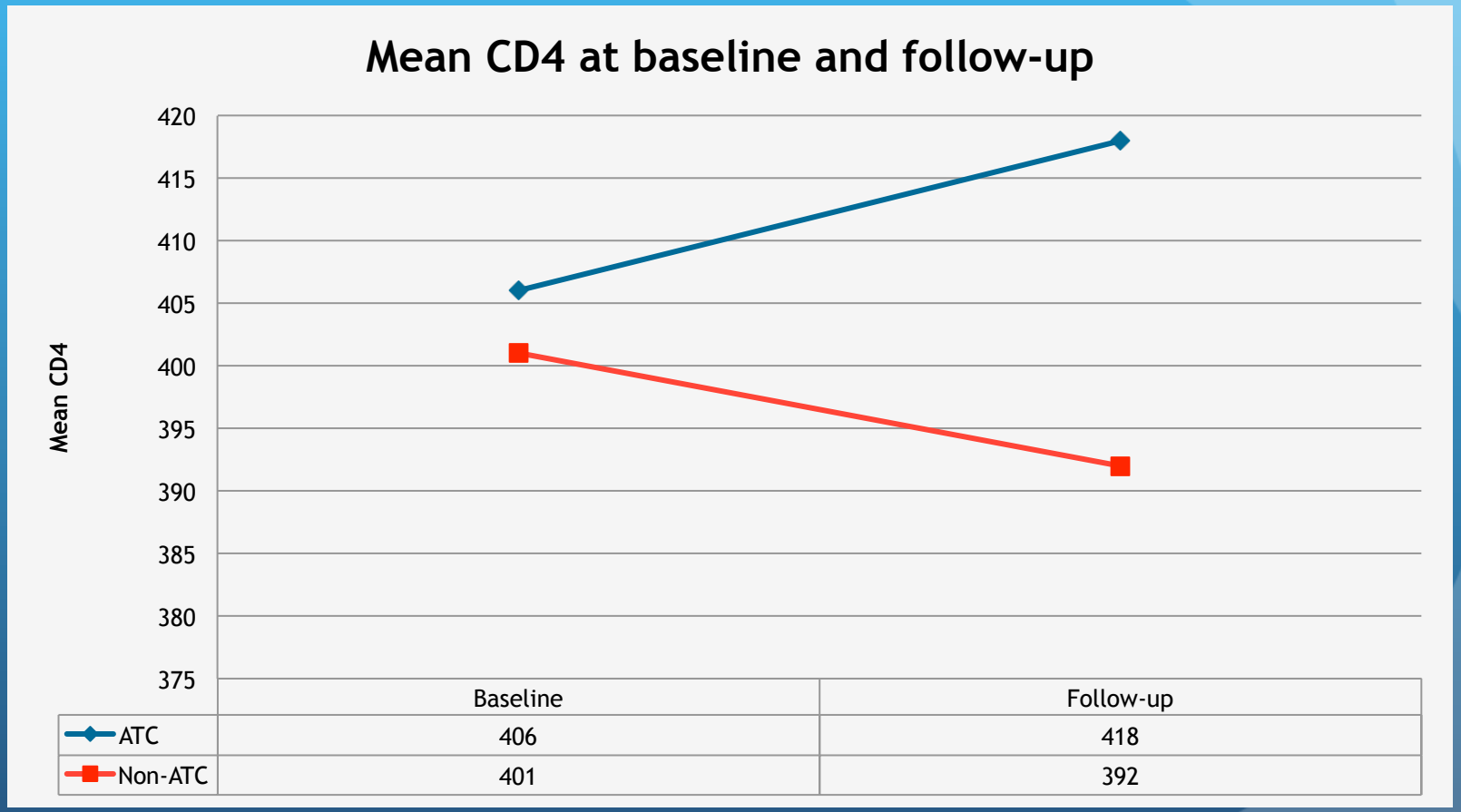








Program Outcomes



	Baseline	Follow-up
ATC	406	418
Non-ATC	401	392

Why Care Coordination? Decrease Barriers to Care

- Harlem United's patient population is more than 65% homeless. These clients have many barriers that can and do prevent them from accessing the proper care needed.
- These barriers are:
  - Retention in Care
  - No Show Rates
  - Same Day Access
  - Cycle Times
  - System Orientation

