# Patient-Centered Care for Underserved Populations: Best Practices

## *A Case Study of Senior Health and Wellness Center, Eugene, Oregon*

*prepared for*

The W. K. Kellogg Foundation

*by*

Tanya Alteras

**Economic and Social Research Institute**

2100 M Street, N.W., Suite 605
Washington, DC 20037
www.esresearch.org

March 2006

## Acknowledgements

The authors would like to thank the W. K. Kellogg Foundation for supporting this research. The W.K. Kellogg Foundation is a nonprofit organization whose mission is to apply knowledge to solve the problems of people. Its founder W.K. Kellogg, the cereal industry pioneer, established the Foundation in 1930. Since its beginning the Foundation has continuously focused on building the capacity of individuals, communities, and institutions to solve their own problems. "To help people help themselves through the practical application of knowledge and resources to improve their quality of life and that of future generations." For more information, see www.wkkf.org

We also thank the following Senior Health and Wellness Center staff: Dr. Ron Stock, Medical Director; Mary Backus, Manager; Kat Chinn, Nurse Practitioner; Dan Reece, Regional Director of Care Coordination Services; and Sandy Sanders, LCSW, Care Coordinator.

## About the Economic and Social Research Institute

**The Economic and Social Research Institute** (ESRI) is a nonprofit, non-partisan organization based in Washington, D.C that conducts research and policy analysis in health care and in the reform of social services. ESRI specializes in studies aimed at improving the way health care services are organized and delivered, making quality health care accessible and affordable, and enhancing the effectiveness of social programs. For more information, see www.esresearch.org.

## About the Author

**Tanya Alteras**, M.P.P. is a Senior Policy Analyst at ESRI. Ms. Alteras specializes in examining issues of access to health care for the underserved within Medicaid, SCHIP, and other public programs; financing and organization of health care reform proposals; and strategies for leveraging private dollars to stretch limited public resources in the delivery of health care and health insurance coverage. Her recent projects include studying best practices in oral health care for the underserved, reviewing coverage for adults without dependent children, and examining early experiences of the Trade Act of 2002 Health Coverage Tax Credit.

# Case Study: Senior Health and Wellness Center, Eugene, Oregon

## Background

The Senior Health and Wellness Center (SHWC) is a geriatric outpatient clinic in Eugene, Oregon that has been in operation since 2000. It is staffed with a range of professional and support workers who specialize in caring for the elderly. The SHWC is part of the PeaceHealth[1] network's Oregon Region, and is the only geriatric clinic in the Pacific Northwest that provides coordinated, patient-focused care through an interdisciplinary team model. In its six years of existence, it has provided primary care for a panel of over 1,700 patients.

When PeaceHealth considered opening a geriatric clinic, staff spent three years thinking about and researching the ways in which to best deliver quality health care to elderly patients. After a series of focus groups, more than 300 interviews with patients, caregivers, and families, and participation in an Institute for Healthcare Improvement (IHI) consortium project, the SHWC made its debut.

SHWC's mission is to provide patient-centered care based on the Group Health of Puget Sound MacColl Institute's Chronic Care Model; in other words, forging a close, personal relationship between a patient and his or her caregiver, with all members of the team working together to develop a personalized and proactive care plan. Given that the majority of patients served by SHWC have multiple, interacting conditions, the interdisciplinary team approach has helped to improve quality of care and health outcomes by addressing not only the patients' medical needs, but also their psychological, social, and spiritual needs. SHWC staff drives patient-centered care by focusing on what patients want (in terms of their health and social well-being) in their later years, rather than having the physician solely determine what their goals should be. Considering that providers at this center are treating patients whose conditions range from dementia to depression and diabetes, this mindset is extremely important in the day-to-day operations of the center.

