

SLIM Network: Sharing Better Ideas

Albert Yu, MD, MPH, MBA
Director, SFDPH Chinatown Public Health Center
Clinical Professor, UCSF Department of Family & Community Medicine
(415) 364-7909 or Albert.Yu@ucsf.edu

EXPANDING CAPACITY: MANAGING SUPPLY AND DEMAND

Chinatown Public Health Center

- Part of the SF Community Health Network, has been serving Chinese immigrants, “vulnerable” residents and those with limited English proficiency since 1929.
- Our TEAM – MD (2.45 clinical FTE), NP (2.55), RN (4.0), MEA (3.0), HW (2.8), EW (4.5), clerk (1.0), med record (1.0), nutritionist (1.0), health ed (0.9), MSW (1.0), psychiatrist (0.2), DDS (1.1), dental aide (1.8), podiatrist (0.1), PharmD (0.2)
- Services – in addition to primary care: public health nutrition, medical nutrition therapy, community health education and outreach, pediatric dentistry and audiology, podiatry, dementia screening and assessment by UCSF Memory Center, Eye Van, Disability & Autism clinic for children, WIC, refugee-asylee-newcomer’s program and mental/behavioral health
- Clients – 84% speak Chinese, 65% female, all age groups, insurance (HSF 27%, Medi-Cal FFS & Cap 32%, CHN Capitated 29%, Medicare 5%, uninsured 6%)
- Productivity and utilization – active patient panel (about 5K), average panel per clinical FTE (MD: 1,380, NP: 1,120), annual PC medical visits (13K) & all visits (22K), average visits per hour (MD: 2.5, NP: 1.9), average no show rate: 10% and daily capacity 89%

Demand Moderation and Supply Enhancement Change Strategies

- 1) Pilot SMART Clinic (Same-day Medical Attention Response Team) – daily afternoon clinics staffed by designated teamlet (PCP/RN/MEA) and designed to: a) address the needs of patients who need “timely” medical attention with or without an appt, b) facilitate panel management and communication within teamlet, and c) promote MEA identification of “overdue” clinical preventive services for next-day patients.
- 2) Initiate brief RN visits for BP check and/or panel management related actions as part of the SMART pilot.
- 3) Pilot brief focused-intervention telephone visits between PCP and pre-scheduled pts.
- 4) Implement Orientation Clinic – a 2-hour introductory visit with a RN and a MSW in a group setting, designed for new Cantonese-speaking pts as a way to: a) introduce them to services available at CPHC and SFGH, b) review medication labels and refill procedures, c) highlight insurance coverage, d) explore the benefits of a “proactive” visit, and e) complete standing orders for recommended clinical preventive services and laboratory studies before the initial visit with PCP.
- 5) Offer group medical visits for patients with diabetes and/or coronary heart disease
 - a) POGMA (Planned One-stop Group Medical Access) – a planned monthly multidisciplinary clinic staffed by a MD, PharmD, RN, MEA and MSW, designed to provide ALL evidence-based services in one 3-hour visit to pts at high-risk for developing complications or for not adhering to recommended treatments
 - b) ABCD (A1C, BP, Cholesterol, Do Not Smoke) is a planned monthly clinic staffed by MD and health educator, designed to: a) educate pts about the harm from tobacco use, b) help pts set action plans to stop smoking, c) review ABC treatment goals and actual test values and d) reconcile and adjust medications to ensure attendees are taking Aspirin, Statin and ACEI/ARB .
- 6) Expand nursing roles through training and mentoring to:
 - a) Motivate pts through coaching and setting action plans (RN, MEA, HW, PCP)
 - b) Identify “due” recommended clinical preventive services using standing orders (MEA)
 - c) Complete diabetes-related medication reconciliation and limited adjustment based on decision-support algorithms (RN)
- 7) Ensure diabetic pts get necessary blood tests before medical appointment with PCP.
- 8) Make continuity a priority
 - a) Clean up the PCP designation field in EHR (LCR) by matching pt visit pattern to PCP assignment
 - b) Schedule pts with their own PCP whenever possible
 - c) Combine several part-time clinician positions into one full-time family physician hire

- 9) Enhance office flow through deliberate design
 - a) Bring all services to pts (in-room intake, PCP visit and discharge)
 - b) Conduct pre-clinic huddles to ensure clinic starts on time
 - c) Introduce teamlet patient care teams to include 2 PCPS , 1 RN and 1 MEA/HW
 - d) Standardize supplies and referral forms in each exam room
 - e) Redesign a central space for team huddles, chart preparation, pt orders and easy surveying of clinic flow
- 10) Engage clinicians to rethink appt intervals
- 11) Enforce late arrival and frequent no-show policies

