Replicable, Scalable Medical Home Transformation Built on Leadership Commitment and a Proven Patient Centric Model of Care

Abstract

The Affordable Care Act (ACA) has expanded insurance coverage for millions of Americans. As a result, Federally Qualified Health Centers (FQHCs) must respond in order to remain viable within the Accountable Care Organization concept (ACO) established as part of health care reform. FQHCs must adapt to ensure that they can continue to fulfill their mission of providing comprehensive care to low-income and minority populations. ACCESS Community Health Network, located in Chicago, IL partnered with Coleman Associates with the overarching objective of achieving increased patient satisfaction via the improvement in operational outcomes such as Cycle Times and No-Show Rates. This paper examines the results of these efforts over the course of three years, and offers a successful Patient Visit Redesign™ blueprint for other FQHCs to follow as they examine their Patient Centered Medical Home (PCMH) capabilities and their ability to provide timely access to care.

Background

ACCESS Community Health Network has been providing community-based health care for more than 20 years. ACCESS consists of close to 40 FQHCs which provide a continuum of care model connecting patients to health care resources within and beyond its health centers. The mission and vision of ACCESS is to offer outstanding preventive and primary health care, accessible to all in their own communities, providing the health care home of choice for individuals, families, and communities, exceeding quality standards, and engaging patients and staff in addressing health disparities.[1]

In 2012 ACCESS began moving toward the Patient Centered Medical Home (PCMH) model. ACCESS began by conducting a gap analysis in order to better understand the strengths and weaknesses facing the health centers, particularly in the areas of technology of patient access to care. Leadership also examined external factors impacting the way in which they did business, including the ACA and ACO evolution. In an effort to improve patient care and achieve medical home status, ACCESS sent out a request for proposal (RFP), and chose Coleman Associates to lead their redesign efforts. Coleman has extensive experience seeing best practices created and carried out with many variables: different staffing levels, different technology, different architectures/floor plan designs, different provider specialties, different patient populations, and varying support structures and support staffing configurations (community health workers, social workers, etc.).

[1] ACCESS Community Health Network.

Redesign

Coleman Associates' Dramatic Performance Improvement™ emphasizes work process design and teamwork. It is focused on the end-user of clinic services—the patient—though the staff and the organization reap the benefits of redesign as well. Coleman applies the scientific method with clinics going through the Dramatic Performance Improvement™ (DPI) process. Similar to a PDSA cycle[2] yet different in speed, risk-taking, and evaluation, Rapid iterative testing—Rapid Redesign Tests (RRTs)—involves forming a hypothesis and testing it to develop best process solutions: "The goal of redesign is to virtually eliminate patient waiting. Redesign requires all staff to look at the way they accomplish work with a fresh perspective in order to recreate a patient visit process that is efficient and above all patient-focused. It is best to think of redesign (or reengineering) not as an 'improvement methodology,' but rather as a method that seeks to transform the patient experience, the health care workplace, and the organization as a whole. A transformed patient experience means easy access to care, minimal waiting time during visits, and a significant drop in clinical errors (i.e., patient safety). A transformed workplace is an exciting place to work where learning is optimal, teamwork is the norm, and everyone can work to her/his full potential. And, a transformed organization is optimally productive, financially healthy, technologically savvy, and hierarchically flat. Such an organization adapts quickly and well to change."[3]

After meeting with Coleman Associates and reviewing their options, ACCESS chose the DPI™ Collaborative Approach. The collaborative method is the best choice for organizations hoping to enact large-scale change in a number of health centers at one time. In January 2013 ACCESS started its collaborative with eight health centers. The process began with a Leadership Conference that involved leaders from across the organization, including senior leadership, health center managers, regional operations managers, and regional medical directors who worked together to identify the goals of the DPI™. ACCESS identified goals that included 90% of visits to be completed in 35 minutes or less (Cycle Time—the baseline Cycle Time average was 110 minutes, so this was a significant improvement over the starting point); a Third Next Available Appointment (TNAA – or measure of average wait for an appointment[4]) wait of five days or under; and a No-Show rate of 5% or less. These goals were established prior to a data review as is part of the Coleman methodology. The goal was to set goals that would exceed evolving patient expectations & stretch the organization rather than set goals that would be incremental based upon baseline data.

