



Blue Shield of California Foundation is an Independent Licensee of the Blue Shield Association

Year in Review: Celebrating Successes & Planning for the Future

Expanding Access through Team Care

Monthly Technical Assistance Webinar #10

June 18, 2015

Agenda



1. **Welcome-** Veenu Aulakh, CCI
2. **Team Sharing: Celebrating Successes and Looking Forward**
 1. San Francisco Health Network
 2. Mendocino Community Health Clinic
 3. Los Angeles Christian Health Centers
 4. Hill Country Health and Wellness Center
 5. Northeast Valley Health Corporation
3. **Reflections from the TA Team**
 1. Center for Community Health and Evaluation
 2. MacColl Center for Health Care Innovation
 3. Coleman Associates
 4. Carolyn Shepherd, MD
4. **Notes & Wrap-Up** - Susannah Brouwer, CCI

EATC Project Teams



Celebrating Successes and Looking Forward

San Francisco Health Network

Mendocino Community Health Clinic

Los Angeles Christian Health Centers

Hill Country Health and Wellness Center

Northeast Valley Health Corporation

SFHN ACCOMPLISHMENTS

- Trained 20 RNs and Pharmacists in Health Coaching for chronic disease management
- Created/expanded RN chronic care visits at all pilot sites
- Integrated pharmacists into the RN diabetes visits at one specific pilot site
- Implemented workflows for DM visits
- Pharmacists are integrated into the care team

FUTURE PLANS

- Develop a curriculum and training plan for Medical Assistants to teach and reinforce the essential competencies of their role
- Identify core competencies for RNs seeing diabetic and hypertensive patients
- Identify metrics to evaluate the impact of RN/Pharmacist visits on patient outcomes
- Develop and pilot workflows and templates for RN and pharmacist led visits
- Work on addressing specific barriers to implementation of RN visits
- Experiment with other approaches to DM and HTN patient populations (IE group visits)
- Explore “flip” visits to maximize provider productivity; experiment with joint RN/PharmD visits to maximize each discipline’s strength and look at impact on patient outcome/experience.

EATC Project Teams



Celebrating Successes and Looking Forward

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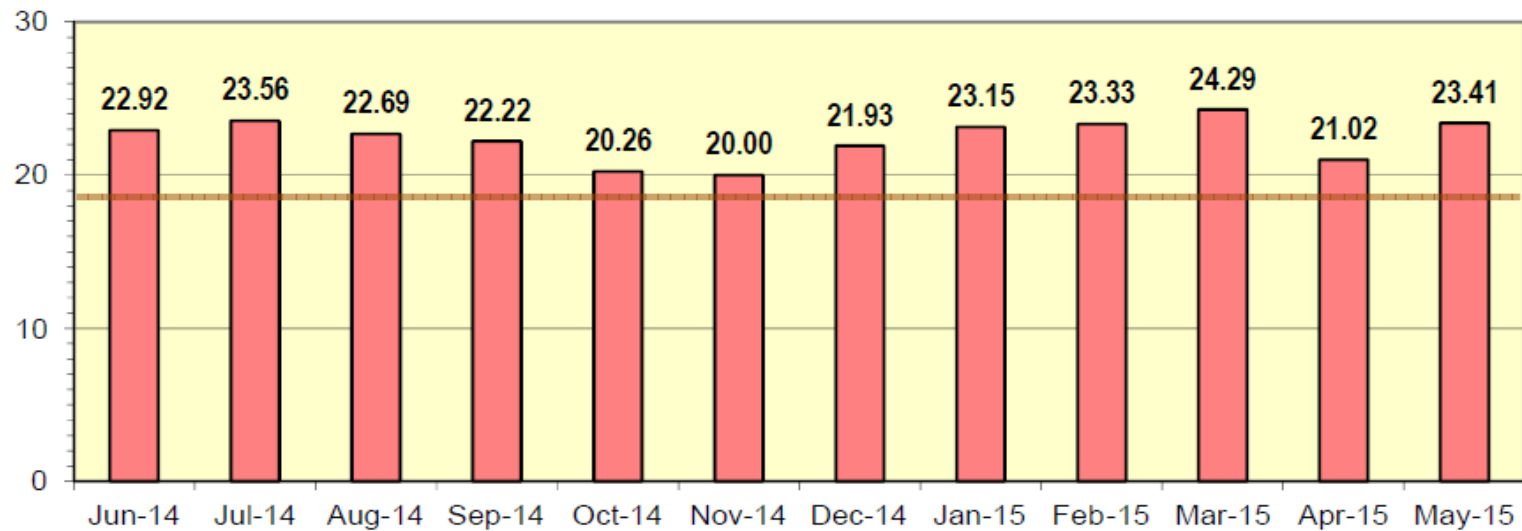
Northeast Valley Health Corporation



