Stories From The Clinical Front Lines

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Moving the Dot

Beacon Robust Clinic Participation

Helping the Homeless

What They Do

- By increasing homeless Utahns' access to primary care, Fourth Street Clinic is a major partner in ending homelessness, promoting community health, and achieving across-the-board health care savings.

Who They Are

- Founded in 1988 as triage clinic: One part-time nurse--relied heavily on hospitals for treatments
- Today: staff of 50; volunteer network of more than 150
- Comprehensive health care home that serves
  - -- 3,783 homeless men, women and children
  - -- 22,300 primary care, behavioral health and specialty care visits
- Fourth Street Pharmacy dispenses 44,600 medications annually

Survival Top Priority, Not Good Health

- Lack of transportation, housing, insurance
- Low health literacy, formal education
- Lack of trust in others
- High rate of substance abuse/mental health disorders, other medical problems
- No place to store medications, medical equipment
- Lack of income results in poor nutrition

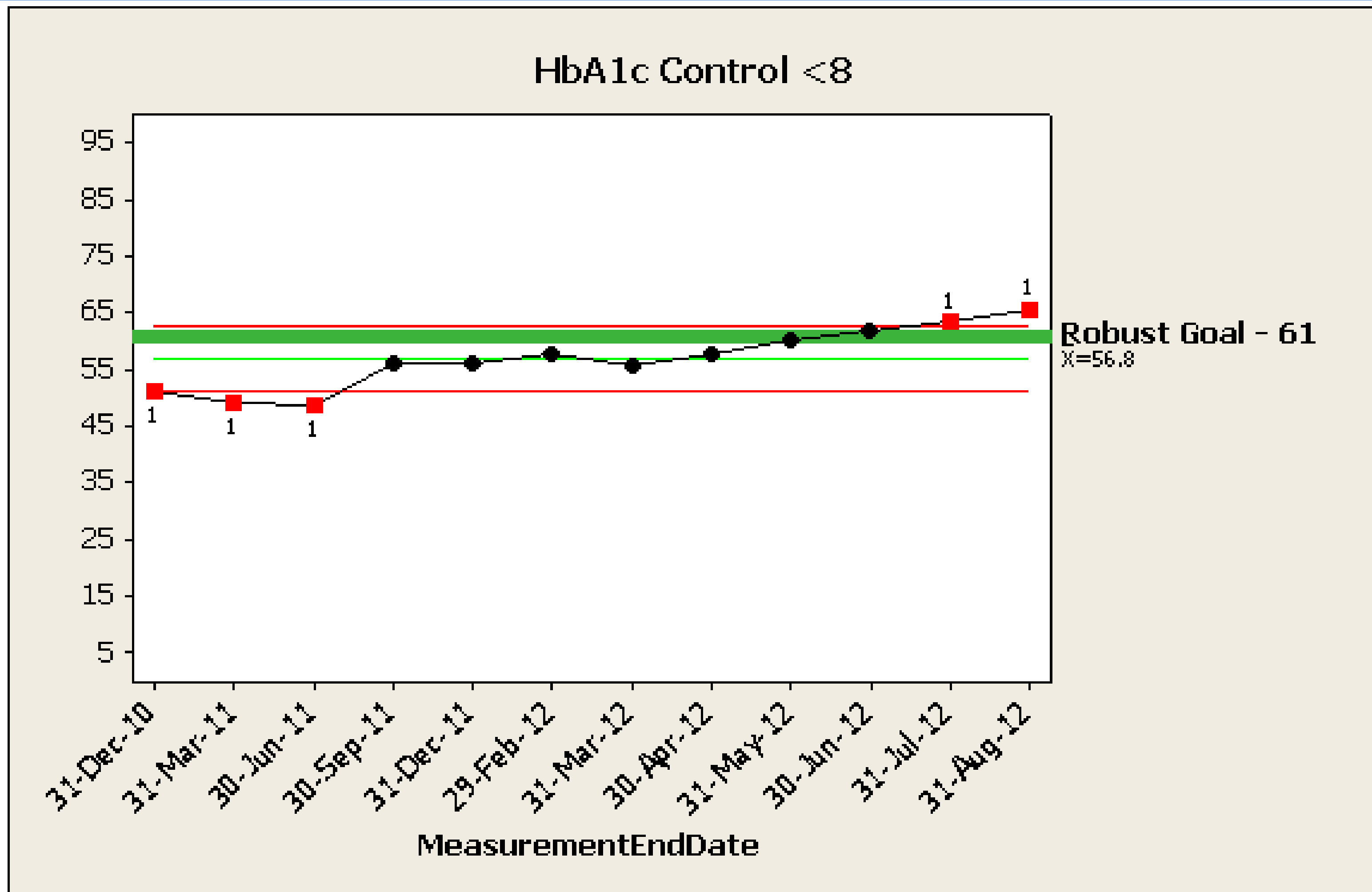
4th Street Approach

"Our homeless patients need more than a Band-Aid approach to medicine. They need ongoing access to high-quality services that promote better health for years to come."

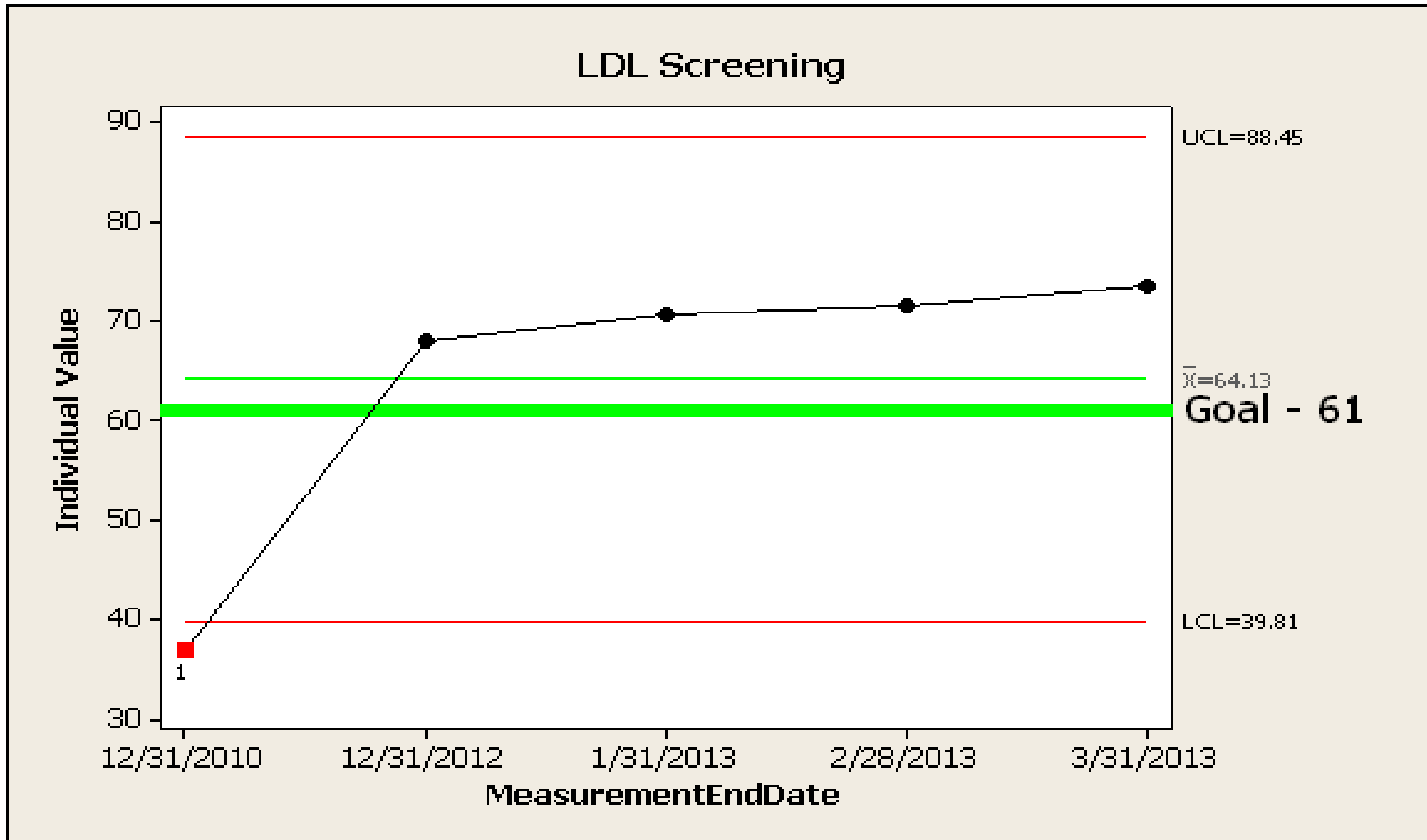
Dr. Christina Gallop, Clinic Medical Director