According to COO Janie Gawrys, ACCESS chose the DPI™ Collaborative in order to train as many clinics as possible. VP of Operations Eddie Cruz agreed that the DPI™ Collaborative lined up well with improvements they wanted to make in patients' access

[2] "The W. Edwards Deming Institute." Deming.org Accessed June 21, 2015. https://www.deming.org/theman/theories/pdsacycle
[3] "Patient Visit Redesign." Coleman Associates. Accessed June 21, 2015. http://ColemanAssociates.com.
[4] "Institute for Healthcare Improvement." Institute for Healthcare Improvement. Accessed June 21, 2015. http://www.ihi.org/resources/Pages/Measures/ThirdNextAvailableAppointment.aspx

to care. He was drawn to the team approach: "You like to think you are patient centered, but are you really? DPI™ was dramatic, and the teamwork piece was key, allowing every staff member a voice." While the first round of training was grant funded, the CEO of ACCESS, Donna Thompson, RN, MS, was so impressed with the results that she actively sought funding for subsequent learning sessions. ACCESS saw the value of DPI™, not only because metrics were improving, but because there was also a clear change in staff attitudes. There was a significant shift in power dynamics as staff became empowered, realizing they each had an equal say as part of a team, regardless of their position.

Coleman Associates provided key ingredients for success that other consultants interviewed by ACCESS lacked: passion, in-depth experience with Community Health Centers, consumer driven data, experienced and trusted consultants, a personal and hands-on approach, and the ability to bring about innovation and think outside the box in order to engage staff in non-traditional ways.

Quantitative Results

The effectiveness of redesign for all four waves of the DPI™ Collaborative was examined across the categories of Cycle Time, TNAA, and No-Show Rates.

Overall Median Cycle Time: From February 2013 to February 2017, the overall median Cycle Time for all participating clinics decreased 68%, down to 35 minutes from a baseline of 110 minutes.

Overall Average No-Show Rate: From February 2013 to February 2014, the overall average No-Show rate decreased from 24% to 9%. In December 2015 the average No-Show rate had risen to 16% and has remained steady. One explanation for the rise is provider vacation time as higher TNAAs typically yield a higher No Show rate. Many organizations report an uptick in TNAA when providers take vacation time. When a provider who is the sole Primary Care Provider takes a three week vacation, regardless of his/her availability before and after that time, TNAA reflects the increase of 21 days (7 days x 3weeks) that the provider is unavailable, which skews the results of improvement in the short term until the provider returns. Still, this represents a significant overall decrease in the No-Show rate from baseline to completion.

Overall Average TNAA: From a baseline of 10.5 days in February 2013, the average TNAA dropped to an average of 6 days, with an average of 3 days for full-time Primary Care (PC) and 5 days for Obstetrics (OB), a 71% decrease from baseline for PC and a 52% decrease for OB. While ACCESS focuses primarily on Primary Care, some practices also provide robust OB services. As the project progressed, it was noted that TNAA was more varied in OB, so the two areas of service were tracked separately. See *Table 1.*