Access NY* Collaborative

- ***ACCESS NY*** *for Primary Care is a comprehensive program designed to improve access to care and retention in care. Participation in this collaboration with other agencies has assisted us in our understanding of how to increase access to care, improve on continuity of care, and retention of patient's care.*
- *ACCESS NY includes a number of PDSA projects. There are 7 indicators that are being measured to improve access to and retention in care.*

*Sponsored by Primary Care Development Corporation, NY Trust and Amida Care

Key Measure	Measure Definition	GOAL	Baseline	Current
Third Next Available Appointment	To ensure that clients have access to their primary care provider within a reasonable time frame	0-3 days	5 days	0 days
Same Day Appointment Availability	To ensure that clients requiring medical attention are able to be seen on the same day as they call for an appointment, a same day appointment is defined as within 24 hours/ walk in appointments	40% Availability in the schedule	15%	22%
No Show Rate	The percent of clients scheduled who do not come in for their appointment. A reduction in no show rate improves provider productivity and capacity.	15%	38%	32%
Cycle Time	The time the client spends in the clinic from arrival to departure. Wait Time is time the client does not have face time with staff or provider	<=60 mins for 90% of visits	~90 minutes	~71 minutes
Capacity	The percent of clients seen by the provider vs. the number of scheduling opportunities for a particular day. (i.e. if the expectation is for providers to see 14 clients per day. If they see 10 clients their capacity is 71%)	> = 90%	75%	98%
Continuity / Retention Rate	The rate that a client see the same provider from initial visits to all subsequent visits	85%	78%	95%
PCP Productivity	The number of clients a provider averages for the hours of scheduled appointment time to be worked	>= 3 pts/hr	2	3

The Collaborative Pre-work

- Secret Shopper calls
- Allowed us to check costumer service
- Improved Phone scripts
- Evaluated team for care coordination to improve efficiencies
  - Developed Medical Assistant-Provider Teams
  - Remove Reminder Calls from Receptionist work
  - Medical Assistant perform reminder calls for their provider
  - Pre-visit planning identifies gaps and need for ATC support

Third Next Available Appointment

- Third Next Available Appointment (TNAA) allows clients to see their provider within a reasonable time.
  - The TNAA appointment is calculated by reviewing the schedule and counting the days to the next available appointment.
  - The Access NY teams goal was to maintain all providers TNAA with in 0 to 3 days.
  - We created a tracking tool to monitor the providers and enforced a policy that all patients receive an appointment within 72 hours

TNAA

- TNAA tracking tool has been used over the course of the collaborative to maintain our goal on 0 to 3 days for access to care.

Third Next Available (TNAA) Calculation Tool																		
Heath Center:	Harlem United																	
New Visits																		
		Dr. Bookhardt		Dr. Walker		Dr. Harewood		Dr. Antonio		Aviva Cantor		Emily Hackenburg		J Braun				
		FTE:		FTE:		FTE:		FTE:		FTE:		FTE:		FTE:				
Week	Date Collected	Date	# days	Date	# days	Date	# days	Date	# days	Date	# days	Date	# days	Date	days	Mean	Min	Max
1	4-Apr-12			4-Apr-12	0	4-Apr-12	0	5-Apr-12	1	10-Apr-12	6	5-Apr-12	1	5-Apr-12	1	1.5	0	6
2	11-Apr-12	5/30/2012	49	12-Apr-12	1	17-Apr-12	6	16-Apr-12	5	17-Apr-12	6	18-Apr-12	7	18-Apr-12	7	11.6	1	49
3	18-Apr-12			19-Apr-12	1	23-Apr-12	5	19-Apr-12	1	19-Apr-12	1	19-Apr-12	1	24-Apr-12	6	2.5	1	6
4	25-Apr-12			30-Apr-12	5	25-Apr-12	0	25-Apr-12	0	25-Apr-12	0	26-Apr-12	1	27-Apr-12	2	1.3	0	5
5	2-May-12			3-May-12	1	2-May-12	0	2-May-12	0	3-May-12	1	3-May-12	1	8-May-12	6	1.5	0	6
6	9-May-12			22-May-12	13	9-May-12	0	15-May-12	6	10-May-12	1	16-May-12	7	10-May-12	1	4.7	0	13

Same Day Access

- Same day Access ensures that patients requiring medical attention are able to be seen on the same day as they call for an appointment.