Change Process

- 1) Participated in the Kaiser-CHN PHASE (Preventing Heart Attack & Stroke Everyone) initiative
 - a) Received training on health coaching, panel and medication management
 - b) Created a disease registry and performance dashboard that staff review regularly
 - c) Created many point-of-care enabling tools (progress notes, standing orders, pt education materials, etc.)
 - d) Shared ideas with and learned from change leaders within CHN
 - e) Held monthly CPHC Phase team meetings to include: MD, RN, MEA, PSA and nurse manager
 - f) Assigned panel management teamlets (PCP/RN/MEA)
 - g) Delineated and expanded non-PCP staff roles and responsibilities
- 2) Participated in the PCDC-Changing The Way We Care Redesign initiative
 - a) Convened a change team that meets 2-hrs weekly (MD, NP, RN, HW, principal clerk & nurse manager)
 - b) Shared ideas and learned from other change team leaders from other CHN clinics
 - c) Participated in Webinar and periodic learning sessions
 - d) Engaged entire staff in the change process
 - e) Applied PDSA rapid improvement cycle principles and tools to test change ideas
 - f) Received feedback and coaching from PCDC and UCSF consultants
- 3) Critical factors that promote buy-in, spread test strategies and sustain momentum
 - a) Articulate clear and coherent clinic goals and staff expectations
 - b) Eliminate inefficiency in a transparent and meaningful way (remove something before adding new tasks)
 - c) Communicate succinctly and regularly about planned actions, highlighting especially the potential benefits from change strategies to staff and patients
 - d) Create enabling tools to facilitate work – IT, forms, physical space and etc.
 - e) Empower staff to speak willingly and problem-solve actively
 - f) Develop internal change champions to serve as liaison to other unit staff
 - g) Listen and appreciate staff's insights and perspectives
 - h) Understand existing data capability and leverage them fully to design and evaluate change tactics
 - i) Appreciate variable computer/technology fluency among staff; and that adoption is slow and requires experiential learning and often coaching
 - j) Be prepared to deal with resistance and don't take "no" for an answer

OUTCOMES

- Myriad new models to care for pts (new or PHASE) are sustained with positive feedback from staff and pts
- New patient appointments are consistently within 2 weeks – moderate Orientation Clinic to meet demand
 - Average panel size growth since July 2008 (MD: 1,260 to 1,380 and NP: 1,090 to 1,120)
- Clinic flow enhancement tactics are now fully spread and part of standard clinic operation
 - 75% of visits are now under Cycle Time (CT) goal of 60 minutes
 - Average visit CT are now near goal of 60 minutes (baseline: 84 minutes)
 - Patient visit stops dropped from an average of 9.4 per visit to about 3-4 stops per visit
- Patients without PCP assignment – over 25% in August 2007 to less than 5% in April 2009

SLIM Network: Sharing Better Ideas

Albert Yu, MD, MPH, MBA
Director, SFDPH Chinatown Public Health Center
Clinical Professor, UCSF Department of Family & Community Medicine
(415) 364-7909 or Albert.Yu@ucsf.edu

Establishing “Right Size” Provider Panels to Optimize Continuity of Care

Chinatown Public Health Center

- Part of the SF Community Health Network, has been serving Chinese immigrants, “vulnerable” residents and those with limited English proficiency since 1929.
- Our TEAM – MD (2.45 clinical FTE), NP (2.55), RN (4.0), MEA (3.0), HW (2.8), EW (4.5), clerk (1.0), med record (1.0), nutritionist (1.0), health ed (0.9), MSW (1.0), psychiatrist (0.2), DDS (1.1), dental aide (1.8), podiatrist (0.1), PharmD (0.2)
- Services – in addition to primary care: public health nutrition, medical nutrition therapy, community health education and outreach, pediatric dentistry and audiology, podiatry, dementia screening and assessment by UCSF Memory Center, Eye Van, Disability & Autism clinic for children, WIC, refugee-asylee-newcomer’s program and mental/behavioral health
- Clients – 84% speak Chinese, 65% female, all age groups, insurance (HSF 27%, Medi-Cal FFS & Cap 32%, CHN Capitated 29%, Medicare 5%, uninsured 6%)
- Productivity and utilization – active patient panel (about 5K), average panel per clinical FTE (MD: 1,380, NP: 1,120), annual PC medical visits (13K) & all visits (22K), average visits per hour (MD: 2.5, NP: 1.9), average no show rate: 10% and daily capacity 89%

