

# Hill Country Community Clinic Case Study

## September 2015

Prepared by the Center for Community Health and Evaluation



In June 2014, Blue Shield of California Foundation (BSCF) launched the Expanding Access through Team Care (EATC) Program to support safety net clinics across the state in strengthening their team-based care model in order to increase access to care. BSCF partnered with the Center for Care Innovations (CCI) to administer the program and coordinate technical assistance and peer learning opportunities. BSCF contracted with the Center for Community Health and Evaluation (CCHE) to evaluate EATC. The evaluation included case studies of three clinics that demonstrated progress both strengthening their care teams and improving access as a result of participating in the program. Evaluation results for the program overall are available in the full evaluation report on [CCI's website](#).

### EATC consisted of:

- **Grant funding** (\$50,000-\$75,000)
- Two **in-person learning sessions**
- Monthly **webinars**
- Individualized **practice coaching & technical assistance**
- **Site visits** to primary care clinics with exemplar practices related to team care (supported with additional funding from the Hitachi Foundation)

### Background

Hill Country was well positioned to participate in the EATC program and built on existing clinic infrastructure and experience, including its efforts to achieve Patient Centered Medical Home (PCMH) Level 3 certification, existing quality improvement capacity, and processes for using data to drive clinic decisions and change. Like other community clinics, Hill Country is grappling with increasing demand for services due to the implementation of the Affordable Care Act (ACA) and the expansion of Medicaid. To local residents, however, Hill Country is not only a clinic, but also a highly regarded, community-oriented organization that houses the local radio station, youth program, and community library.

<p><b>Geography:</b> rural, Shasta County, Northern California</p> <p><b>Organization size:</b> 1 main facility and 1 satellite clinic</p> <p><b>Team-based care:</b> PCMH Level 3 certification</p> <p><b>Care teams:</b> primary care provider (PCP), Medical Assistant (MA), Licensed Vocational Nurse (LVN), front desk staff, behavioral health consultant (BHC), behavioral health care coordinator (BHCC)</p> <p><b>Other clinic staff:</b> Registered Nurse (RN)</p> <p><b>Other clinic services:</b> Behavioral Health, Dentistry, Chiropractic</p> <p><b>Quality improvement (QI) experience:</b> Existing QI infrastructure and experience, including a 3-year PCMH certification process and previous work with EATC TA provider Coleman Associates.</p>
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## Expanding Access through Team-based Care

Hill Country used participation in EATC to improve access by strengthening care teams, defining and expanding team roles, and implementing new scheduling practices. Through its efforts, timely access to both primary care and behavioral health services increased.

### *Strengthening Care Teams*

The clinic worked to strengthen care teams through a team branding exercise, where staff chose a team name, logo, colors, and motto. Team members' badges were redesigned to reflect their team's brand. Team names were also added to patients' after visit summaries so patients remember their care team.

**Flip visit** – primary care visit where a nurse provides a majority of care and the primary care provider comes in at the end to review and approve the treatment plan.

### *Defining Team Roles & Workflows*

RNs have taken on new responsibilities within the strengthened care teams at Hill Country, with a new **flip visit** protocol and workflow implemented. The concept of flip visits was introduced to the teams by EATC and nurses welcomed the opportunity to do “hands-on nursing.” Empowered to expand their role and work at the top of their licensure, RNs now spend more time directly providing patient care.

Like the RNs, MAs have also expanded their role on the care team by providing health coaching and spending more time with patients. The additional one-on-one attention the MAs provide during coaching gives some patients the extra support they need to be more engaged in their own health care.

### *Integrating Behavioral Health*

Hill Country integrated behavioral health services into their primary care teams during EATC. A behavioral health consultant (BHC) and a behavioral health care coordinator (BHCC) is housed with medical services, central to all of the primary care providers. At Hill Country, care teams huddled in the morning and afternoon to coordinate care for patients. During huddles, the BHC helped identify patients on the PCP's schedule who could benefit from a quick check-in before or a warm hand-off after their appointments for additional behavioral health support. The BHCC then helped fit these patients in between the BHC's regularly scheduled appointments. The BHC's schedule is designed with gaps between shorter regular appointments (20 minutes) to accommodate coordinating with all the primary care teams. On busy days the BHCC can fit up to seven additional patients into the BHC's schedule.



*An 80-year old woman came into the clinic with a bag of pills. One of the MAs who had been trained as a health coach sat down with her and went through all of the medications, figuring out what she had, what she didn't need anymore, and divided the dosages up into a pill box. The MA was really excited about the work and said, 'I felt like I had really made a difference in her life.'*



*I can always be interrupted...that's an expectation that I set at the beginning because I need to be available [if another patient needs to see me right away].*

- Hill Country Behavioral Health Consultant

During these behavioral health visits, the BHC will conduct safety assessments for controlled substances, brief interventions (e.g. crisis, suicidal ideation, de-escalation), health coaching, or will connect patients to longer term resources in the community that fit their needs.