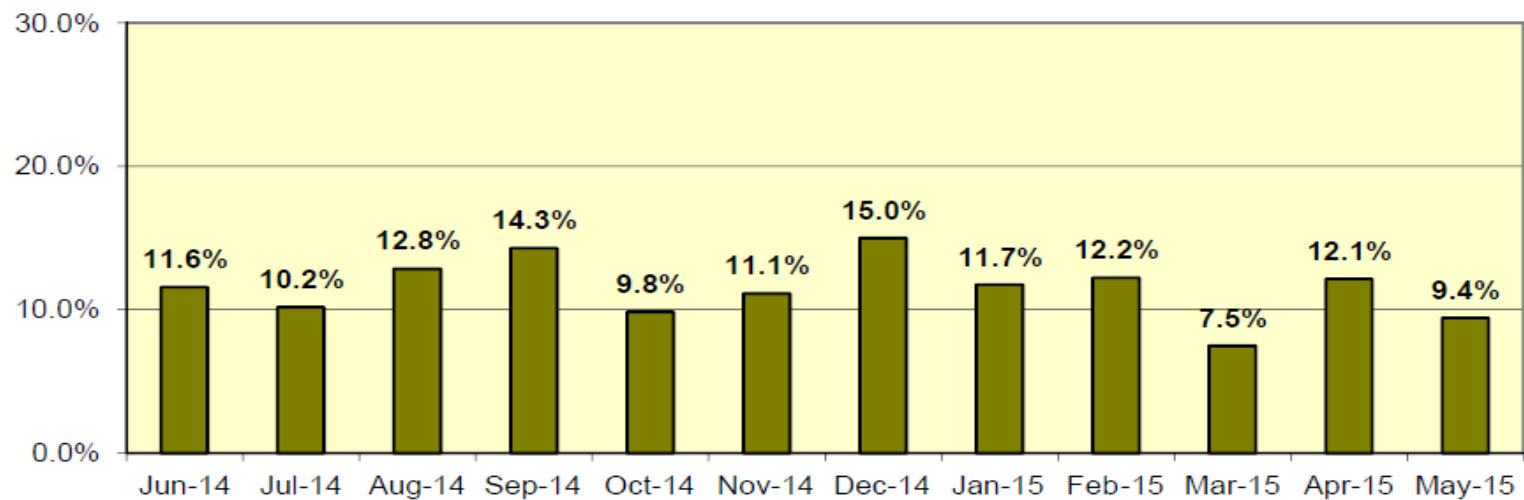
MENDOCINO COMMUNITY HEALTH CLINIC, INC.

An independent nonprofit healthcare corporation serving Lake and Mendocino Counties.

Ebert Average Visits per Day



Ebert % No Shows





Current Care Team Huddle Report

i2iTracks Morning Huddle (Due Indicators)

NextApptTime	Med Rec #	Name	Age	BP (Last Value)	BP (Last Date)	Pap (i2i) (Last Value)	Mammogram (Last Value)	Depression Screening (i2i) (Last Date)	PHQ 9-Total Score (Last Value)	PHQ 9-Total Score (Last Date)
9:00 AM	10000	John, John J	39 Yrs	110/80	10/23/2014	Received				
Immunization: Tetanus (i2i)										
Immunization: Tdap										
Procedure / Referral: Depression Screening (i2i)										
Procedure / Referral: Cervical Cancer Screening										
Procedure / Referral: Annual Health Screen										
Procedure / Referral: HIV Screening										
9:15 AM	10000	John, John J	31 Yrs	112/76	5/22/2015			4/27/2015	8	3/20/2015
Immunization: Tetanus (i2i)										
Immunization: Tdap										
Procedure / Referral: Cervical Cancer Screening										
Procedure / Referral: Annual Health Screen										
Procedure / Referral: HIV Screening										
9:15 AM	10000	John, John J	39 Yrs	124/84	5/21/2015			5/21/2015	4	1/7/2014
Immunization: Tdap										
Procedure / Referral: HIV Screening										
9:30 AM	10000	John, John J	25 Yrs	110/60	5/21/2015			4/14/2015		
Procedure / Referral: HIV Screening										
9:30 AM	10000	John, John J	51 Yrs	120/70	4/20/2015					
Immunization: Tetanus (i2i)										
Immunization: Tdap										
Procedure / Referral: Depression Screening (i2i)										
Procedure / Referral: HIV Screening										
9:45 AM	10000	John, John J	52 Yrs	118/76	5/22/2015			5/22/2015	6	4/20/2015
Immunization: Tetanus (i2i)										
Immunization: Tdap										
Procedure / Referral: Cervical Cancer Screening										