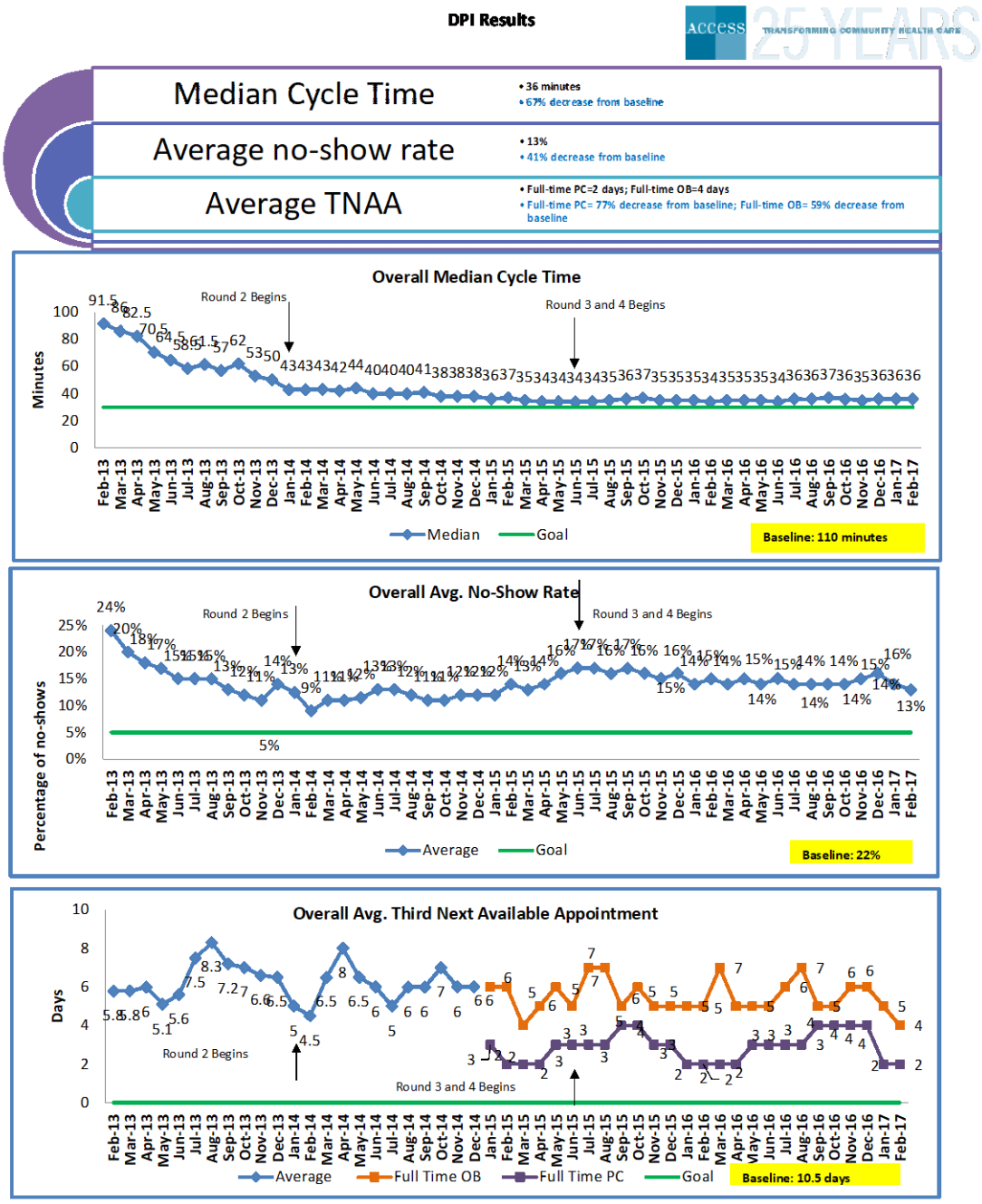

Table 1: ACCESS DPI™ Results

In addition to Cycle Time, TNAA, and No-Show Rates, an increase in overall patient satisfaction was a primary goal of Patient Visit Redesign™. Over the course of the three-year implementation period, overall patient satisfaction increased across all categories.

Receptionist Friendly and Helpful: Patient surveys indicate an increase in satisfaction from 73% to 81%. The goal remains 85% patient satisfaction in this area.

MA Friendly and Helpful: Patient surveys indicate an increase in satisfaction from 76% to 83%. The goal remains 85% patient satisfaction in this area.

Provider Answers Your Questions and Spends Enough Time With You: Patient surveys indicate an increase in satisfaction from 77% to 79%. The goal remains 85% patient satisfaction in this area.

Calls Get Through Easily: Patient surveys indicate an increase in satisfaction from 53% to 61%. The goal remains 70% patient satisfaction in this area.

Overall Experience: Patient surveys indicate an increase in satisfaction from 66% to 78%. The goal remains 80% patient satisfaction in this area. See *Table 2.*