The challenges associated with delivering patient-centered care are exacerbated for the senior population, despite the availability of health insurance coverage through Medicare. Not only do seniors face multiple acute and chronic conditions in a fragmented, complex health care system, but in many areas it is becoming increasingly difficult for new Medicare patients to find providers willing to take them on as patients due to physician concerns about the adequacy of Medicare reimbursement rates.

[1] The PeaceHealth organization is a health care network with hospitals and providers in five regions throughout Oregon, Washington, and Alaska. It was founded in the late 1800's (although not named PeaceHealth until 1995) as a health care ministry based at St. Joseph's hospital in Whatcom County, Washington.

In addition to the outpatient care, the SHWC also provides transitional care, serving patients through home health and hospice care, as well as seeing clients who are in subacute, long-term care, skilled nursing facility, and residential care settings. (i.e. a team of 2 geriatricians and 5 nurse practitioners support primary care physician patients in these settings and serve as the providers for patients who are institutionalized.)

## How SHWC Practices Patient-Centered Care (PCC)

The SHWC's mission is to establish a system of care that acknowledges and addresses – through interdisciplinary teams—the psycho-social aspects of life that affect an individual's physical health. The center's leaders assert that in order to provide high-quality, cost-effective care to a growing elderly population, new models of care are needed. While the staff acknowledges that the interdisciplinary team model is at this time a financial "loss leader," and that the center would not be able to survive without financial support from the parent organization, PeaceHealth, it is a promising model to be studied for its long-term efficiencies and improved health and functional outcomes. In addition to the interdisciplinary team approach, the SHWC utilizes a tool called the "Shared Care Plan," and other practices described below.

### *Coordination and Integration of Care via the Interdisciplinary Team Approach*

In addition to physicians, the SHWC employs advanced practice nurses, a geriatric pharmacist, a nutritionist, gerontological registered nurses, a licensed clinical social worker[2], a chaplain, and a health information librarian.[3] All SHWC staff are dedicated to creating a holistic health care environment for the patients who walk in the door. This approach grew out of the staff's understanding of the Chronic Care Model as being an integration of the community, the health system, informed activated patients, and a prepared, proactive practice team. The community and the patient make up one half of the model, while the health system and the practice team make up the other half. Working together, they can create successful functional and clinical outcomes.[4]

To put this model into practice, each week the interdisciplinary team members decide which patients will be "care planned" (e.g. whose cases will be discussed). A licensed clinical social worker on staff leads the team, and gathers data in advance of the meeting from each team member, including information on the patient's medical condition, what is happening in their daily life that could be affecting their health, and what prescriptions they are currently taking. The team then meets to discuss that patient's care plan and next steps in helping the patient meet his or her goals. If necessary, a member of the team will contact the patient either by phone or sometimes by house call, to go over relevant issues.

At the client level, staff conduct an evaluative meeting for patient's deemed to be at "high risk" for adverse outcomes or in situations where staff are "stuck" with how to best meet the needs of the patient. The meeting is held with all members of the patient's provider team, during which

[2] The licensed clinical social worker provides psychotherapy to patients.

[3] Physical therapists, home health, and hospice staff are not directly employed by the SHWC, but the center contracts with them and they participate in weekly patient care conferences.

[4] For more info on the CCM model see the Improving Chronic Illness Care program website at http://www.improvingchroniccare.org/change/

they review the patient's goals, discuss what treatments and actions have been taken to date, and consider what next steps or services are needed.

### *Patient Empowerment and Activation via the Shared Care Plan*

The Shared Care Plan (SCP) web-based internet tool was developed by the Community Health Improvement Consortium (CHIC), a group of healthcare providers in Whatcom County, Washington, one of whom is affiliated with PeaceHealth.[5] The SCP is a personal health record that patients can fill out with a pen or online and lists a patient's personal profile, self-management goals, treatment goals, prescriptions and medications, allergies, chronic diagnoses, document advance directive, and health care team members. Developed as a tool to help individuals with chronic conditions better manage their multiple needs, providers, and pharmaceuticals, it is becoming widely used by SHWC patients and practitioners.

