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PART 3: REPORT FROM THE FIELD

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Summary: Caring for underserved patients presents great challenges for community practices. This report discusses an interdisciplinary underserved practice that was reorganized in 2008 allowing for practice improvement and greater community presence. Current practice structure is discussed and a model provided that can enhance productivity, revenue, and community outreach.

Key words: Underserved, interdisciplinary.

Eastside Community Practice (ECP) was established in response to the local community’s desire to have a medical home for the residents in East Gainesville, Florida which is in Alachua County. The more affluent residents (mostly White) reside on the west side of town, which is also the location of major resources such as hospitals, malls, major grocery chains, movie theaters, and hardware stores.

Eastside Community Practice is a collaborative practice of health professionals. Medicaid is the largest payer (50%), and 12% of the patients are self-pay. Eastside Community Practice’s funding comes from multiple sources, including state grants, hospital funds, Area Health Education Center (AHEC) funds, and patient revenue. Area Health Education Center has special interests in serving rural and underserved communities and has centers covering all 67 counties in Florida. The practice has a provider staff of eight and 12 support staff (including nurses, medical assistants, financial counselors, office representatives, medical records clerk, referral clerk, clinic supervisor, and clinic

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manager). Students from multiple colleges rotate through the practice and care is further strengthened by a faculty nurse practitioner and nursing students who conduct home visits for less mobile patients.

Oversight of the practice began as collaboration among the University of Florida Office of the Vice President of Academic Affairs, Shands Healthcare, and the AHEC program. In late 2007, oversight of the practice was moved to the University of Florida College of Medicine (UF-COM) and evolved into a separate division within the Dept. of Family Medicine. A division chief was named, providing internal leadership for the practice as well as vision and drive. Under this new model enhancements have been made to improve practice productivity, increase revenue, and reshape community engagement.

**Methods for practice enhancement.** Methods used to enhance clinic effectiveness fall into four areas: developing internal clinic leadership and vision, improving provider productivity, enhancing the interdisciplinary model, and creating sustainability.

*Developing internal practice leadership and vision.* Leadership from within a practice is often more practical than leadership from without for improving clinic outcomes and financial stability. The leadership team pursued funding for a grantwriter, a mobile unit, and solicit practice donors. Its vision allowed us to conduct practice-wide community outreach and use disease registries for disease management and future grant opportunities.

*Improving provider productivity.* Creating opportunities for encouraging and recognizing clinical accomplishment is crucial for provider retention. There is evidence that there can be financial practice improvement when clinical staff is rewarded for outstanding accomplishments.\(^1\) Integration into the community itself through local service projects increases providers’ sense of commitment, but good moral conscience about serving underserved patients is not enough. Equally important is the creation and enforcement of productivity targets. Under the new model, provider targets and evaluation methods were created. Providers are given opportunity to develop clinical and professional goals through community service projects and opportunities for publication.

*Enhancing an interdisciplinary model.* The decision to adopt an interdisciplinary model arose from the realization that underserved patients have a variety of concerns outside of medicine that affect quality of care. A study of rural general practitioners in Canada demonstrated that when there is difficulty accessing resources, a more exhaustive approach to patient care can often be employed in lieu of patient referral.\(^2\) This is certainly the case when working with the underserved, and is one sound reason for taking an interdisciplinary approach. Additionally, non-physician providers and family physicians are more likely than specialists to care for underserved populations.\(^3\) The major benefit of Eastside’s interdisciplinary structure lies in more comprehensive contact with patients. Literature suggests that a practice model with closer contact and more frequent follow-up can improve care. This was demonstrated in a chronic care model that allowed for the redesign of the typical diabetic office visit, allowing for more education and time spent with the patient.\(^4\)

The three areas involved in our interdisciplinary care model are pharmacy, social work, and nurse-directed outreach. Patients can enter our practice through any of these avenues, and by enhancing these offerings we improve access to care.
Patient education and co-management are provided in our practice through hour-long visits with the pharmacy staff. Their services include medication review, diabetic teaching and management, lipid, anticoagulation and hypertension management, and any other service related to medications. These visits, in contrast to the 15 and 30 minute visits with practitioners, provide added time for needs assessment. General practitioners value time management, and this model provides the best of both worlds for patient and practitioner. Pharmacists in effect create more time for providers, and this has been shown to be favorable for provider productivity. Visits are discussed with the practitioner and a plan of care is formulated. We have enhanced this offering by more frequent visits for those patients whose chronic disease state is poorly controlled. The pharmacy staff also handles the bulk of medication refills and medication-related questions from patients. When conducting medication refills, pharmacy staff members review patient information to make sure they are being seen in clinic at appropriate intervals and receiving any necessary lab work. They also use evidence-based medicine, formulary, and prior authorization procedures that ensure patients are receiving appropriate medications for their conditions.

Identifying poor disease control and immunization compliance are another approach we are using to improve access and we do this through disease management and tracking systems. We are now using the Florida SHOTS (State Health Online Tracking System) program to track the immunization rates of children two years of age and younger, and are looking at mechanisms to increase our compliance. We have employed a database for our diabetic patients that will track blood pressure, blood sugar, and cholesterol and vaccination history. With this data we will be able to construct targeted interventions for our poorly controlled diabetics, in addition to making the case for additional funding to aid our efforts. Plans have been made to expand disease management to include other chronic diseases.

