

# Practice Transformation: Lessons From a Safety Net Clinic

**Health system serving uninsured and needy patients improves efficiency and outcomes through medical home initiatives.**

David Twiddy

**E**ven if a practice offers excellent care at an affordable price, it can always do better. That was the thinking five years ago at Terry Reilly Health Services when the system's leadership wondered if being the cheap, easily available health care option to the area's needy patients was enough.

Although the leaders felt the quality of care that the Nampa, Idaho-based organization provided was good, they wanted to build on it – and prepare for what they saw as the coming changes in health care financing. Terry Reilly elected to transform into a patient-centered medical home (PCMH), dramatically changing how it provided service to patients and managed patient populations.

The 42-year-old system, which is a federally qualified health center (FQHC), has seven primary care and behavioral health clinics, four dental sites, and four mental health clinics spread across three southwest Idaho counties. It serves approximately 29,000 people a year, two-thirds of whom are living at or below the poverty line, and employs a staff of 260. Roughly 35 percent of patients either have Medicare/Medicaid or private insurance with the rest paying on a sliding scale subsidized by federal grants.

Although its structure, financing, and even mission are very different from a lot of medical practices, Terry Reilly has faced many of the same challenges private practices have in transitioning to a medical home. Those include cost, staffing, workflow, and documentation, as well as

helping patients adapt to new requirements for accessing services and taking a larger role in their own care.

In the end, practice leaders say Terry Reilly is better because of the transformation, with improving patient outcomes and better job satisfaction among staff and physicians, achievements that led to the health system receiving *Family Practice Management's 2012 Practice Improvement Award*. And they were able to do it mostly within the already lean budget of a nonprofit organization.

"We want to be positioned to be able to say we're a community health center that can do what you need us to do in terms of quality, affordability, and comprehensiveness," said Bethany Gadzinski, the organization's medical operations program manager.

This article looks at some of the key lessons Terry Reilly's leaders learned as they transformed their operation, steps that Gadzinski said apply not just to government-supported health care groups like hers but practices catering to a wide range of patients.<sup>1</sup>

## Getting started

Sometimes the hardest step is the first, choosing to begin transforming to a medical home. In 2009, then-executive director Tim Brown threw his support behind integrating the PCMH model as a way to help move treatment of the system's very poor and uninsured patients from mostly episodic care to ongoing preventive care and better outcomes.

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### About the Author

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Leaders also wanted to combat survey results showing that many staff members were not happy with how they were integrated as a team.

The organization had one big advantage in that it already had been using an electronic health record (EHR) system for several years. Buying and training staff to use an EHR can be a major financial and logistical hurdle for nascent medical homes.

The process of switching to a medical home cost around \$200,000, mostly for additional staff time, reordering workflow, adding necessary reporting and patient-tracking capabilities to the EHR, and for the organization to bring Gadzinski in to help oversee the changes. Most of these costs were covered through grants that Terry Reilly received as part of the Safety-Net Medical Home Initiative, a not-for-profit effort to turn community health centers in five states into PCMHs. After the initial period, however, the organization has absorbed those added costs into its regular budget and likely could have made the changes without the outside money, Gadzinski said.

Gadzinski said it was important for managers to provide very visible leadership in the clinics to keep the staff focused. Also, physician champions were vital for clinicians to make the needed changes. For inspiration in designing their medical home, physicians and administrators also visited PCMHs in Colorado and Seattle and relied on guidance from the Idaho Primary Care Association and health care consultant Qualis Health. The system has since received Level 3 certification for its PCMH from the National Committee for Quality Assurance.

### Moving to patient-centered care

One of the practice's initial challenges was moving from a system where patients came in and saw whatever clinician was available to one where they were saw their own primary clinician, a bid to improve consistency and

continuity of care. That first required creating defined panels for each physician.

The organization started with 2,500 patients per panel. But this number proved too high, especially as the system's average patient has multiple chronic conditions, and it was burning out clinicians, Gadzinski said. After some trial-and-error, the average panel size was reduced to 900 patients. Some of the shrinking was possible through attrition as highly transient patients, such as migrant workers and the homeless, didn't return for treatment. But Terry Reilly also eventually hired six additional clinicians to take up the slack. Some physicians have remained productive enough to keep panels near 1,100 patients, although that is their personal choice, Gadzinski said.