The Shared Care Plan offers an efficient way for practitioners to understand at a glance the various services their patients are receiving, from whom, and when. The main purpose, however, is to ***activate*** patients to take on a greater role in their own care while providing them with information and support. As leaders of the Whatcom County program where the SCP originated said, "people cannot just be presented with this new role and expected to run with it. They have to be trained, and supported." The SHWC does this by making staff available to patients who decide to create a SCP for themselves. For example, a health information librarian is available in the reception area two days a week to assist patients with registering and creating a shared care plan. Once a patient does so, however, it is up to them to keep it current . As one interviewee put it, "people can receive help with the SCP but they are not 'assigned' an SCP to keep up." It does not in any way replace the electronic medical record technology that is used to keep track of patients' care visits.

The SCP enables patients to think of themselves as active participants in their own care, which some in the PeaceHealth organization see as even more important to patient-centered care than getting providers to give patients a greater role. In fact, those involved with the *Pursuing Perfection* program view *patients* -- not providers—as the leaders of the patient-centered care movement.

### *Welcoming, Familiar Environment*

Prior to their first meeting with a physician, patients and their families/caregivers are provided with an orientation in which they meet with staff members, review their medications, insurance information, and medical history, and generally become familiar with the SHWC environment. As they tour the facility, they are given an overview of available services, which helps to broaden their awareness of primary and preventive services from which they could benefit.

---

[5]In Whatcom County, Washington, a community of almost 180,000 people in the northwest corner of the state, a consortium of providers has come together to provide care in accordance with the "patient-centeredness" aims outlined in the Institute of Medicine's 2001 *Crossing the Quality Chasm* report. This "Community Health Improvement Consortium (CHIC) of Whatcom County" includes the Family Care Network, North Cascade Cardiology, Center for Senior Health, SeaMar Community Health Center, St. Joseph Hospital, and three health plans: Regence Blue Shield, Group Health Cooperative, and Community Health Plans of Washington. The group applied for and received a Robert Wood Johnson Foundation/Institute for Health Care Improvement *Pursuing Perfection Program* grant in 2001, to develop and implement patient-centered care practices.

### *Socio-Cultural Competence*

As one administrator explained, all of the staff at the SHWC recognize the importance of seeing a patient as a whole person, and understanding their educational, cultural, and social history, not just their current clinical needs. Each new patient who walks in the door receives a "new patient" packet, including questionnaires that elicit information on a variety of issues, such as their past medical history, basic demographics, current living arrangements, frequency of contact with family and friends, recent emergency department, hospital, and physician visits, ability to conduct activities of daily living (ADLs), screening for previous falls, urinary incontinence, depression, immunizations, and concerns about health risks, such as fear of falling. These data are used to create a health risk stratification rating[6] A patient is determined to be either low, medium, or high risk based on this rating. This allows their interdisciplinary team members to focus on specific issues right from the beginning of their relationship with the SHWC. Finally, physicians are trained to probe patients on their responses to gather complete information.

### *Easy Access to Care*

An important priority among community members (learned through focus groups, discussed below), was for elderly patients to be able to get as many services as possible in one location, thereby cutting down on travel which could be physically and mentally exhausting. As a result, the center now provides not only primary and consultative care services, x-ray and laboratory services, social work and care coordination, but also specialty care such as audiology, and foot care. In addition to making the center a "one-stop shop" for patients, one administrator noted that diversifying the income stream by adding services that are paid for out-of-pocket can help the clinic become more financially stable.

