Multnomah County Health Department
Primary care clinic site visit, May 12, 2011

History and demographics

Multnomah County is Oregon's most populous county, including the city of Portland. Multnomah County Health Department (MCHD) runs a network of 7 Primary Care clinics and a specialty HIV Primary Care clinic, serving about 45,000 patients. MCHD has a strong collaborative relationship with its largest payor, CareOregon, Oregon's largest Medicaid managed care plan.

In 2006, CareOregon launched a program – Primary Care Renewal -- to provide training, grants, and a collaborative learning environment for five safety-net clinics, including MCHD, to create team-based, high quality patient-centered medical homes. MCHD began its transformation with a pilot team at one clinic (Mid County Health Center) and spread across all other Primary Care clinics by 2010.

The following is a description of Multnomah County Health Department's primary care clinics, with details of team function based on a visit to one of the clinics, East County Health Center.

Empanelment and panel size

Empanelment is the process for ensuring that every patient has an assigned primary care provider (PCP). Several years ago, the Multnomah clinics empaneled their patients to specific providers. Multnomah County Health Department's medical director Amit Shah cited four reasons were cited why empanelment is so important: it provides a systematic way to allow patients to see their own primary care provider, it provides the clinic system and providers a denominator (the total of each clinic's and each provider's patients) for measuring performance, it enables the clinic system to manage supply and demand, and it allows for a group of patients to be easily identified including those who do not come in for care. Details of empanelment can be found in the Safety Net Medical Home Initiative Empanelment Guide, www.qhmedicalhome.org/safety-net/empanelment.cfm#Guide.

Ideal panel sizes were also adjusted by primary care specialty since each specialty (Internal Medicine, Family Practice, and Pediatrics) has different average utilization. Internal medicine maximum panels are approximately 900, family medicine 1000, and pediatrics 1300. When a provider reaches that number, his/her panels are closed so that they are not required to accept new patients until their panel size has dropped to their calculated ideal. Most providers still see 1-2 new patients per week in order to maintain a stable panel size when they are at capacity. Every month, providers can see their panel size on their team

dashboard. Providers are required to see two new patients per day if their panel is less than 95% full; providers with open panels see four new patients per week.

Continuity of care and access to care

Currently, 86% of patient visits are to their own provider, demonstrating a high continuity of care performance. To sustain continuity of care, personnel answering the phones and making appointments have a standard script they must follow. Patients are strongly advised to see their own provider. The precise script can be found on page 18 of the Empanelment Implementation Guide.[2]

In order to assure the commitment to continuity, all new providers at MCHD work at least 50% time and see patients in the clinic at least 4 days per week in order to increase the likelihood that patients on their panel will be able to see them. At MCHD, all providers have a practice partner, and the 2 practice partners must cover all clinic sessions five days per week. When one practice partner is on vacation or continuing medical education time off, the other practice partner needs to be present in the clinic.

After tackling empanelment and continuity, Multnomah County clinics adopted a modified open access model. Clinics open their schedules for 2 weeks; patients who need to return in 4 or 6 weeks are given a card with the name of their provider, team, and phone number and are asked to call for an appointment when they want to be seen for follow up. If a provider is concerned about a patient following up, the wait list function in EPIC is used as a tickler system and the team's panel manager calls the patient on the appointed day. Each day, 20-25% of appointment slots (late morning and late afternoon) are kept open (40% for pediatrics) for patients who call that morning for same-day care. The remainder of the slots can be scheduled up to two weeks in advance. Teams are given discretion on when their same day appointments and double books are within their schedule. If personnel receiving incoming phone calls are unable to make the appointment requested by the patient for that patient's provider, the call is transferred to the team to solve the problem because the team knows its patient and can figure out the best way to meet their needs. After hours, patient calls go to a nurse triage line and an on-call provider is available to back up the nurse.

The expectation is that providers will see 18 patients per 8-hour day and behavioral health professionals will see 10 per day. Providers have 20 minute appointment slots, with the first slot of the day open for team planning and the last two slots of the day open for finishing the day's work. If a provider's no-show rate is less than 10%, 2 additional appointment slots are added; if the no-show rate is 10-15%, 3 additional slots are added, and if the no-show rate is greater than 15%, 4 additional slots are added. These expectations are to allow sufficient capacity to sustain patient access to care.

Care teams

Multnomah County primary care clinics all have stable teams, with the same team members working with one another every day. The team consists of two providers (MD, NP or PA) with 1.3 – 1.8 FTE between the two, 1 RN, 2 certified medical assistants (CMAs), 1 panel manager (CMA or LPN), and a team clerical assistant for making and tracking referrals. Front desk personnel are not team-based.

In 2008, East County did an architectural re-design to enable co-location of its teams. The process of knocking down walls and changing where providers and other team members work creates a strong message that the clinic is changing and will never go back to what it used to be. Not only does the architecture change, but the culture changes with it. Previously, providers had shared office space with other providers; now, everyone on the team is together in the same office space.