The second arm designed to enhance patient access is social work. When working with underserved patients, a system must be in place to address concerns that may have no direct medical connection to care, but have a bearing on whether medical recommendations can be followed. The system in place to address the social needs of patients begins with needs assessment. Determinations are made regarding patient needs and resources available to meet those needs. This service is not only for our uninsured and underinsured, but for our insured patients as well. Co-payments for medicines can be expensive even in the presence of insurance, and deciding to address other financial obligations rather than purchase medicines is not uncommon. The initial social work assessment covers employment status, household income, and services needed. Services needed range from assistance with medication, labs, and imaging to specialty care needs and assistance with acquiring durable medical equipment. After the social work assessment, during which it is determined how provider visits will be paid (volunteer programs are available); the patient sees a provider and medication samples are provided as needed. The patient medication assistance program (PMap) may come into play, providing the patient with 90 days worth of medicine until time to recertify (required every 90 days). This medicine is provided free to the patient directly from sponsoring pharmaceutical companies. To qualify for the PMap a patient must have no access to insurance and meet household size and income criterion of 250%
or less of the poverty level. These social services increase access to care for patients, as established patients can see the social worker for fresh concerns and new patients are assisted in finding ways to cover health care expenses.

The third arm enhancing the interdisciplinary model of care is nursing outreach. Nurse management is effective, especially in diabetes education. Nursing care has been enhanced through increasing the numbers of nurse-directed patient care visits. Patients are scheduled for nurse visits for blood pressure and blood sugar rechecks, wound evaluation, and common vaccinations. This model increases access for existing patients and allows for closer patient contact. In addition to Registered Nurse-directed outreach we have an Advanced Registered Nurse Practitioner who oversees home visits with less mobile patients. This outreach is conducted as part of training for public health nursing students and is a valuable asset to patients and practitioners alike.

Creating sustainability. The most important part of innovation—along with practicality, ease of execution, and modest financial impact—is sustainability. Sustainability is directly related to finance. Underserved practices tend not to make money due to the lack of resources of the patient population served. The parent institution’s financial standing can suffer, making practice innovation and enhancement difficult. A lesson learned from the restructuring of Eastside Community Practice is that while financial stability is achievable, patient revenue alone is not enough. The shift to more grant acquisition and donor resources is a current focus that will allow us to further enhance our offerings to the community.

The results of methods employed to enhance the productivity and offerings of Eastside Community Practice can be summed up by our most current revenue data. Under the new structure we have seen clinic revenue increase by over $150,000 in two years, a 31% increase. There was minimal cost associated with this increase as this result was directly from reworking an existing system. Not only has there been an increase in collections, but also a decline in patients who fail to keep appointments. Reasons for no-shows include transportation problems, forgetting appointments, and a disregard for scheduled appointments. Patient no-show percentages are calculated against patient visits with a status of arrived.

Aggressive efforts have been undertaken to attract donors to the practice. With most recent donations, we have been able to create the Eastside Cares Prescription Program, which is a program that allows the practice to purchase low-cost prescriptions for needy patients. In addition, our grantwriting team has secured a childhood obesity grant that has been structured for the community.

A grant that has enhanced the clinic’s offerings is Reach Out and Read, a federal grant-funded program that provides a new book to children six months to five years of age at every well-child visit. Over 1,000 books have been distributed since inception of the program. We also fit and provide bicycle helmets for our pediatric patients. Clinic-wide community outreach efforts included pharmacists, nurses, and other providers offering onsite education. Pharmacists conduct Ask the Pharmacist sessions that allow for discussion of prescription and over-the-counter medications. Nurses perform blood pressure, blood sugar, cholesterol, and body mass impact (BMI) screening, with the intention of giving information on our practice to participants with no medical home. Other providers discuss various health topics from asthma and injury prevention to
diabetes management and stroke. These are educational classes offered to our patients and the entire east Gainesville community.

Provider handbooks have been created that outline provider responsibilities, productivity targets, and means of recognizing outstanding performance. There are now regularly scheduled meetings to review provider performance and look at ways of enhancing productivity and overall clinic function. All clinic operations undergo periodic evaluation, and changes are made where necessary.

**Discussion**

Change is not always painless. Obstacles encountered included resistance to goal-setting, and problems with convergence of clinic needs and individual wants. Challenges included a multipronged leadership structure, with multiple responsibilities and external daily practice operations. Change began after searching for other similarly structured practices and visiting an underserved practice in a neighboring city.

Change arises from practice vision; once the vision is developed, it is important for everyone involved to support it, even if the vision goes against tradition in a system unchanged for years. Beyond practice support of the vision there must be institutional support for the visionary. More experienced faculty members provide support in the form of advice. Financial support is important as well and a key in addressing low rates of reimbursement is to look for monies outside of revenue generated from collections. Grant money and donations are important resources to maintain outreach efforts and practice sustainability.

Garnering the support from community leaders is imperative. A model allowing for community penetration by interdisciplinary health professionals aimed not only at screening patients for disease, but providing medical homes is a direct way to fight health disparities and is part of our mission. A problem encountered with this model is compensation for employees engaged in community activities and appropriate billing for off-site clinical services. Our current model of community outreach involves volunteer time from staff. Providers are required to participate in four outreach efforts per year for which credit is given. This is unheard of in academic settings where community outreach is usually not viewed as part of the academic mission.

The model of care described in this report can help the restructuring of floundering practices that serve the underserved. Change begins with vision, a review of current practices, and a deep desire to enhance clinic offerings. Underserved clinics are in a unique position to make a substantial impact in reducing health disparities and creating healthier communities. Provider productivity, practice vision, enhancing current offerings, and practice sustainability are key areas for any practice to become more efficient, effective, and profitable.

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Notes