Patient Education

HBA1C Control



Cholesterol Screening Rates



What Makes Beacon Work

- **Commitment from Senior Staff – CEO and Medical Director**
- **Dedicated Resources to Data Management**
- **Incentives to Provider Team**
- **Feedback loop for performance**
- **Transparency with Stakeholders – Dashboard**
- ***HealthInsight* staff guidance and support; kept us moving in right direction**

Team Comparison

		Goal		May	
				num/deno	%
1	*HbA1C screening-QM19 (HbA1c<1000)	90%	Team average	260/273	95%
			Joel / Dominique	23/27	85%
			Christina / LeBeth	61/63	97%
			Allisa / Joanna	124/127	98%
			John / Dominique	54/56	96%
			Tanya / Jeff	43/44	98%
			Robert / Sam H	7/8	88%
			Alison / Mellisa	27/28	96%
2	HbA1C good control -QM19 (HbA1C<8.0)	61%	Team average	172/273	63%
			Joel / Dominique	15/27	56%
			Christina / LeBeth	36/63	57%
			Allisa / Joanna	78/127	61%
			John / Dominique	34/56	61%
			Tanya / Jeff	30/44	68%
			Robert / Sam H	5/8	63%
			Alison / Mellisa	23/28	82%
3	LDL screening -DM4	58%	Team average	128/290	44%
			Joel / Dominique	7/19	37%
			Christina / LeBeth	11/48	23%
			Allisa / Joanna	46/94	49%
			John / Dominique	22/50	44%
			Tanya / Jeff	22/39	56%
			Robert / Sam H	12/24	50%
			Alison / Mellisa	6/13	46%

Team Report Card

Individual Team Performance - Beacon Measures & Pap - 05/2012				
	Team - John / Dominique			
	Measures	Goal	Clinic averge	My team
1	HbA1C screening-QM19 (HbA1c<1000)	90%	95%	96%
2	HbA1C good control -QM19 (HbA1C<8.0)	61%	63%	61%
3	LDL screening -DM4	58%	44%	44%
4	LDL control-QM2 (LDL<100)	41%	27%	36%
5	BP control - QM3	73%	71%	64%
6	Nephropathy - QM16	90%	62%	71%
7	Retinal eye - QM14	10%	4%	4%
8	Foot- QM15	72%	76%	61%
9	Cervical Cancer Screening - PAP -QM21	80%	55%	53%

Beacon Challenges

- **Training large number of volunteer providers to document consistently in EHR**
- **Learning EHR system; program updates that changed denominators**
- **Continued funding for data management**
- **Consenting homeless patients to the cHIE**

Successes

- **One of first clinics to reach Robust goals**
- **Learned importance of data for performance feedback and population management**
- **Improved patient flow processes**
- **Improved understanding of quality improvement processes**
- **Positioned for Medical Home designation**