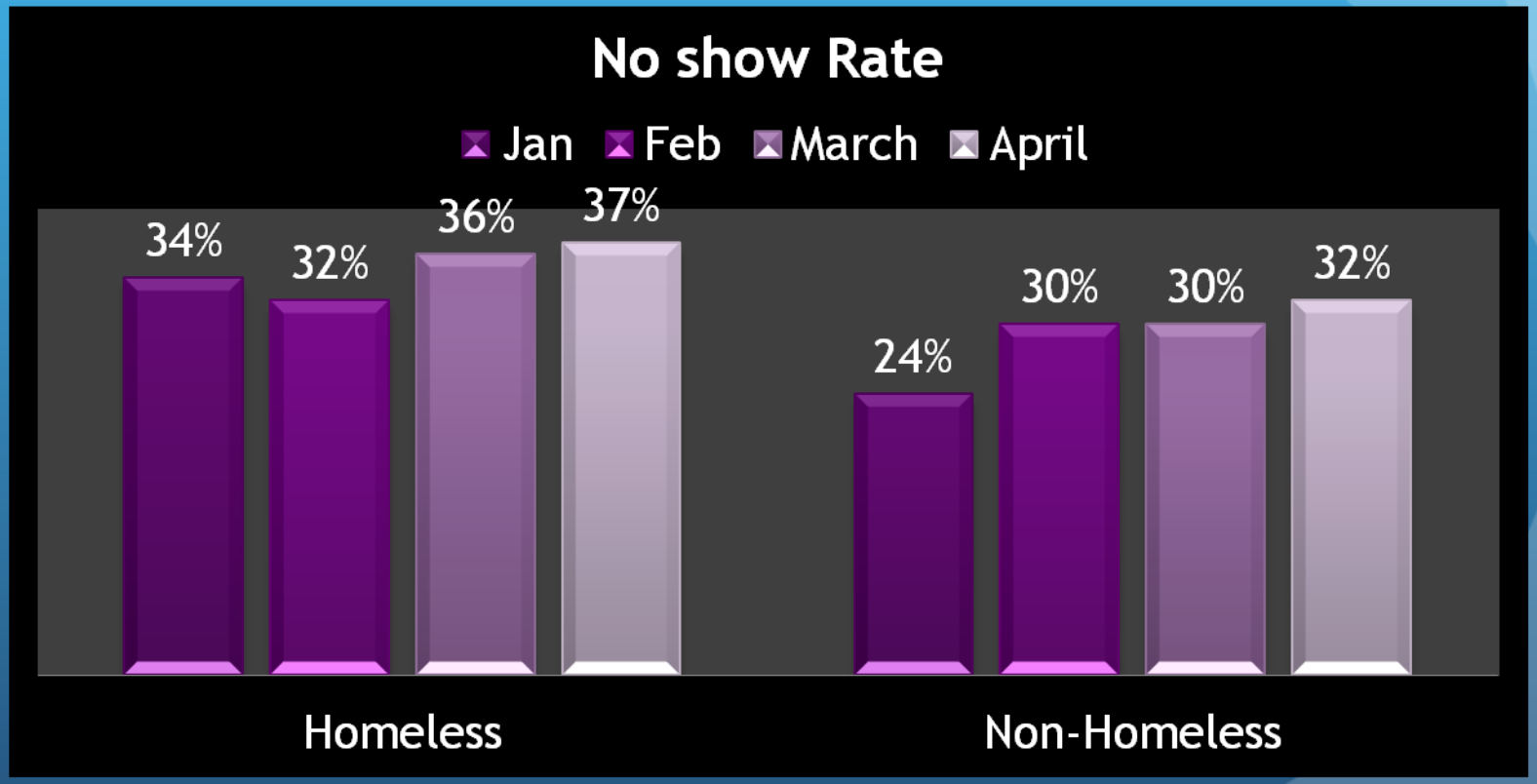
- A same day appointment is defined as within 24 hours/ walk in appointments and is calculated by the number of open slots on the providers schedule , divided by the total number of slots available.

- Our goal for same day access is 40% availability on the providers schedule.

Ways to improve Same Day Access

- Template schedules for Same Day Appointments
- Cancelled Appointment slots can be replaced with SDA
- Set aside specific clinic hours for Walk In appts
- Outreach teams can be provided with available appt slots to bring patients in.

