2014 Gage Awards

Reference #	7492054
Status	Complete
Name of hospital or health system	Broward Health Medical Center
Name of project	Internal Medicine Resident Clinic
CEO name	Calvin E. Glidewell
CEO approval	Check here to confirm that your CEO approves of this project being submitted for a 2014 Gage Award
Submitter name (first and last)	Natasha Bray, DO
Submitter title	VP/DIO/Director of Graduate Medical Education
Submitter email	nbray@browardhealth.org
Submitter phone	(954)355-5134
Project contact person's name (First and Last)	Natasha Bray, DO
Project contact title	VP/DIO/Director of Graduate Medical Education
Project contact email	nbray@browardhealth.org
Project contact phone	(954)355-5134
Within which of the two categories does your application best align?	Population Health

1. Provide a brief description of the project. (This section should resemble an abstract for a poster presentation or an abstract for a peer reviewed journal. Include an objective, data sources, study design, findings, and conclusions.)	Chronic medical diseases (Diabetes mellitus, Chronic Obstructive Pulmonary Disease (COPD), and cardiovascular disease) are often followed by a life-long risk of morbidity and patient reported decrease in quality of life. Healthcare entities that develop comprehensive disease management strategies can help to improve outcomes and quality of life with fewer emergency room visits and hospitalizations, while also decreasing utilization of costly health care resources. Broward Health Medical Center (BHMC), a not-for-profit hospital, refers its hospital/emergency room discharged uninsured, underinsured, and Medicaid patients with chronic medical conditions to its own community outpatient primary care clinics. However, these patients face challenges navigating through the present Broward Health community outpatient primary care model. They must wait days for an appointment, spend more than half the day to be seen by the primary care provider and then additional days to receive prescription medications. These factors may all contribute to why this patient population has a high rate of post-hospital discharge emergency room visits and hospital readmissions. BHMC has developed a new hospital/emergency room discharge care model to help decrease hospital readmission rates and emergency room visits for uninsured or underinsured vulnerable populations, such as patients whose healthcare is covered under a tax-funded program, those without insurance who are considered “self-pay”, and the Medicaid population. The new discharge care model strategy includes discharging this vulnerable patient population from the hospital or emergency room under the direct care of a primary care resident physician and a primary care physician by referring them to the BHMC’s Internal Medicine Resident Clinic. Patients are given appointments to be seen in the clinic within seven days of discharge. During Internal Medicine Resident Clinic follow-up visits, patients will be assessed by the primary care team (resident physician, attending physician and nurse) for their chronic medical condition(s) and general health status through physical exam, lab and radiology tests. The primary care physicians evaluate each patient’s medication needs and compliance with a goal of ensuring appropriate, affordable prescriptions. Social work is available to help patients identify community resources to offset costs of medical care. Established in July 2013, the clinic went from serving two to three patients per week, to 109 visits during the month of November. The total number of patients seen since July 2013 is 304. We have estimated that 24 hospital admissions have been avoided, with a net direct cost saving of $37, 500. Should this trend continue, we estimate $180,000 in cost savings on an annual basis. The utilization of primary care resident physicians

	to provide timely access to a medical home for a vulnerable population with chronic medical conditions will improve access to quality health care and decrease readmissions to the hospital and emergency room.
2. Describe the methods use in this project. Include where, why, and how the project was accomplished.	The Internal Medicine Resident Clinic is located at Broward Health Medical Center (BHMC). A respected leader in healthcare since its founding in 1938, BHMC's mission has remained constant over the decades: to provide all the people of Broward county with the best possible medical care. BHMC continues to deliver on that promise through its commitment to physician excellence, technologic advancement and academic affiliation. Caring for our community goes far beyond the walls of the medical center. There are two needs that are being addressed through the Internal Medicine Clinic. The first is to assist with the primary care medical needs of a specific, vulnerable patient population. The Internal Medicine Resident Clinic was developed for patients to seek immediate access to primary care services without utilizing the emergency room as their primary source of care. Patients served by the clinic are patients that have chronic medical conditions (diabetes, hypertension, coronary artery disease, COPD, etc.). These patients do not have primary care providers and are having difficulty getting into the community health care clinics due to wait times for appointments. The goal in establishing this clinic is to provide timely access to primary care services, while decreasing emergency room utilization for non-urgent medical issues or prescription refills/renewals. This service also assists with reducing preventable hospital readmissions by offering timely follow up care. The second goal of this clinic is to aid in the training of primary care physicians. The state of Florida has a recognized shortage of primary care physicians. According to the 2013 Association of American Medical Colleges (AAMC) State Physician Workforce Data Book: •Florida ranks 30 in the nation for the number of active primary care physicians in 2012 with only 77.4 physicians per 100,000 population. •In 2012, 29.4% active physicians in Florida are age 60 or older (National Median is 26.5%) This innovative program is matching the goals of training an increased number of primary care physicians to practice in Florida, with the current need to provide critical access for a vulnerable patient population to primary care services. The Internal Medicine Clinic began in July 2013 and provides appointments for four half-days of the week. The Clinic is staffed with a full health care team including: attending physicians, resident physicians, nurses, pharmacists, etc.

3. Describe the results of the project. What data was used to support improvement results?	There is a well-documented need for access to primary care all over the United States, and definitely in Broward County. This clinic was established in July 2013. The clinic went from serving two to three patients per week, to 109 visits during the month of November. The total number of patients seen since July 2013 is 304. We have estimated that 24 hospital admissions have been avoided, with a net direct cost saving of $37, 500. Should this trend continue, we estimate $180,000 in cost savings on an annual basis.
4. Describe what happened as a result of the project. Was the improvement related to the intervention? Can the project be duplicated by other organizations?	As a result of this project, we are able to provide needed healthcare services to a vulnerable patient population. The Internal Medicine Resident Clinic provides immediate access to follow up care for patients who have recently been hospitalized or seen in the Emergency Room for their chronic medical condition(s). Establishing this post-discharge care allows us to see patients within seven days of their visit and maintain them as a patient. The patients are able to establish a relationship with a primary care physician, who will ensure their continuity of care. These physicians consult with nursing and pharmacy to oversee medication management for the patient, as well as make appropriate specialty referrals. This service helps the patient manage their chronic health condition(s), which increases their quality of life. The utilization of residents allows the physicians to spend more time educating the patients on their chronic medical condition(s). This partnership allows patients to engage in lifestyle modifications and self-management of their medical condition(s). This involvement ultimately improves their quality of life. This clinic model is something that can be duplicated by other organizations, regardless of if there is access to resident physicians.
5. Describe how patients, families, and if appropriate, community was included in the work.	Broward Health Medical Center supports patient and family-centered care. Many of our patients bring family members to their appointments with them. By having family members there, they are able to assist in the management of their loved one's chronic medical condition(s). The family members also find themselves being educated on conditions, which they themselves may be predisposed to. The patients are thankful to have this support system, and an additional person to help them with the management of their medical condition(s). The patients are also glad that they have been able to establish a relationship with a primary care provider, which encourages them to manage their condition(s) by keeping doctors' appointments, taking their medications, etc. The implementation of this program also helps alleviate some of the strain on community outpatient primary care clinics. The wait time for appointments at some of these clinics can be 3 months or greater.
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