### *Community Outreach*

Community outreach was an important element to the original design of the center, as the SHWC's founders conducted focus groups and interviews with over 450 patients, administrators and providers to better understand their need and priorities. Currently, community outreach is reflected in other ways. For example, the center has space on-site for community-based organizations to hold meetings. In addition, staff are trained to actively link patients with relevant community resources. While not traditionally considered community outreach, it should be noted that SHWC physicians and nurses play an important role in the care provided to their patients at off-site skilled nursing facilities, long-term care facilities, and nursing homes, by conducting on-site visits and continuing to coordinate their care. SHWC providers also contract with those same off-site facilities to provide care to patients there who were not originally SHWC patients. According to some interviewees, this practice counters the trend by which fewer geriatric providers in the community are taking the time to visit their patients in these facilities.

[6] The SHWC uses a Health Risk Stratification system developed by Provident Health Care System, Portland OR, to create a risk rating for each patient.

## Institutional Supports and Critical Success Factors

### *Committed Leadership and Customer-Driven Planning Process*

In February, 1997, after getting the green light from the PeaceHealth Oregon Region Governing Board to begin working on a senior clinic concept, a number of staff began to think about how to create a service delivery environment tailored to the unique needs of the elderly population. They employed an information-gathering model utilized by Toyota and others in the manufacturing industry called the *Quality Functional Deployment* tool, or, as the SHWC leadership refer to it, "the voice of the customer." The tool involves the following steps:

- Identifying the project scope and objective
- Organizing the team
- Listing expected results
- Identifying exactly who are the customers
- Collecting information on the needs of those customers (the "whats")
- Organizing those needs into groups, and prioritizing them
- Establishing how will those needs be met (the "hows")

Through interviews with patients, caregivers, doctors, administrators, and insurers, the leadership identified 109 consumer needs, and out of those, developed 275 "hows"—actions and solutions. In the end, they came up with 57 prioritized "whats" and "hows."

Besides the obvious value of the information collected, going through the *voice of the customer* process made the planners acutely aware of the need to focus on the "relational" aspects of patient care. According to one founder, "seniors received 'high tech' care, but in reality wanted 'high touch' services," meaning services that were user-friendly, holistic, respectful, and personalized.

Specific "whats" and "hows" that came out of this process closely mirror the Chronic Care Model's elements, including:

- Receiving care from a trained geriatrician and geriatric nurse practitioner;
- Convenient, easy to access services;
- Additional quality time with providers;
- Patient/family participation in the care process;
- Comprehensive care (one-stop shopping) in a multi-disciplinary care format.

The planners spent two years carefully planning the Senior Health and Wellness Center, reflecting their passion and commitment to creating a space that both reflects and provides for the needs of the elderly community in Eugene. Since the center has opened, a number of individuals have been identified as being superb leaders, such as Mary Backus RN, the center's Operations Manager, and Lorelei Cesario, Director of Senior Business Development. In the words of some interviewees, the SHWC could not run as well as it does without Ms. Backus' leadership and innovative thinking.

### *Staff Recruitment and Development*

Like clinical care, staff recruitment and hiring at the SHWC is done in a team setting. That is, physicians, nurses, and other provider and administrative staff work together to determine staffing needs, interview prospective employees, and train those who are hired. Through this process, the staff are able to carefully determine whether an applicant is an appropriate fit, and do not hire those who are uncomfortable with the highly integrated, interdependent, interdisciplinary work team model that they have established. Those interviewed said that generally, the SHWC attracts professionals who are already interested in working in a patient-centered environment.

One important aspect of the SHWC's staffing is that all of its registered nurses are certified as geriatric specialists. This ensures that the nurses are especially trained in working with elderly patients, and understand the acute and chronic conditions as well as non-medical issues faced by this population.

Ongoing staff development activities reinforce patient centered care at SHWC:

- *Intra-Staff Communication Workshops:* The center conducts workshops once or twice a year for staff to re-establish *why* they chose to practice at a patient-centered, interdisciplinary-team based clinic for patients who have multiple and challenging conditions.
- *Patient-Staff Communication Workshops (Senior Sensitivity Classes):* Held more frequently than the intra-staff workshops, these are focused on training staff – both new and established -- on how to communicate effectively with elderly patients in a manner that is conducive to patient-centered care. Staff are also educated in how to be more aware of the physical and emotional challenges that their patients may be experiencing by spending time in a wheelchair, putting on black-out glasses or ear plugs, etc. By raising the staff's awareness of the challenges their patients face in daily life, they can develop strategies to treat them in a way that preserves their dignity.