Appointments Scheduled For		6/18/2015		...						
Time	Provider	Resource	Type	Patient	Age	Sex	Language	Race	PCP	Acuity
9:00 AM	Ebert PAJustin	Ebert PA, Justin	*EMR Adult Office Visit	[REDACTED]	39 Yrs	F	English	White (inc Hispanic) (uds)	Ebert PAJustin	
	Reason: HA's - med refill. History (12 Mo.): No Shows: 0 Canceled: 5 Visits: 4 ER: 0 Admits: 0 Last Visit DR: Ebert PAJustin Outstanding Referrals: 0									
	Last BMI: 38.67 Weight Change (6 Mo.): Last BP: 110/80 Last PHQ: 0									
	Last Pap: 9/6/2011 LMP: Smoker: Framingham Risk Factor:									
	Due: Immunization: Tdap, Immunization: Tetanus (i2i), Procedure / Referral: Annual Health Screen, Procedure / Referral: Cervical Cancer Screening, Procedure / Referral: Depression Screening (i2i), Procedure / Referral: HIV Screening									
9:15 AM	Ebert PAJustin	Ebert PA, Justin	*EMR Adult Office Visit	[REDACTED]	39 Yrs	M	English	White (inc Hispanic) (uds)	Ebert PAJustin	
H B	Reason: Chronic back pain -med refill (Percoset.) History (12 Mo.): No Shows: 2 Canceled: 0 Visits: 19 ER: 0 Admits: 0 Last Visit DR: Ebert PAJustin									
	Outstanding Referrals: 3									
	Last BMI: 40.75 Weight Change (6 Mo.): -8 lbs. Last BP: 124/84 Last PHQ: 4									
	Smoker: Yes Framingham Risk Factor: Last 3 BP: 124/84, 132/94, 154/104 Last 2 LDL: 120, 0									
Due: Immunization: Tdap, Procedure / Referral: HIV Screening										
9:30 AM	Ebert PAJustin	Ebert PA, Justin	*EMR Adult Office Visit	[REDACTED]		F	English	White (inc Hispanic) (uds)	Ebert PAJustin	
	Reason: Chronic Pain-med refill (Norco.) History (12 Mo.): No Shows: 4 Canceled: 4 Visits: 23 ER: 0 Admits: 0 Last Visit DR: Ebert PAJustin									
	Outstanding Referrals: 1									
	Last BMI: 23.59 Weight Change (6 Mo.): -2.5 lbs. Last BP: 110/60 Last PHQ: 0									
	Last Pap: 9/19/2013 LMP: Smoker: Yes Framingham Risk Factor:									
Due: Procedure / Referral: HIV Screening										
9:45 AM	Ebert PAJustin	Ebert PA, Justin	*EMR Adult Office Visit	[REDACTED]	49 Yrs	M	English	White (inc Hispanic) (uds)	Ebert PAJustin	
D H B	Reason: DM_lumbago- med refill (Hydrocodone.) History (12 Mo.): No Shows: 3 Canceled: 4 Visits: 15 ER: 0 Admits: 0 Last Visit DR: Ebert PAJustin									
	Outstanding Referrals: 0									
	Last BMI: 32.24 Weight Change (6 Mo.): -10 lbs. Last BP: 138/80 Last PHQ: 14									
	Smoker: Framingham Risk Factor: 8.6% Last 3 A1c: 4.8, 5.2, 12.9 Last 3 BP: 138/80, 128/76, 132/86 Last 2 LDL: 0, 0									
Due: Lab: Microalbumin, Urine Random (mg/L), Procedure / Referral: HIV Screening										

EATC Project Teams



Celebrating Successes and Looking Forward

San Francisco Health Network

Mendocino Community Health Clinic

Los Angeles Christian Health Centers

Hill Country Health and Wellness Center

Northeast Valley Health Corporation

Greatest Successes & Looking Ahead

Overall Success - Better Communication

- A more cohesive care team
- Resolved the front office “bottleneck” (e.g. Lobby attendant)
- implementing strategies similar to the “Quickstart” method to improve clinic flow

What's next...

- Implement successful pilot strategies organization-wide
- Continue monthly Clinic Team meetings within team care context.
- Develop PDSA committee (long-term)



EATC Project Teams



Celebrating Successes and Looking Forward

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Northeast Valley Health Corporation



Hill Country

Health & Wellness Center

- Appointment Access
 - Scrubbing the schedule
 - Jockeying the schedule
 - Strategic double booking (red light green light)
 - Flip visits
 - Health Coaching
- Care Teams
 - Branding the team with logo, color and moto
 - Adding the care team name to the visit summary
 - Future : Adding a patient service coordinator to the teams
 - Further defining of team member roles
 - MA driven huddles
 - Team member working at the top of their scope

EATC Project Teams



Celebrating Successes and Looking Forward

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Northeast Valley Health Corporation
a californiah⁺health center

Expanding Access
June 18th, 2015

Team Success

Presented by

Sandy Gutierrez
Clinic Administrator
Santa Clarita Health Center

TEAM SUCESS



- Created a Complete Care Team Environment
 - Core Team (Provider, MA & Front Office)
 - Implemented consistent Care Team Huddles
- Implemented Robust Calling
 - Increased access for patients
 - Decreased missed appointment opportunities
- Implemented pre-scrubbing of patient's chart (1 day ahead)
 - Created tools to facilitate the chart scrub process
- Increased Patient Satisfaction

SPREAD PROCESS



- Each Health Center performed Care Team Self-Assessments
- Each health Center will perform PDSA's focusing on areas that only partially or do not meet the requirements
- Pilot Health Center will assist with implementation of their Team success
- Current Grant Funded Workflow Coordinator retained to train other staff on the process
- Start spread process July 2015

Sample Scrub Sheet

ADULT BACK OFFICE SCRUBS

DATE: _____

NAME & TIME	REASON FOR APPT: (circle)	REFERRAL/ORDERS XRAY, MHLA	MEDICATION	LABS/INSURANCE/ COMMENTS/SO/FORMS
	F/U LABS ER F/U DEPRESSION CPE DM SICK ANEMIA HTN PRE OP OTHER:	FOBT: MAMO:	RETINALS: DM COORD:	SO: HA: LABS: YES/NO
	F/U LABS ER F/U DEPRESSION CPE DM SICK ANEMIA HTN PRE OP OTHER:	FOBT: MAMO:	RETINALS: DM COORD:	SO: HA: LABS: YES/NO
	F/U LABS ER F/U DEPRESSION CPE DM SICK ANEMIA HTN PRE OP OTHER:	FOBT: MAMO:	RETINALS: DM COORD:	SO: HA: LABS: YES/NO