Creating panels for physicians, however, doesn't necessarily mean patients are using them. The system trained schedulers about the importance of matching patients with their primary clinician instead of just offering the first available appointment and has developed metrics to measure how often patients are actually seeing their own physician and how often the physicians are seeing their own patients.

Using these panel reports helps balance supply and demand among clinicians and determine when to reopen a physician's panel to new patients. The system is also developing ways to accommodate patients who wish to change their primary clinician.

### Instituting care coordination

Care coordination is a key piece of the PCMH model. Terry Reilly has six care coordinators who monitor daily patient registries for diabetes, hypertension, childhood immunizations, obstetrical care, anti-coagulation therapy, and other key areas, looking for patients who haven't visited recently to get them on a more regular schedule of preventive care. During office visits, they work with high-risk patients

on such things as diet and education.

To better coordinate emergency care, each physician holds open four slots every day for same-day appointments, making it easier to get these patients scheduled.

All of the care coordinators are registered nurses who spend roughly half their time on care coordination and half on regular nursing duties. They all came from the existing staff, which required managers to rebalance workflows to make up for the time the nurses were off the floor and doing care coordination and avoided the extra cost of hiring new staff.

The system also has four referral coordinators, all medical assistants also drawn from the current staff, who schedule MRIs and specialist visits requested by the system's physicians. They also make sure results from these tests and outside visits make it back to the requesting physician, closing the loop on the patient's care.

Much of that coordination hinges on the system's EHR. Gadzinski said the sooner a practice can add the technology the better. She said having had the EHR in place for six years was a big help because staff could focus on using it to further the PCMH's goals of managing patient population. With that familiarity, as well as attentive EHR technicians, staff created a number of templates and tools in the EHR.

The system also created an online portal through its existing EHR that patients can use to access lab results, make appointments, and communicate directly with physicians and nurses.

## ABOUT THIS SERIES



Many physicians spend time tweaking the operation of their medical practices, looking for shortcuts and add-ons that may boost productivity and profitability, lower costs, or improve quality. But what about practice transformation, the act of dramatically changing the way a practice operates, presents itself to patients, and plans for the future? *Family Practice Management* is profiling several of these practices, showing what problems they faced, what changes that made, and how that transformation benefitted them in the end.

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## Improving teamwork

Responding to the demands of the PCMH and staff, the system built care teams to support each physician. These consist of between two and four midlevel providers and a registered nurse. In addition to the teams, each physician also has the support of one and a half medical assistants.

A benefit of having a dedicated care team for each physician means patients can still see a familiar face for their care even if their primary care physician isn't immediately available or if they have a health care issue that doesn't require a physician's attention.

The PCMH model was also useful in designing Terry Reilly's newest clinic in Boise from the ground up. It includes 11 exam rooms, four nursing consult rooms, two staff bullpens, two procedure rooms, and no private offices. Gadzinski acknowledged that there was initial concern about noise and a lack of privacy in the bullpens, but physicians later found value in better access to support staff.

Making sure the medical home is working correctly requires time for planning and evaluation, Gadzinski said. The clinics close their doors every Wednesday morning for an hour and a half to give the care teams that time, remaining open later that evening to make up the difference.

## Focusing on efficiency, quality, and safety

One of the system's early innovations was getting patients through the check-in process and into an exam room faster by using "lean" productivity strategies to remove steps that didn't provide additional value to the patient. It eventually instituted a "10-10-20 rule," meaning the patient spends 10 minutes at the front desk, 10 minutes with a nurse or medical assistant taking their basic vitals and handling medication reconciliation, and then 20 minutes of face time with their primary care physician.

Gadzinski acknowledged that 20-minute visits are likely not possible for many private practices, but the longer time is

necessary for the system's more complicated patient population. That said, the clinics have been able to improve productivity through their use of care teams to increase the number of patients seen to around 10 per clinician for each four-hour block of clinic time, she said. For less complicated cases, Terry Reilly also has open access clinics that see around 30 patients a day.

To spearhead quality improvement, the system uses a quality improvement committee, made up of front desk staff, nurses, physicians, and others who take the big goals set by Terry Reilly's board of directors and translate these to the ground level. Staff then use the "plan-do-study-act" model to continually make small changes, often in as short a cycle as two weeks. Gadzinski said this approach has empowered employees to think more creatively and consider ideas they may have avoided in the past because they would take a long time to implement.