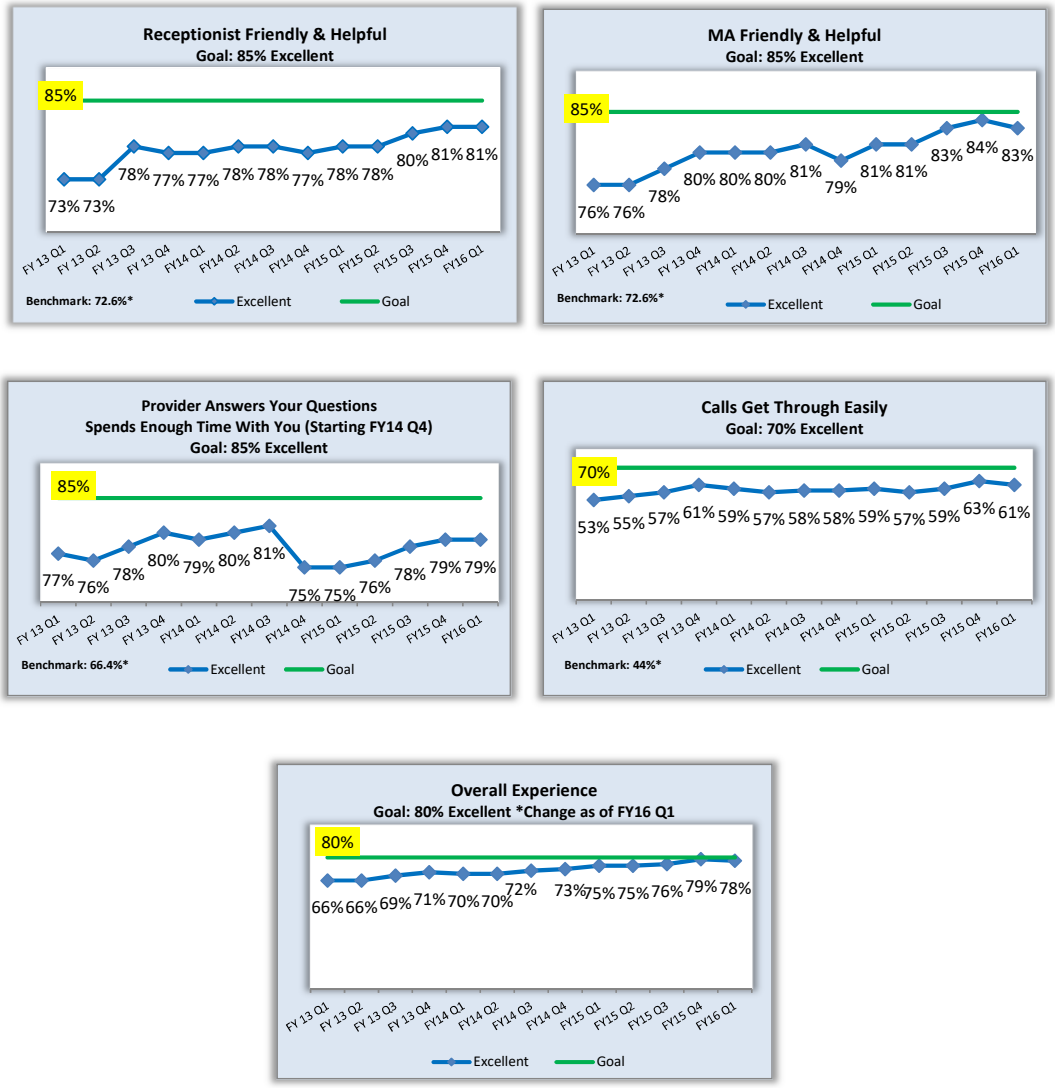

Table 2: Overall ACCESS Patient Satisfaction Results FY13 – FY16 Q1

Another significant indicator of improvement can be found in ACCESS' 2014 Employee Engagement Survey results. The purpose of the Employee Engagement Survey is to solicit employees' opinions on a variety of topics to determine: 1) their overall level of engagement in their work and the organization; 2) the areas of satisfaction (where ACCESS is performing well), and 3) the areas of dissatisfaction (opportunities for improvement). Throughout the survey, results from ACCESS' 2014 survey are compared with the results of its 2013 survey, and in some areas to the 2010 survey. Lastly, the results are compared with relevant National Healthcare Normative data.

ACCESS used the same 29 survey questions in both 2013 and 2014. The questions were grouped into 5 dimensions that represent the major themes impacting employee engagement: ***Outcome Variable, Organizational Effectiveness, Recognition/Career Advancement, Supervisory/Management, and Coworker Performance/Cooperation***. In 2013, ACCESS scored lower in four dimensions, but did show a 3% increase from 2010 in the "Coworker" category. In 2014, ACCESS scored significantly higher in all five dimensions, but still slightly below the National Healthcare Norm Differential (in all five dimensions). It is clear that these increases are due, in large part, to the changes brought about by redesign. See *Table 3*.