Client No Show Rate Homeless vs. Non-Homeless



Client No Show Rate

- No Show is the percent of clients scheduled who do not come in for their appointment.
  - A reduction in no show rate improves provider productivity and capacity and also increases same day access.
  - Our no show goal is 15%. We have worked hard to reduce our no show rate and currently we are at 32%.
  - Maintaining a no show rate of less than 20% is a huge barrier with the homeless patient because they are bounced around from shelter to shelter, numbers are changed , and sometimes the clients are lost to care until they have transitioned into a stable environment for themselves.
  - We have set up many PDSA's to launched campaigns, advise patients of same day appointment availability, set up reminder phone calls, as well as created and send off missed appointment letters.

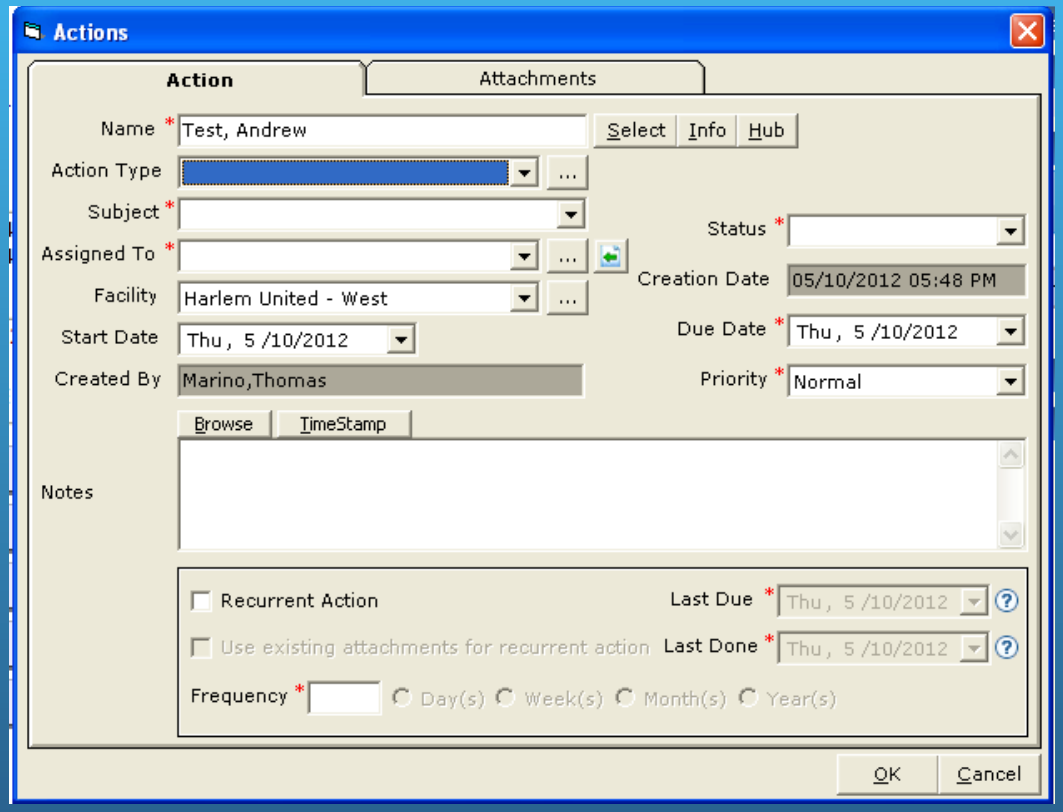
Client No Show Rate

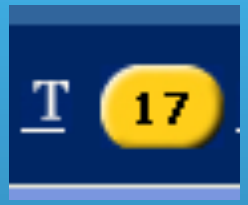
- Flyers for the "Let us Know, Call Us" campaign were distributed in our clinics to assist in reducing the no show rate as well as creating more room on Providers schedules for same day access.
- While reviewing data and numbers after PDSA cycles, the data showed that after making follow up calls and a patient has been confirmed, 47% of clients did not return for a visit, however when contacted, 40% did return within 24 hours, a total of 60% return within 48hrs.