"We have much more open communication now because people are no longer afraid that, 'If I do this wrong I'm going to get fired,'" she said.

She did acknowledge that the practice made the mistake of moving all of its clin-

ics over to PCMH at the same time, which caused more disruptions than expected. Instead, she recommended that practices stagger the changes to give staff and patients more time to adjust. She added that the system's smaller clinics embraced the changes faster than the larger clinics, again mapping a strategy for other practices.

### **Measuring success and managing pushback**

Terry Reilly's changes in care provision and practice administration have had a measurable effect on patient outcomes. Between 2009 and 2013, the percentage of hypertensive patients with blood pressures less than 140/90 increased from 60 percent to 71 percent, an amount greater than national and state averages for similar patients treated in a FQHC. The number of child patients being fully immunized grew from 54 percent in 2009 to 80 percent in 2013. The national average for FQHCs is 44 percent.

The number of patients with diabetes who are controlling their blood sugar and the number of female patients who are getting mammograms and pap smears have also increased.

### **TRANSFORMATION TIPS FROM TERRY REILLY HEALTH SERVICES**

1. Get practice leaders onboard early in the transformation initiative. They will be key in getting staff and especially clinicians to take the necessary steps to implement changes and commit the necessary resources.
2. Switch to an electronic health record (EHR) system, even if transformation initiatives aren't in your immediate plans. This gives staff time to get used to using the EHR in a somewhat less pressured environment, and it also reduces the financial burden by distributing investments over a longer period.
3. Form quality improvement committees to help steer transformation initiatives. These groups should include not only managers and physicians but also nurses, medical assistants and front-desk workers who can provide input from the trenches.
4. Provide ample time for planning. Terry Reilly closes its offices for a brief period every week so care teams can evaluate their progress and look for ways to improve.
5. If transforming multiple sites, start with the smallest ones first and pace yourself.
6. Seek out payers who may be open to offering enhanced payment for defined improvements in patient outcomes.
7. Be prepared for pushback. New models of care such as the patient-centered medical home require additional work for both patients and their health care providers. Helping both groups get used to the new ways of doing things and explaining the potential (or realized) benefits can take some time and patience.

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Those gains didn't come without costs, however, at least initially. Patient satisfaction numbers fell from 2010 to 2011, reflecting perceived problems with access, communication, time with providers, promptness, and assuming a partnership in their own care. But those metrics swung back and now 98 percent say they're satisfied with their care, which Gadzinski said showed patients becoming more used to the new model and their role in their own health care.

"It was surprising, and it shouldn't be, how difficult this is for our patients," she said. "I've worked with very low income patients in the past, but to really make the change and turn the dial, diet has to change and [amount of] exercise has to change. They really have to take ownership."

Staff also struggled, with provider satisfaction scores dipping from 2010 to 2011. Physicians said they didn't understand PCMH and others initially questioned if the changes improved patient care and promoted teamwork. . But like with the patients, those scores rebounded – the latest survey had job satisfaction scoring a 4.06 out of 5 – as employees became more accustomed to the new processes and began seeing their effect on patient outcomes, Gadzinski said.

### Making it pay

Since 2009, the system's spending for medical services has increased 8.6 percent to almost \$11 million. Although it's difficult to pinpoint how much of that is because of the

PCMH initiatives, it has created additional work and expenses. But given the productivity gains, Terry Reilly hasn't seen a decline in revenue. In fact, the organization has attracted additional revenue in the form of a Medicaid/private insurance medical home collaborative that boosts per-member-per-month fees.

The PCMH status also has made Terry Reilly more competitive, Gadzinski said. The idea of team-supported health care has attracted both patients who have always had insurance and those receiving coverage for the first time through the health care reform laws.

Plus, team-based care is designed to lower overall medical costs by providing more preventive and coordinated care and reducing emergency department visits and hospital readmissions.

"Terry Reilly has positioned itself really far ahead in the PCMH arena in Idaho," she said. "It's always kind of evolving and you have to keep refreshing what you're doing and moving forward. There's no end game." **FPM**

*Editor's note: Portions of this article are based on Gadzinski B. *Implementing PCMH in a Safety Net Clinic: The Terry Reilly Experience*. Presented at: The Fifth National Medical Home Summit; March 14, 2012; Philadelphia, Pa.*

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