TA Support Team



Reflections from the TA Team

Center for Community Health and Evaluation

MacColl Center for Health Care Innovation

Coleman Associates

Carolyn Shepherd, MD



EATC Access Metrics

No-shows

Missed
opportunities

TNAA

Clinical
measures

Optional:
Avoidable
ED visits

Patient
experience



EATC Access Metrics

No-shows

Missed opportunities

TNAA

Clinical measures

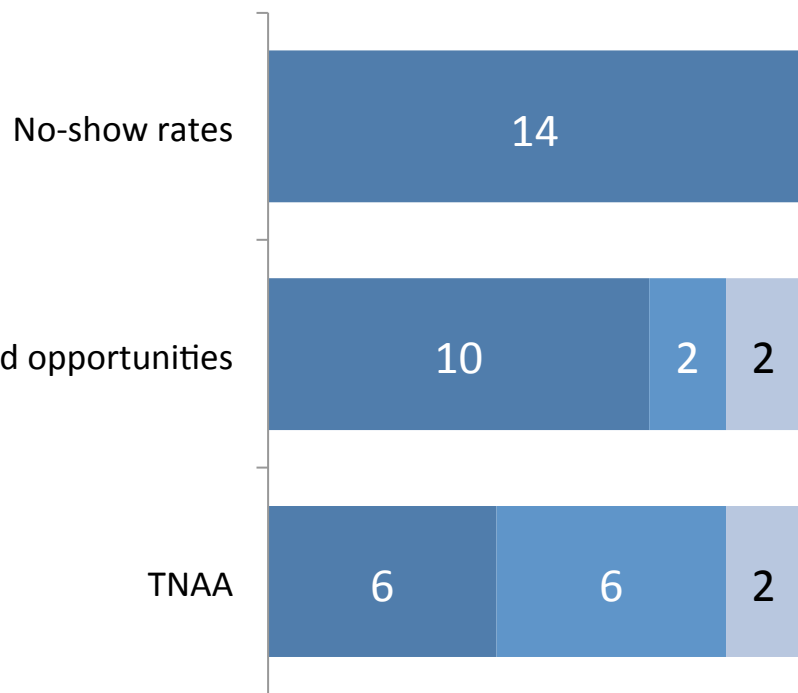
Optional:
Avoidable
ED visits

Patient experience

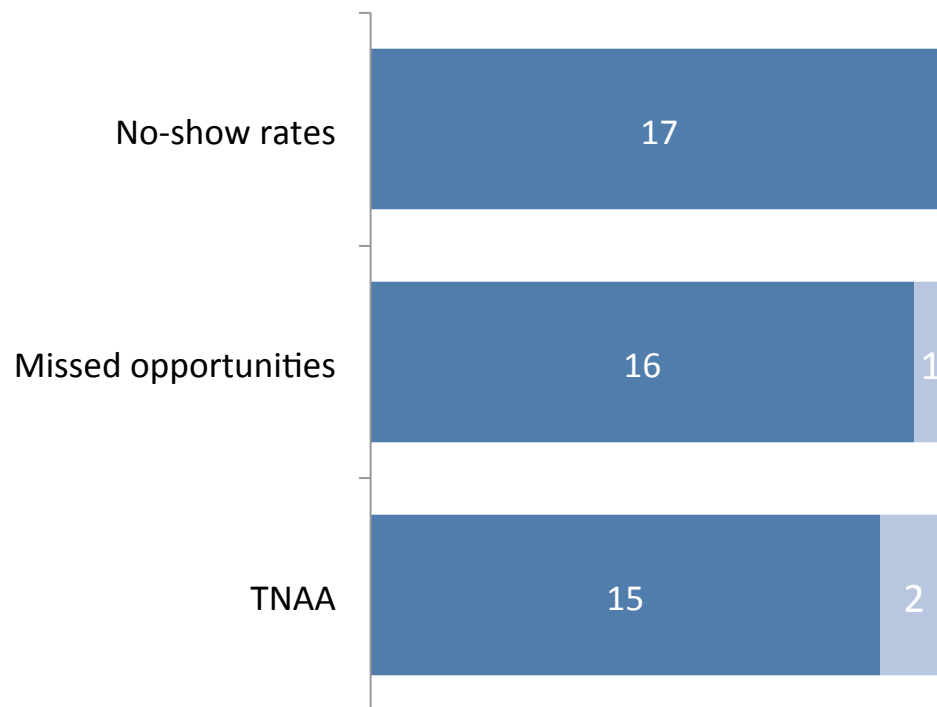


Access measures: data submission

Pilot – Q3 2014 (14 clinics)



