

La Clínica de la Raza Transit Village Family Medicine: Better care for patients on Coumadin

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La Clínica de la Raza Transit Village Family Medicine, near a metro station in urban Oakland, California, is bursting at the seams. As a health center that experiences continual and overwhelming demand, the clinic has explored models of team-based care that allow them to use the skills of their medical assistants to the greatest degree possible to promote better patient continuity and care.

This summary of La Clínica de la Raza's operations is based on a September 2011 visit to the Transit Village Family Medicine department.

History and demographics

La Clínica de la Raza was founded in 1971. It operates 26 clinic sites across Solano, Contra Costa, and Alameda counties. At the Transit Village site, there are approximately 35,000–40,000 active patients, defined as patients with a medical visit within the last two years, spread across family medicine, women's health, and pediatrics. In any given month, the family medicine department of the Transit Village has about 2,500–3,000 encounters. The primary preferred language spoken by patients at the health center is Spanish (83%) followed by English (16%). All providers are bilingual in English and Spanish.

Panel management

Population-based management is a proactive approach to healthcare that considers the healthcare needs of all of the active patients at a clinic. This population is also known as a panel, and the process of helping to ensure that the population gets needed care is also known as panel management. Panel management may be conducted through outreach, as clinic staff call or send letters to patients to invite them to come in for needed care, or through inreach, as staff take advantage of medical visits to identify other care that should be addressed.

One of the most well-developed panels, informally known as the Coumadin panel, is for patients on blood thinners. Prior to implementing panel management, there was significant variation

between providers in how often they checked the INR, and there was no way to ensure that patients were not falling out of care and therefore putting themselves at risk of complications. Moreover, INR results were not documented in a consistent place in the chart, so if the primary care provider was out of the office, staff had to search the charts to clarify patient's current dose and lab results.

In order to implement the Coumadin panel, providers agreed to common standards about the frequency of testing the INR and the practice for documenting medication dosage and test results. The clinic created a flow sheet to track INR results and medication dose changes, and it initiated a new protocol for testing frequency. At the same time, the clinic was starting to use registry software to track patients with diabetes, and they realized that the same software could be a tool to manage patients on blood thinners.

Now, new patients on blood thinners or patients with newly prescribed blood thinners usually are connected with the panel manager of the Coumadin panel within 24 hours. The panel manager for patients taking blood thinners schedules appointments with her patients at least monthly, if not requested more often by the provider. She uses point-of-care INR testing and alerts the provider or Doctor of the Day when the result is out of range, so medication titration can occur immediately when it is needed. In addition, the panel manager conducts medication reconciliation, assesses patient adherence to medications, and helps to ensure that patients understand changes to their medication instructions. She provides information about blood thinners and diet to patients.

The panel manager also conducts quality assurance activities, periodically sending patients to the lab to an INR there as well so that results can be compared with point-of-care testing. The panel manager was also trained in use of the point-of-care testing equipment by the company that makes their machine, so as to reduce user error that would otherwise create variability in the results.

One of the providers who helped to launch panel management of patients on blood thinners said, "It's been hugely effective for us, and because we are only measuring one variable with Coumadin (as opposed to the multiple variables tracked in our other panels), it is also relatively easy to set up and maintain. I think our patient care has improved immensely as a result."

The panel manager in charge of the panel of patients on blood thinners has become the de facto point of contact for many of her patients. As she observes, "Since I have a group of patients, I get to know them more. I know how to talk to each person. They know me."

Panel management outreach efforts were started about two years ago with the PHASE program, targeted at patients with high cardiovascular risk. The program focused on telephone outreach as well as group visits. La Clínica adopted an electronic patient registry (i2i) to manage their patients with diabetes. They later found that the registry was a useful tool for patients with other

conditions, and they currently have registries to track patients with diabetes, HIV, or who are on blood thinners. They can also use the software to screen for patients across the clinic who are due for vaccinations or mammograms. In the future, they hope to develop panels so as to track patients with pre-diabetes, pediatric obesity, or asthma.

The PHASE project continues as an outreach effort that is shared across all medical assistants. The panel manager identifies patients within this panel of almost 2,000 patients that require follow up. The medical assistant assigned to PHASE panel management for the day conducts calls to follow up with the patient. Patients may be flagged for a call because of one of the following reasons:

- Their labwork (e.g., Hemoglobin A1c, Lipid panel, ALT, creatinine, potassium, eGFR) is out of date;
- They have been seen within the last three months;
- They are out of medications according to pharmacy records; or
- They have not had a foot check in more than a year.

In addition to addressing the primary reason for the call (e.g., to schedule labwork), the medical assistant conducting outreach uses the phone call to reinforce self-management support behaviors. For example, the medical assistant may talk to the patient about home blood sugar measurements, conduct medication reconciliation and assess the patient's knowledge of their medications, and remind them of upcoming appointments.

The Lead Medical Assistant feels that it is important that all medical assistants cycle through panel management time because this reinforces skills, such as medication reconciliation, that medical assistants can use in other roles. Having a dedicated panel manager helps to ensure that panel management outreach on the part of all of the medical assistants in the PHASE program is productive, because the panel manager ensures that appropriate patients are targeted for outreach efforts.

The staff of La Clínica have found a number of facilitators to effective panel management. They have found that smaller panels are easier to manage and understand. For example, the panel of patients on blood thinners has been a group for which it is easy to identify and manage the needs.

The panel managers at the Transit Village also talk about the importance of cleaning up panels. In an early phase of panel management at La Clínica, one panel manager found that the providers did not trust the panels, because they did not agree that the patients on a panel were their patients or they were not confident that these patients really had the diagnoses in question. Only after she solicited provider help in correcting errors did they begin embrace panel management.

Panel management requires a radical shift in mindset. In essence, panel management asks that the provider and team hold themselves accountable for patient care and outcomes even if a

patient does not come in for care, or if they do not seek out recommended preventive and chronic care. The lead panel manager reports that when they began looking at their entire population of patients, she found a significant number of diabetic patients who had been out of care for a long period of time. She investigated the barriers to care, such as outstanding bills, in order to bring them back into care.

Group visits

The Transit Village Family Medicine Department developed a group visit model several years ago. This effort was driven and coordinated by Medical Assistants, who saw a need for greater education and social support for patients with diabetes. The groups included discussions based around a topic like foot problems or chronic liver disease, and visits would include social activities such as dancing, bingo, or raffles. A provider would come at the end of the visit to answer questions. There was no charge for the classes. The medical assistants that spearheaded the efforts felt that it was valuable to mix patients with good and poor control of their condition, because it allowed patients to learn from and be inspired by each other.

These group visits have recently been revamped by the Preventive Medicine department of La Clínica. They are now structured as a series of four educational classes. In the last class, the patients do their own vitals, and a provider comes to have individual meetings with each patient. Attendance of these new classes has not been as great as the original group visits. This may result from a disconnection between the classes and the care team. Because the original classes were spearheaded by the medical team, they were more likely to refer patients to the classes, and patients were more likely to attend a class lead by people that they knew.

Group visits are also available to address stress and mental health through La Clínica del Sol, the behavioral and mental health arm of La Clínica de la Raza.

In the future, staff of the Transit site hope to build on the group visits. They would like to hold group visits for areas such as pediatric obesity, asthma, and menopause.