Chart 1.0 Survey Dimensions	ACCESS Percent Favorable 2014	ACCESS Percent Favorable 2013	2014 – 2013 Point Change	National Healthcare Norm	National Healthcare Norm Differential	Best-In-Class Healthcare Norm
1. Outcome Variable	72	55	17	77	-5	83
2. Organizational Effectiveness	71	59	12	75	-4	82
3. Recognition/Career	69	59	10	72	-3	78
4. Supervisory/Management	63	51	12	65	-2	74
5. Coworker	79	73	6	86	-7	92

Table 3: Employee Engagement Survey

Clearly, ACCESS experienced many quantitative improvements by participating in the DPI™ process, including improvements in patient satisfaction, employee engagement, patient data engagement, and slot utilization. In addition, Eleva Riley, Vice President of Human Resources noted that in 2014 Avatar Solutions (a subsidiary of Press Ganey) honored Access Community Health Network with their "First Place, Most Improved Overall Job Satisfaction" award.

The Return on Investment (ROI) has been measurable in many cases and is less direct in others. In most ACCESS health centers, they no longer have monthly staff meetings, as they have daily huddles and communicate as a strengthened team. Staff and managers have been trained to be future change leaders, to coach, and to use data for decision-making. In order to achieve such a significant ROI, top leadership have had to be completely invested—and patient. According to CEO Thompson, "we had invested in technology and saw the shaping of the Affordable Care Act. We couldn't be the place of last resort—we wanted to attract all payers. The overall landscape has become more competitive. All Community Health Centers need to look at population health. We need to remember that consumers have a choice."

Qualitative Results

Teamwork: Leadership realized that in order for DPI™ to work, they all needed to be part of the change. They had to set expectations, form the teams, and complete all the steps,

even if that meant sitting in discomfort for a short period of time. Persistence is a key part of this program's success. The impact of teamwork cannot be understated. ACCESS Chief Medical Officer Dr. Jairo Mejia emphasized the shift in staff relationships and work culture when teams were formed and implemented as part of DPI™: "Now we work in teams. Every day we have a team. My teams include two MAs, one student, and a doctor. In the past, I would walk in to work not knowing which MA would be working with me that day. There was no organization. With the creation of teams, staff have more empowerment, and the role of MAs has been completely redesigned. Our MAs are now in high demand."

Sustainability: Having a sustainability plan in place early on is key to success, particularly in large organizations that experience high rates of turnover and ongoing competencies. Introducing the DPI™ model during new employee orientation, providing internal coaches who conduct quarterly onsite reviews with health centers, and taking half a day to review patient flows and the DPI™ framework are all steps that have been taken to improve program stability and sustainability over time. Dr. Mejia also noted the importance of educating new employees from the moment they enter the health centers, and stressing that this model is the way ACCESS is now practicing medicine to new providers coming in or returning. VP of Operations Cruz noted that while sustainability was a concern of those participating in round one, as each successive round of clinics received training, sustainability was no longer questioned. It was clear that DPI™ was working, and that the working model would become self-sustaining.

Patient Satisfaction: Patient satisfaction and quality of care has improved tremendously since the implementation of the DPI™ Collaborative (see Table 2). According to COO Gawrys, patient complaints have dropped significantly. The new model creates more time to focus on the patient, and that time is quality time. Patients are happier because they are not waiting, which leads to more positive patient-physician interactions. VP of Operations Cruz noted that occurrence reports from clinics requesting to ban patients for inappropriate or threatening behavior decreased from one or two requests per week to one or two requests per year. Changing the model of care lessened everyone's anxiety. In addition, staff and providers gained a better understanding of the difficult choices patients were often faced with. Could they take time off of work to make an appointment with the doctor? Did they have to choose between seeing a doctor and providing food for the family? Redesign was a transformative experience for patients, staff, and providers, as they all gained empathy for one another and worked to develop relationships based on trust and shared accountability. Even board members, many of whom are community members who are patients themselves, noticed the significant improvement that resulted from the redesign work.