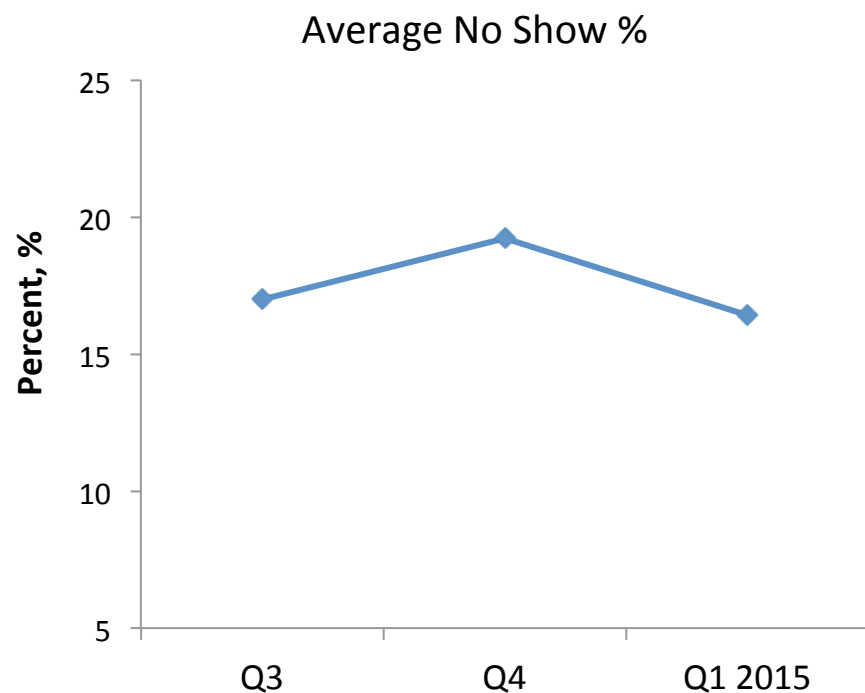
Q1 2015 (17 clinics)



Complete Partial Missing



No-show rates



Celebrating...

6 clinics:



no-show rates
(from the beginning of EATC)

3 clinics:

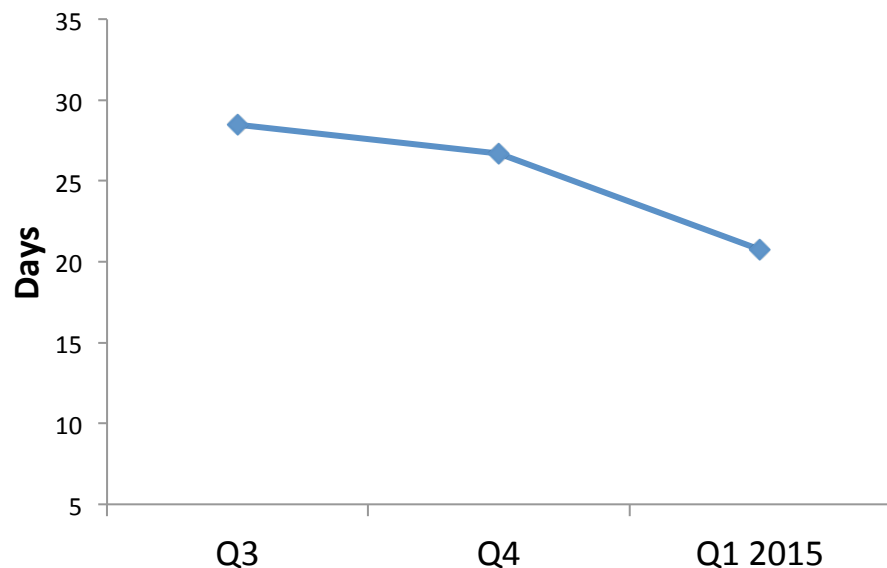
no-show rates at or
below 10% (versus 1 in pilot)



Third Next Available Appointment

Celebrating...

Average TNAA



5 clinics:



TNAA
(from the beginning of EATC)

7 clinics:

TNAA is 2 weeks or less
(versus 5 in pilot)

2 clinics:

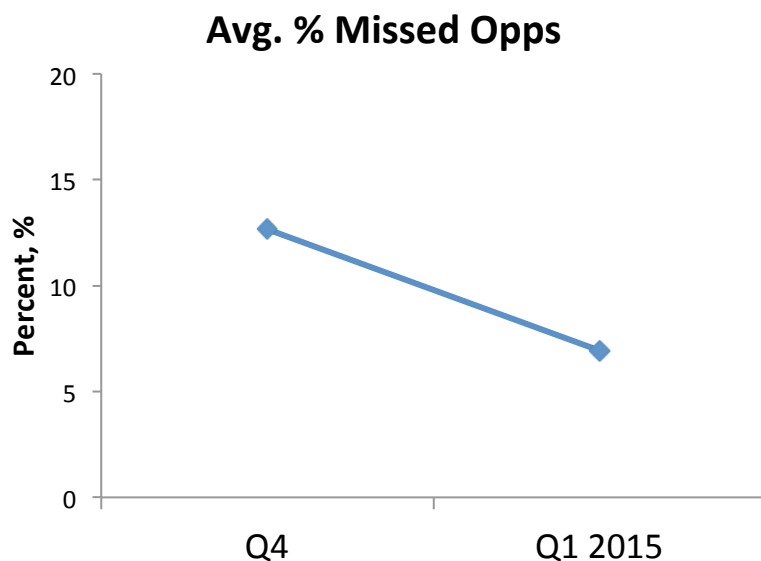


TNAA by > 7 days
(from Q4 2014 to Q1 2015)



Missed Opportunities

Celebrating...