### *Technology*

All PeaceHealth clinics and hospitals utilize an electronic medical record that houses all outpatient and inpatient encounters as well as lab, X-Ray, and ancillary services. Also, as mentioned above, the SHWC has begun to explore using a tool called the Shared Care Plan (SCP), which enables patients to collect all of their pertinent health information in one place – ideally online, but also available in hard-copy format – in a way that puts them in control of their data, and at the same time gives all the members of their health care team an easily digestible snapshot of where the patient is in the care protocol. Used mainly in Whatcom County, Washington for chronically ill diabetes patients, the SHWC is putting it to use in a step-wise process. It was originally used simply as a way for providers and the center's geriatric pharmacist to reconcile patients' extensive pharmaceutical usage and make sure that they were not being prescribed drugs that were contraindicated. The center was a pilot site for an Agency for Healthcare Research and Quality (AHRQ) Patient Safety grant study looking at medication safety, and the role that technology such as the Shared Care Plan can play. As a result of this study, the center is aiming to broaden its use by registering all 1,700 of its patients in the program and have them develop their SCPs. Since patients at the SHWC often see other non-center providers for specialty care needs, the cen-

ter's staff hopes that the SCP will make it easier for these patients and their providers to coordinate their care needs.

Because their patients tend to have extensive health histories, and are likely to be taking multiple prescriptions, SHWC has staff on hand to train patients in how to collect their data and input it into the SCP secured website. There is also a computer terminal in the lobby of the center so that patients can create and update their SCPs before or after their appointments. As a result of the AHRQ grant work, interfaces have been developed to give healthcare providers access to their patients' SCP from the providers EMR and vice versa, for patients to have better access to important information in their EMR record.

### *Administrative Mechanisms*

There are a number of processes and mechanisms built into SHWC that support its ability to provide patient-centered care:

- *Billing Increments:* All appointments at the center are scheduled in 30, 60, or 90 minute increments, as opposed to the 10 minute appointment increments used by other geriatric providers in the community. It became clear early in the planning process that without longer appointment times, the interdisciplinary team approach would not work.
- *Formal PCC processes:* As one interviewee noted, staff need to be formally trained to provide patient-centered care. There must be system for getting the patient from step A to step B, and formal processes for all aspects of service delivery. In other words, patient-centered care cannot simply be a mindset that the staff have, but must be pervasive in the clinical *and* administrative aspects of care. Such processes and policies include:
  - Inviting family members and/or caregivers into the exam room with the patient, if the patient so desires;
  - Having a staff person whose sole responsibility is to greet new patients and give them their full attention as they arrive, as opposed to having one person who both mans the phone and greets patients;
  - Training all staff to introduce themselves to the patient, giving them their name and their role at the center;
  - Providing patients with a written "patient instruction sheet," which includes notes of what was discussed during the visit, so that patients have a written record and do not have to rely on their memory for post-visit care instructions.

Inherent in making these processes work is a staff that is able to "put ego and agenda aside, and invite patients to tell you what it means to be served at your clinic."

### *Measurement and Feedback*

SHWC is currently in the midst of a number of studies to evaluate how well it is doing at accomplishing its mission. With the generous support from the John A. Hartford Foundation of New York City through the Geriatric Interdisciplinary Teams in Practice (GIT-P) initiative, the SHWC conducted a quasi-experimental 30 month study to evaluate whether the interdisciplinary team

approach leads to improved health outcomes including patient satisfaction, clinical measures, functional, and utilization/cost. Qualitatively, staff spoke to 29 patients and 8 caregivers over the course of five focus groups, and came away with significant validation that the center's use of interdisciplinary teams, one-stop shopping, employment of geriatric nurse practitioners, longer appointments, availability of health information through a designated librarian, and other features, were all in line with what the community needs and wants. The focus groups also provided staff with issues on which there is room for improvement, including expansion of services, having specialists on site, and giving patients their "own" doctor.