The behavioral health providers also started working with the primary care teams to run group visits, including one substance abuse group for women run by a psychologist and one group for patients with co-occurring disorders run by the BHC. They may expand to other groups, such as diabetes patients needing support with self-management. The group visits include patients who have been identified from the primary care teams' patient panels, and Hill Country is able to bill the patients' insurance for a medical visit. Group visit activities include evidence-based cognitive behavioral therapy, patient education, role-playing, and discussion.

Integrating behavioral health services into primary care was accelerated by Hill Country's participation in EATC and is strongly supported by both the behavioral health and primary care team members. Clinic staff members reported that they are seeing behavioral health integration reduce the stigma for behavioral health services—when the PCP does a warm hand-off for a patient needing extra support, it is rare for the patient to be hesitant to talk to the BHC.

Clinic staff members also suggested that the integration of behavioral health is increasing Hill Country's overall positive reputation in the community due to the level of service they are able to provide.

### **Lessons for integrating behavioral health**

Facilitate strong communication by including behavioral health providers in team huddles. Build in time for the team to look for opportunities in the schedule to coordinate with behavioral health.

Establish a schedule template that permits the behavioral health provider to be available as needed for warm hand-offs from PCPs. This may require that regular visits with the behavioral health provider are shorter than the typical 50 minutes. Behavioral health providers need to be willing and have the skills to be effective in this abbreviated timeframe.

Treat behavioral health as an extension of primary care, rather than separating the two, to help reduce stigma with patients. Talk about warm hand-offs as an opportunity for the patient to keep discussing their needs with another member of the care team.

Get buy-in from PCPs by presenting behavioral health integration as a strategy to make their schedule more effective and efficient. By integrating services patients can be handed off to a behavioral provider with the appropriate expertise to meet their care needs.



*At this point, if you tried to take the behavioral health providers away [...] the PCPs would be in an uproar.*



*There is a group of patient advocates [at the front desk]. They push the envelope often on getting people in.*

### *New Scheduling Practices*

Since Hill Country is a rural clinic with many patients driving long distances to receive care, it is difficult to fill a same-day cancellation or no-show appointment slot with another patient who could make it to the clinic in time. To address this challenge, the front desk staff were encouraged by care team members to take on more responsibility for managing the team's schedule, keeping appointment slots filled, and maintaining continuity of care for empaneled patients. Many staff members at the front desk are also local residents, with strong connections to the clinic's patients, which motivate them to improve access for the patients.

The front desk consulted with EATC's coaches at Coleman Associates to create a "green light, red light" system for anticipating the likelihood that patients would not make their appointments because they have a history of no-shows, live far away, or other challenges. The new system was used to strategically double-book appointment slots and gave the front desk staff more autonomy when making scheduling decisions, rather than having to check-in with the providers.

Front desk staff educated patients through existing communication structures, such as robust reminder calls, to make sure patients understood that if they no-showed it could be up to four weeks before another appointment is available. Additionally, the front desk displays a sign with the number of no-shows the clinic had the previous day and a message that every no-show is an appointment someone else could have used.

### **Outcomes and Impact of EATC**



*We get calls from people saying, "I hear your clinic is nicer to patients, you spend more time with your patients, you really care." They don't know it's because of the behavioral health integration, but they've heard of the difference.*

Hill Country's prior work on team-based care and patient access was well aligned with EATC activities, allowing the clinic to build on its previous successes and capacity for quality improvement. Through EATC, Hill Country was able to improve efficiency by reducing missed opportunities (i.e., the number of appointment slots that went unused) and improve access to behavioral health services, particularly for patients who may have been hesitant to seek out behavioral health services in the past. Hill Country also integrated flip visits and group visits into patient care as their teams continue to improve efficiency and access.

#### *Key Outcomes*

- Team-building activities increased the visibility of team-based care throughout the clinic, for both staff and patients, and boosted team morale and cohesion.

- Clarifying and expanding team members' roles and workflows helped to offload some patient care from the PCPs. Providers now have more time to see additional patients or focus on complex or high-need patients, while other care team members are more engaged in patient care and find the work in their expanded scopes rewarding.
- Care teams reported reduced stigma related to seeking behavioral health services due to the integration, as patients now consider behavioral health an extension of seeing their primary care team.
- The front desk successfully implemented new scheduling strategies while using their personal connections to patients to discourage no-shows.
- Scheduling changes reduced the number of appointments that went unused while keeping continuity of care high – over 90% percent of appointments are scheduled with a patient's assigned PCP.

### Next Steps

Ongoing challenges for Hill Country include staff turnover and limited capacity to address the growing demand for services. Hill Country opened a new clinic with one primary care team in nearby Redding, CA, in 2015 to help increase access, but anticipate that demand will continue to exceed capacity.

Hill Country plans to continue building on the progress made during EATC. Care teams will continue to work on clarifying roles, strengthening team dynamics and communication, and transitioning to MA-driven huddles. A new **flow coordinator** position will be added to the care teams, to facilitate even more scheduling and workflow efficiencies. Additional group visits will be implemented, such as a diabetes management group informed by materials provided by EATC's coaching support. Finally, Hill Country plans to spread the lessons learned and progress made to the primary care team at the new clinic in Redding.

**Flow coordinator** –  
*Acts as a link between clinical staff and patients and assists with smoothly and efficiently moving patients through an appointment with their care team.*