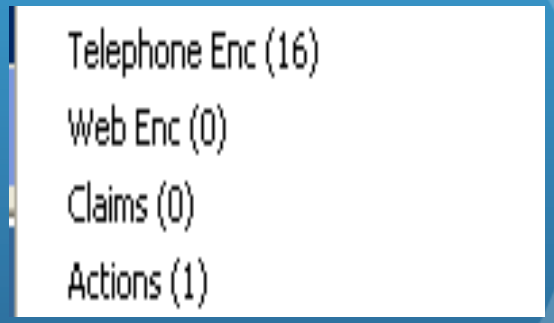
What do you do about the Chronic No Show patient who takes up space in your schedule?

- Enter them into a tickler system
- Do Not provide a follow up appointment
- Set the tickler to remind you when the patient is due to come in
- Set the tickler to alert clinic staff or ATC staff

EMR tickler is an Action Item







Cycle Time

- Cycle Time-The time the patient spends in the clinic from arrival to departure.
- This begins with the medical receptionist checking in the patient and ends when the medical receptionist checks out the patient
  - Wait Time is the difference between the cycle time and the providers face to face time with the provider.
    - It is the time the client spends being screened by the Medical Office Assistant, having lab work done, injections, and immunizations and the time in the waiting area.
  - Harlem United's cycle fluctuates between 70 to 80 mins.

Cycle Time

- The Cycle Time worksheets were created to assist in the client flow and reduction of cycle time in the clinic.
- We can see where the bottle necks in the patient flow and how long the patient is in the clinic.

Cycle Time Work Sheet					
Provider (please circle)	Date	Visit Type			
Dr. Harewood Dr. Walker		Non homeless		HCH	
	Person Responsible	Time in	Time Out	Total Time (min)	Btwn Time
Arrival Time (document time to check in, verify insurance, and register client)	Receptionist				
Prep/Screening Time (performing vitals, etc)	MOA				
Provider Time	Provider				
Other					
Check out time	Receptionist				
			Total Cycle Time		

Cycle Time

Model for Improvement
PDSA LOG

AIM: *Reduce the wait time between screening and provider to less than 20 minutes for Dr. Harewood*

PDSAs					
d #	Cycle Date	Plan *What improvement is being tested?*	Do *Who/What/Where/When?*	Study *What were the results? (Please include impact on aim and other measures)*	Act *What is the next step?*
	4/11/2011-4/15/2011	*Collect baseline data on wait time from client being prepped to seeing the provider*	*Medical Receptionist, MOA and provider record times at each point during provider visits for 1 week*	*The wait time was 35 minutes between prepping and seeing the provider. It was also discovered that there are several interruptions for the provider with clients coming into the clinical space to knock on the exam room door*	*Continue to collect baseline data on other primary providers. Investigate options to reducing the interruptions*
	May 21, 2011 to June 13, 2011	*Post signs to stop clients from entering clinic space and causing disruption*	*J. Rodriquez develops stop signage to be posted in the waiting area and at the end of the hallway into the clinical space and post by May 21, 2011.*	*On June 13, the wait time from prepping to provider was 34 minutes*	*Leave stop signs posted indefinitely. Continue to educate clients on remaining in waiting area until called. Front Desk to monitor and prevent clients from entering clinical space.*
	June 13, 2011 to June 30, 2011	*Reinforce stop signage and educate clients*	*Medical receptionist, medical office assistants will discuss remaining in the waiting areas and not enter clinical space unless accompanied by staff. The team will also point out the signs for clients. Conduct on June 30,2011*	*The wait time was recorded to be 30 minutes from prepping to provider. Clients were observed stopping other clients from entering unauthorized area. Another observation made by provider is the amount of time to document in the EMR.*	*Continue to reinforce signage and educate clients. Continue to investigate ways to reduce time for documentation.*
	TBD	*Update the order sets and train provider on merging templates and personal assessments*	*T. Marino to update order sets and templates and conduct training for Dr. Harewood by July 28, 2011*		

- Example of a PDSA done to Reduce Cycle time for a provider

Continuity Rate

- As a Patient Centered Medical Home, continuity is critical to successful outcomes
- Improving TNAA and Same Day Access leads to improved continuity
- Through PDSA cycles we have improved from 75% to 98% continuity

Summary

- Care Coordination is team work
- Care Coordination leads to good health outcomes
- Communication via the electronic medical record is supportive
- PDSA cycles are a useful tool to implement change
- Engaging patients in supportive services improves retention in care rates

Contact Information

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