Preliminary, unpublished assessment of the Hartford funded study has shown the following findings about a sample of their patients, compared to other elderly patients in the community.

- Higher immunization rates;
- Lower incidence of falls, most specifically among older, frail women;
- Lower average number of medications;
- Despite physical function decline over 30 months, health-related quality of life remained unchanged.

SHWC attributes the lower incidence of falls and lower number of medications among their patients, and improvement in quality of life, primarily to the interdisciplinary, interdependent team approach. For example, any patient taking five prescriptions or more is given an appointment with the geriatric pharmacist, who makes sure that a) all of the prescriptions are actually necessary; and b) there are no interaction problems among the prescriptions that could lead to poor health outcomes. Given the multiple pharmaceuticals taken by most elderly patients, SHWC strives to ensure that medications are taken properly and will not be the cause of further decline down the road.

## Challenges and Opportunities

The greatest challenge when it comes to serving the SHWC's patient population is the fact that the Medicare reimbursement system was not designed to work with an interdisciplinary team system. As one interviewee noted, "patients don't experience care in the same way that care is reimbursed" by Medicare. In other words, while Medicare services are reimbursed according to diagnostic related groups (DRGs), the SHWC's patients require more coordinated interventions that cut across multiple DRGs and are difficult to bill. The SHWC receives most of its revenue from Medicare, but these revenues are not enough to fund the center's operations. It is able to succeed, however, due to its relationship with the PeaceHealth Oregon Region, and the fact that it is licensed as an outpatient clinic of Sacred Heart Medical Center in Eugene. The SHWC and Sacred Heart practice "split billing," whereby the hospital and the physician bill Medicare separately and receive distinct reimbursement. This arrangement was created so that ancillary services could be provided at the SHWC. These services are normally only reimbursable to the facility, or hospital. These ancillary services include such things as nutritional counseling and social work. One interviewee noted that it is the split billing procedure which makes the center financially viable.

Overall, the greatest challenge that the SHWC faces is making its innovative system of care delivery financially feasible, given the health care financing context in which it operates. As one inter-

viewee said, "the way healthcare is financed and organized has a very big impact on whether this care can be delivered in a patient-centered manner." Because organizations such as the SHWC are not in a position to affect large-scale changes in the way Medicare finances care, they must meet these challenges by leveraging their connections to larger provider organizations, and by enlisting the support of the PeaceHealth network, which sees providing patient-centered care as its core mission.

## Lessons Learned

A number of lessons emerged from the development and administration of the SHWC, primarily the following:

- Patient-centered care can be more effectively practiced when PCC-friendly policies and practices become the core of the administration and become embedded in physicians' daily activities. If providers have to conduct processes in addition to those already in place in order to practice patient-centered care, it is less likely that buy-in will occur among the staff.
- The development of an interdisciplinary, interdependent healthcare team is crucial to providing patient-centered care, improve quality outcomes, standardized evidence-based medical care, and sustainability of these practices.
- Another crucial aspect to establishing a patient-centered environment is recognizing two core elements of the provider-patient dynamic: 1) the informed physician/nurse practitioner and 2) the activated, informed patient. Without support for both sides of this equation, patient-centered care will not take place.
- Another key element of patient-centered care is to take the time to assess your target population's needs and wants in a careful and deliberate manner. For example, SHWC's preliminary focus groups made it clear that their patient population would benefit from "one-stop shopping," where they could receive a number of different types of services in one location and during one visit. This guided the number and type of specialists that the SHWC brought onboard, as well as the structuring of reimbursement and financing mechanisms that would support this type of environment.