Strategies to Optimize Continuity of Care

- 1) Clean up the “PCP” field in electronic health record by matching patient (pt) visits pattern to PCP assignment
- 2) Produce monthly panel size reports for PCPs and use the data to inform decisions about panel closure
- 3) Engage system-wide discussions around panel size standards and calculation methodology
- 4) Schedule pts with their own PCP whenever possible
- 5) Combine several part-time clinician positions into one full-time family physician hire
- 6) Cut appointment (appt) types from over 15 to 5 (new, return, urgent, gyn and procedure) and combine “return” option with all other appts to optimize daily capacity and to promote scheduling with assigned PCP
- 7) Educate new Cantonese-speaking pts, during Orientation Clinics, about the meaning of “primary care provider” and the benefits of “care continuity”
- 8) Create teamlets (PCP/RN/MEA) to facilitate panel management and planned visits
- 9) Pilot brief focused-intervention telephone visits between PCP and assigned pts who do not need face-to-face encounters but who do need correspondence before typical 3-6 months follow-up intervals
- 10) Pilot SMART Clinic (Same-day Medical Attention Response Team) – daily afternoon clinics staffed by designated teamlet (PCP/RN/MEA) and designed to: a) address the needs of patients who need “timely” medical attention with or without an appt, b) facilitate panel management and communication within teamlet, and c) promote MEA identification of “overdue” clinical preventive services for next-day patients
- 11) Introduce group medical visits to patient with DM and/or CHD at high risk for complications
- 12) Match knowledge and skills to task requirements in order to increase PCP productivity
 - a) Pilot brief RN visits for BP check and/or planned activities to reduce the need to see PCP
 - b) Train MEA/HW/RN to motivate pts through coaching and setting action plans
 - c) Train MEA to identify “due” recommended clinical preventive services using standing orders
 - d) Train RN to complete diabetes-related medication reconciliation and limited adjustment based on decision-support algorithms
- 13) Engage clinicians to rethink appt intervals to create capacity for manage assigned panel of pts

Change Process

- 1) Participated in the Kaiser-CHN PHASE (Preventing Heart Attack & Stoke Everyone) initiative
 - a) Received training on health coaching, panel and medication management
 - b) Created a disease registry to support planning for group medical visits

- c) Shared ideas with and learned from change leaders within CHN
- d) Assigned panel management teamlets (PCP/RN/MEA)
- e) Delineated and expanded non-PCP staff roles and responsibilities
- 2) Participated in the PCDC-Changing The Way We Care Redesign initiative
 - a) Engaged entire staff in the change process
 - b) Applied PDSA rapid improvement cycle principles and tools to test change ideas
 - c) Tested capacity enhancement and demand moderation strategies
- 3) Persisted in pushing system-wide discussions around “right sizing” panels
- 4) Critical factors that promote buy-in, spread test strategies and sustain momentum
 - a) Hire a full-time family physician eliminated “provider” hopping among pts who had no identified PCP
 - b) Recognize that everyone, especially front desk and PCPs, wants continuity
 - c) Coach front desk staff to verify PCP assignment in EHR before scheduling appts
 - d) Create a culture and supportive environment where staff can speak freely, share their insights, problem-solve, think team and feel appreciated
 - e) Engage staff in regular PDSA rapid cycle improvement activities during weekly clinic meetings
 - f) Articulate clear and coherent clinic goals and staff expectations
 - g) Eliminate inefficiency in a transparent and meaningful way (remove something before adding new tasks)
 - h) Communicate succinctly and regularly about planned actions, highlighting especially the potential benefits from change strategies to staff and patients
 - i) Develop internal change champions to serve as liaison to other unit staff
 - j) Be prepared to deal with resistance and don’t take “no” for an answer

OUTCOMES

- New patient appointments are consistently within 2 weeks – moderate Orientation Clinic to meet demand
 - Average panel size growth since July 2008 (MD: 1,260 to 1,380 and NP: 1,090 to 1,120)
- Clinic flow enhancement tactics are now fully spread and part of standard clinic operation
 - 75% of visits are now under Cycle Time (CT) goal of 60 minutes
 - Average visit CT are now near goal of 60 minutes (baseline: 84 minutes)
 - No show rate is sustained at 10%
 - Daily capacity is sustained at about 90%
- Patients without PCP assignment – dropped from over 25% (August 2007) to less than 5% (April 2009)
- Myriad new models to care for pts (new or PHASE) are sustained with positive feedback from staff and pts