9 clinics: Missed opportunities < 5%

12 clinics: ↓ missed opportunities
(from Q4 2014 – Q1 2015)

5 clinics: ↓ missed opportunities by
½ or more (from Q4 2014 to
Q1 2015)



Next steps

Online survey of provider/staff experience & satisfaction (post) (June/July)



Final quarterly check-in call (June/July)



Quarterly data reporting (July & Oct)



Reporting evaluation results—3 case studies, webinar & final report (Fall/Winter)



TA Support Team



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Teams and Access

- Embedding providers on effective teams can increase access by:
 1. Offloading clinical tasks from providers
 2. Limiting provider involvement in communications and paperwork
 3. Using RNs and others to provide visits
- At the beginning of the EATC
 1. About $\frac{1}{4}$ reported using staff to perform clinical services to their capabilities
 2. Less than $\frac{1}{2}$ of practices with RNs involve them in chronic disease management
 3. Only $\frac{1}{2}$ of practices regularly use standing orders

A Suggestion...

- On the most recent Dashboard, hypertension control was about 62% (almost exactly the national average).
 - Suggestion: Test changes to team roles and use of protocols and standing orders with one important clinical condition.
 - For example, expand the clinical involvement of the team to improve BP control and reduce provider visits for routine HBP check-back.
- Ideas Worth Considering:
 1. Intensify population management of hypertension patients and have staff make appointments for patients not in control.
 2. Have patients not in control routinely spend time with staff trained in self-management support.
 3. Try to get all patients to regularly assess their BP at home or in the community.
 4. Have staff member (MA or RN) regularly contact HBP patients by protocol to assess home BPs, medication adherence, other problems.
 5. Have uncomplicated patients not in control come in for RN only visits or start with conjoint visits with RNs.
 6. Lengthen the interval between clinic visits for patients found to be in control.

TA Support Team



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+ Remember, it's about how to use your ingredients...

Quickstart

Robust
Confirmation
Calls

Chart Prep

SPS – Simplified
Patient Scheduling

Huddles/Cuddles

Tetris-ing the
Schedule



+ It's about using the ingredients, in a process, like with a recipe

INGREDIENTS

1. Huddle
2. Team Dance
3. Quickstart
4. *Tetris the Schedule*
5. Chart Prep
6. *Tetris the Schedule*

DIRECTIONS

8:00 – 8:15- Huddle with Patient Care Team @ Start of Day
8:00 – 12:00 – Patient Care Team communicates and eliminates duplication of work through work process.
8:15-8:25 – Quickstart the Clinic Session to begin on time!
8:15 – 9:00 – Front Desk to proactively control the schedule
8:15 – 12:00 - MA Chart Preps for tmw's patients in between today's patients
9:00 – 12:00 – Front Desk continues to proactively control the schedule

RECIPE



+ Following the recipe yields you...

... a treat for patients and staff!

“We always hope for the easy fix: the one simple change that will erase a problem in a stroke. But few things in life work this way. Instead, success requires making a hundred small steps go right - one after the other, no slipups, no goofs, everyone pitching in.”

[Atul Gawande, *Better: A Surgeon's Notes on Performance*](#)



TA Support Team



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Team Care for Expanding Access

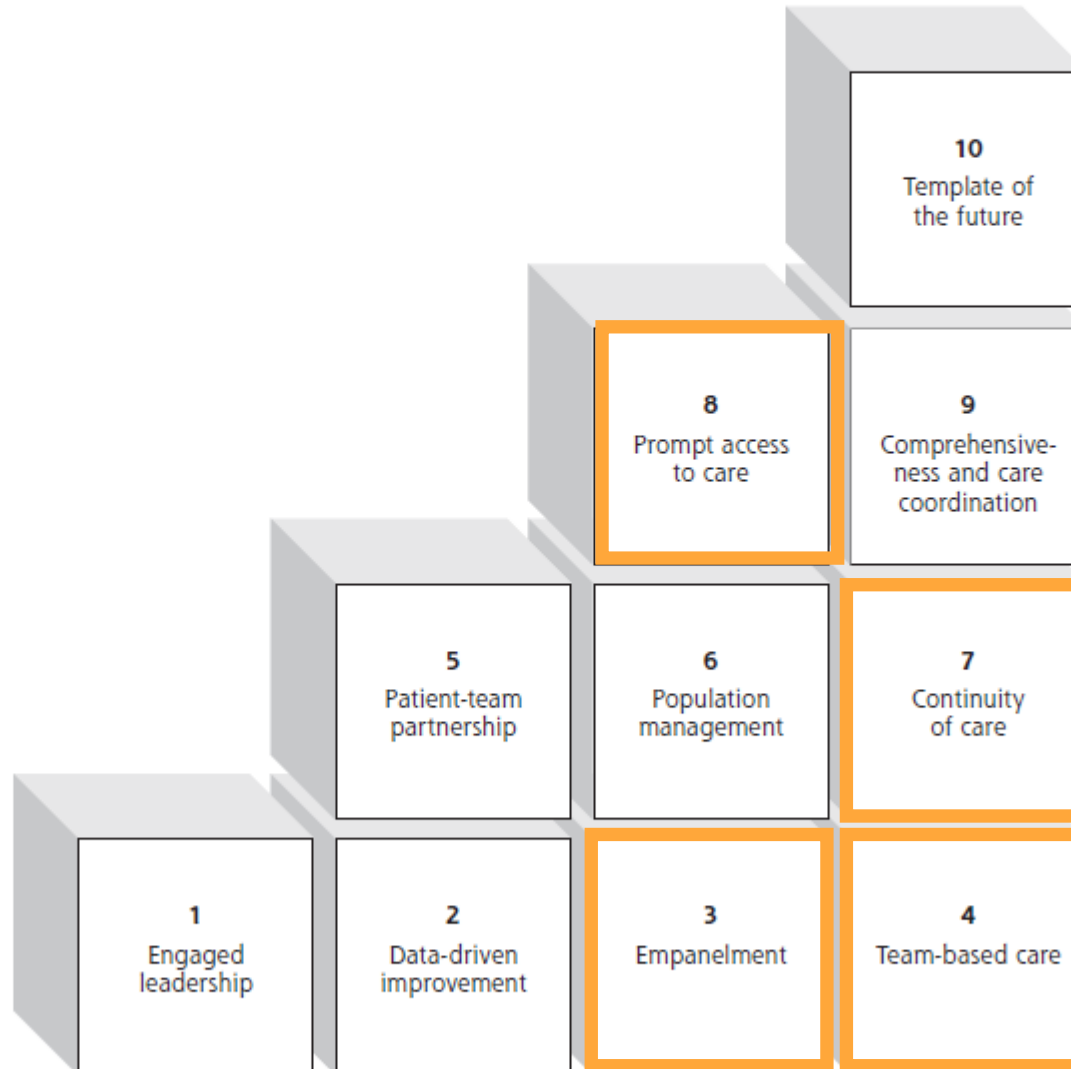
Carolyn Shepherd, M.D.