Care teams huddle for 20 minutes before each session (AM/PM) and meet for 1 hour twice per month. During the team meetings, the team reviews the next two-week schedule, including who is on vacation, discusses the priorities set by the site's sustainability team, and talks about ongoing team workflows. Each site has a sustainability team composed of the site management team plus a representative from each care team. Teams forward their concerns and workflow issues to the clinic manager who puts those issues on the sustainability team agenda. Members of the team know what each others' jobs and responsibilities are. MCHD is part of a union environment and the leadership team has worked closely with the unions in order to make the process of changing roles meeting the needs of the medical home.

The medical assistant role is relatively traditional. The RN on the team formerly spent most of the time on incoming phone calls with clinical content and on triaging phone calls and drop-ins. Starting in late 2010, the RN role was changed to 50% team-based acute care (triage, procedures, same-day visits, and care coordination) and 50% chronic care management.RN care management involves meeting with patients to do patient self-management, education, and coaching on behavior change, nutrition, exercise, medication adherence, and other areas prioritized by the patient. Providers refer patients to the team RN and the RN manages a caseload of patients over the phone and in person. When patient have met their goals, they graduate from the program.

The panel manager on the team (medical assistant or LPN) is the first to answer incoming phone calls referred to the team. They do outreach, inreach, and patient phone calls. They input data and follow-up emergency department and hospital discharges. They fill in for MAs if they are backed up. Their job is truly to manage the needs of the panel. Panel managers "scrub" the EPIC chart before patients arrive looking for care gaps (overdue chronic or preventive care tasks) and highlighting them for the provider. However, the panel manager does not order the services needed to close the care gaps; that is done by the

provider. Panel managers know their team's panel of patients, which makes them the ideal people to function as coordinator of the team.

Behavioral health personnel include psychiatric nurse practitioners and LCSWs. Providers do warm handoffs for patients needing behavioral services. The RN in the new role as care manager is implementing the IMPACT model of depression care, in which the provider refers patients and the RN does regular follow-up.

Panel management

Multnomah County Health Department is a member of Our Community Health Information Network (OCHIN), which has enabled many clinics in Oregon to adopt the EPIC electronic medical record. Currently, the clinics use a web-based registry populated each month from EPIC through a data warehouse. Panel managers can log into the registry and identify care gaps by provider for a wide variety of chronic diseases and preventive services. For in-reach, panel managers identify what needs to happen by scrubbing charts and working the registry, and they electronically transfer the care gap information into the patient's record. Providers, however, order the studies. For outreach, panel managers focus on diabetes, hypertension, depression, and pediatric asthma, making phone calls or sending letters to bring patients into care. Plans are being made for panel managers not simply to identify care gaps, but -- using standing orders -- to close the care gaps, for example, ordering mammograms and labs rather than leaving the ordering to clinicians.

Performance data

Improvements at the Multnomah County clinics are data driven, including both operational data (for example, continuity of care, access, provider productivity, and no-show rates) and clinical performance data on diabetes, hypertension, depression, and preventive care measures. Each clinic and team receive a performance profile each month and each site has a data wall displaying its performance. Examples of operational performance data are the scrubbing and huddling process, 3rd next available appointment, % of phone calls abandoned, referrals, and intakes into RN care management. In addition, sites use real-time indicators ("visual management") of key initiatives to help them see if a process is working or not. One metric which is tracked on the visual management display is whether the team huddles at 8 AM and 1 PM. The teams indicate whether or not the huddle took place by placing a green or red dot on the visual management display.

Creating workflows

As much as possible, workflows are standardized, doing the same thing in all sites, with some room for site-specific innovation. Sustainability teams at each site meet every

month for an hour, reviewing problems uncovered by care team members or by data, and changing workflows to solve the problems. When workflows are created, they may or may not be placed on a formal workflow map.

Leadership

The successes of the Multnomah County primary care clinics are largely due to a solid leadership structure and excellent leaders. The systemwide medical director (Dr. Amit Shah) and director of operations (Susan Kirchoff, RN, MBA) make monthly rounds of all 8 clinic sites, meeting with the site leadership. Before making rounds, they review the site data dashboard and require that site leaders do the same. These meetings have a standard agenda: What's going well? Who has done good work and gets a thank you letter from the top leadership? Follow-up from action items from the previous month. Review of data: access, continuity, telephones, clinical, dashboards, financials. The "visual management" datawall is reviewed. Successes and challenges are discussed. Thus communication flows up and down between top leadership and the care teams in a standardized manner.

This excellent clinic system has implemented primary care transformation in a logical order, moving stepwise from empanelment to right-sizing panels, to continuity, access, and teams. These are essential components of high-functioning primary care practices. For Multnomah County, improvement must continue forever – "we'll never be done."