VP of Operations Cruz also pointed to the importance of easing the pain of a painful system. ACCESS has done this in a number of ways, including establishing a call center at a number of clinics, which can provide patients access to care from 7 am – 9 pm. One outcome of health care reform was an increase in the number of new patients seeking care after years of being uninsured. These patients came into the system with numerous untreated conditions. In order to begin to adequately address their concerns, care had to

be provided in a more collaborative and extensive manner. Electronic health records have helped, and ACCESS has been instrumental in piloting a transition of care program at one hospital. This program gives the hospital providers and staff access to non-confidential portions of patients' Electronic Health Records in order to avoid duplication of testing and to streamline care. In addition, these providers and staff have access to schedule the patients a follow-up appointment with their primary care physician in support of continuity of care.

Sustaining Change

ACCESS Keys to Success: It is important to recognize that there are key components needed to achieve success with any patient visit redesign model. An organization must be ripe for change. In this case, ACCESS leaders were well aware of the obstacles they faced, and they had already taken steps to address these obstacles by conducting a gap analysis and moving toward the PCMH model. They determined that DPI™ aligned with what they already wanted to achieve.

Once the commitment to change is made, organizations need to obtain buy-in across all staffing levels, from front desk staff up to the CEO, and all players must dedicate themselves to every aspect of the program long-term. Organizations that pick and choose which pieces of redesign to follow, or that decide to try redesign for a set period of time, do not experience the same level of success achieved by ACCESS. Leadership needs to recognize that the organization is committing to a change in culture that will require a significant financial investment, dedication, and a willingness to sit in discomfort during transition. ACCESS made that commitment across all staffing levels and all healthcare sites:

- The organization also made a strong commitment to the medical home model by striving to achieve the highest level of recognition (Level 3) at all sites, which required a significant financial investment as well as dedication of resources to capitalize on the new DPI™ processes and concretize the new systems within the PCMH framework. As a result, the scripting, methodology and patient care protocol is now virtually identical at each site. ACCESS has also established an orientation program for new staff so that from day one they learn the model of care established by DPI™, and the organization has obtained a planning grant that will take ACCESS to the next level of shared decision-making.
- Through attrition, the Regional Medical Directors (RMDs) shifted in the organizational structure to report directly to the CEO on a temporary basis. While this took an additional investment of time, it connected the CEO and the RMDs more directly, which led to both parties gaining new insight and perspective into their work. This realignment remained in place for a couple of years as members of the medical leadership team dedicated themselves to DPI™, and accountability lines were rewritten while positions were filled.
- Leadership made a commitment to keep the bar high for DPI™ results. Two sites that did not achieve the desired goals for No Show, Cycle Time, and Productivity after initial training were required to undergo a second round of training in order

to produce stronger results. This was done despite additional time and financial investment. It proved successful and it also underscored leadership's steely commitment to the goals that had been set forth.

These three specific examples do not represent all of the positive changes that resulted from the high level of leadership commitment; however, they are areas of strength that point to replicable models of change, as they have been integral to the success achieved by ACCESS Community Health Network and should serve as a road map for other organizations striving to obtain similar levels of success.

Coleman's commitment to success and development was "the DPI secret sauce," according to CEO Thompson. Coleman provided passion, experience (Coleman consultants are former front line staff who have worked in these roles at CHCs, giving them significant credibility with ACCESS staff), and change know-how by leading goal setting exercises, team selection and iterative testing processes in a way that is both organic and clearly "designed to produce the results that were achieved." According to Thompson, "we were able to give our staff up close and personal professional development" through the modeling of Coleman staff who clearly demonstrated how to engage in effective decision making, hold uncomfortable conversations, and provide constructive support as "consistent consultant confidantes" in a way that only external team members can provide.

Conclusion

With all of the changes being mandated by health care reform and the Affordable Care Act, patients have more choices than ever today. Patients are increasingly expecting the same level of care or better at a public facility as they would receive at a private clinic. Community Health Centers can position themselves well to take in new patients and compete effectively in this market by providing operational experiences to meet patients' evolving needs and expectations. After successfully completing the DPI™ Collaborative, ACCESS is poised to serve as a model FQHC that has successfully embraced and implemented the Patient Centered Medical Home, providing timely access to care.

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