Leibig  Shepherd



Primary Care Access is Essential

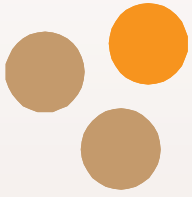
Figure 1. Ten Building blocks of high-performing primary care.



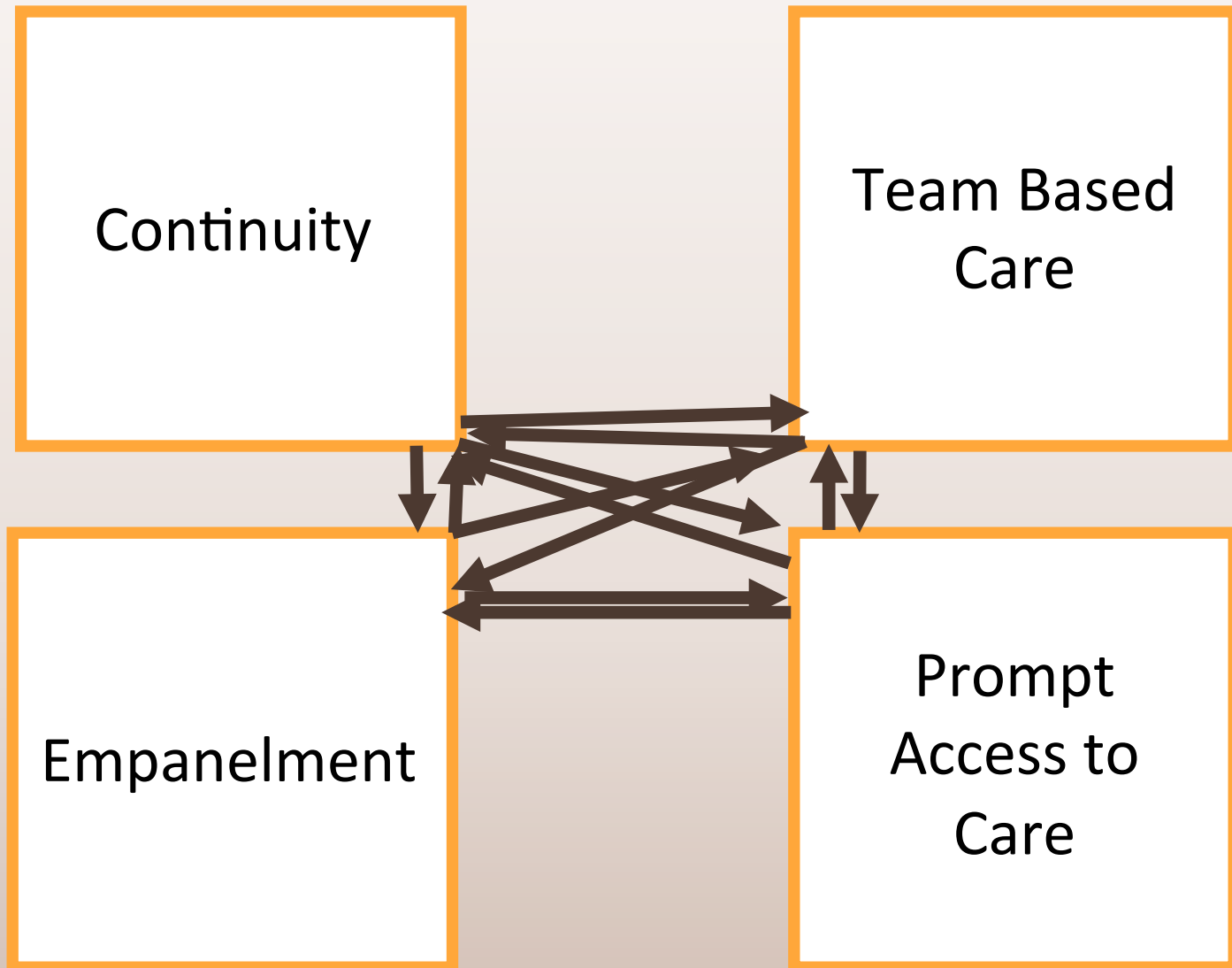


Setting the Vision for Access

- **Agree on the model of care**
 - Access for all that call your clinic vs high quality comprehensive care
- **Agree on the unit of care**
 - Who is on the team-include the patient
 - Continually optimize the team care
- **Agree on panel size for your teams**
 - Define optimal panel size
 - Use team based care to increase panels
- **Agree on strategy to meet demand**
 - Serve your community with growth instead of less

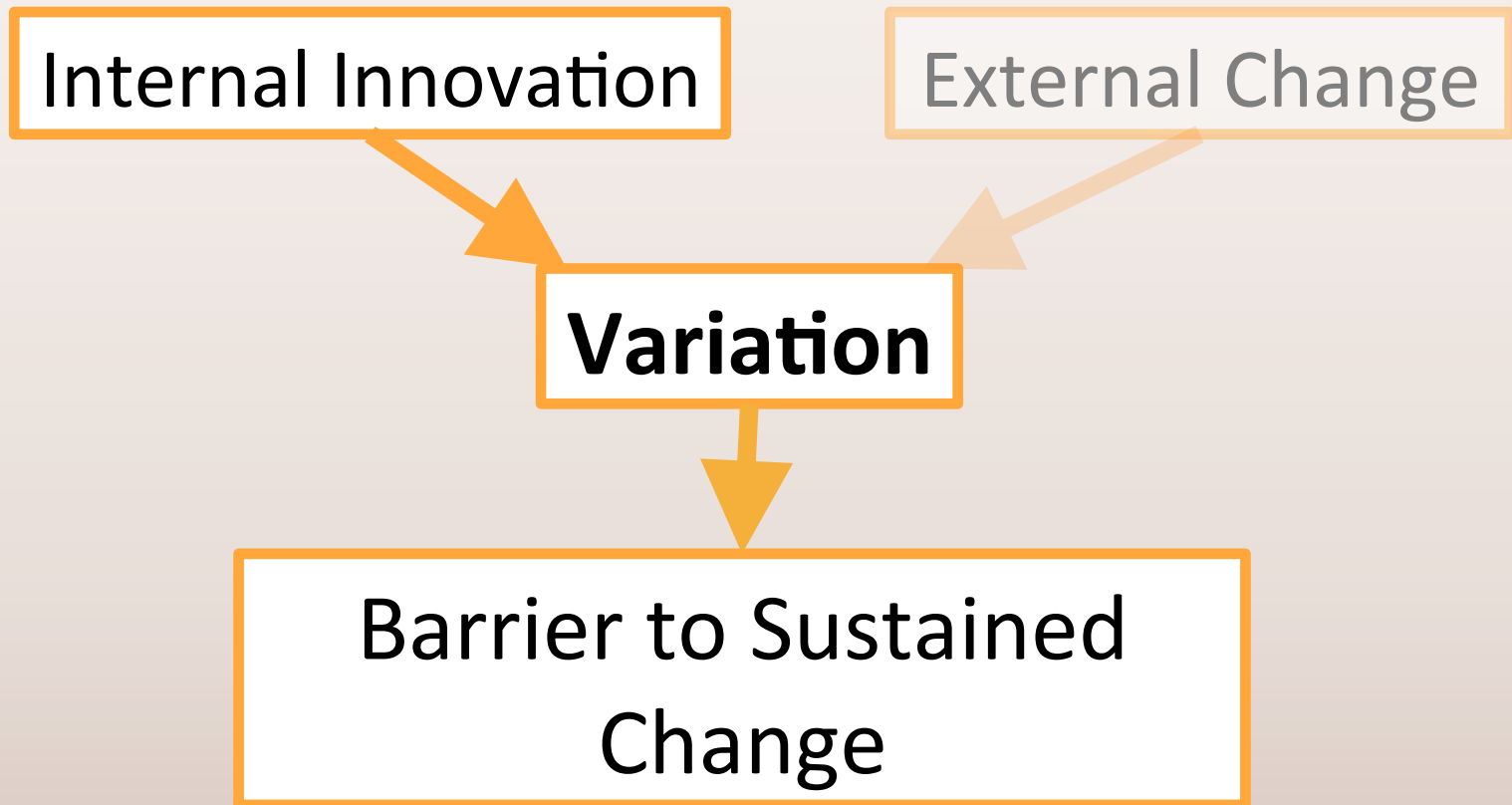


Interdependent Processes





Variation in Primary Care Clinics





Minimizing Variation

1. Innovation to Improve Care

- Internal or external evidence to improve
- Involve staff and patients
- Use a system to test innovations

2. Leadership Change Management

- Spreading change, taking it to scale
- Sustaining change



Primary Care is about the Patient



Notes & Wrap-Up



Complete list of events and reminders on program page: www.expandingaccess.wikidot.com

Reminders

- Spreading Innovations 2015 applications due 6/26/15. Visit CCI website for details.
- Final EATC webinar planned for mid-Fall 2015 to share program evaluation findings from CCHE. Webinar details will be sent in early Fall.
- Q2 Data Pull (April-June): Due to CCHE on 7/31/15
- Q3 Data Pull (July-September): Due to CCHE on 9/30/15
- BSCF Final Report due on 8/1/15 (Templates will be emailed to grant contacts on 7/1/15)

Webinar survey on next slide →