Blue Shield of California Foundation
Expanding Access through Team Care Program

LA Christian Health Centers Case Study
September 2015

Prepared by the Center for Community Health and Evaluation

GroupHealth

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

LA Christian Health Centers (LACHC) participated in EATC with one primary care team at the Joshua House clinic. Located in the Skid Row area of downtown Los Angeles—known for its large homeless population—clinic patients are predominantly homeless and live on the streets, in mission shelters, or in temporary housing. Joshua House has a reputation for providing superior customer service to patients.

Geography: Urban, Southern California (Los Angeles)

Organization size: 2 family practice facilities and 10 satellite clinics

Team-based care: LACHC completed an intensive Patient Care Team Redesign process in 2011

Care teams: primary care provider (PCP), Medical Assistant (MA), patient navigator, front desk patient registration specialist (PRS)

Other clinic staff: charge nurse, float MA, clinical pharmacist, social workers, and enrollment & retention specialists

Other clinic services: Behavioral Health and Dentistry

Quality improvement (QI) experience: LACHC was familiar with some of the tools and strategies taught in EATC and had previously worked with TA provider Coleman Associates. LACHC also had a Continuous Quality Improvement Committee. However, the care team at Joshua House had not worked on QI together before.

Expanding Access through Team-based Care

Through EATC, the LACHC team increased access by strengthening team communication, expanding team member roles, and implementing new scheduling strategies. The clinic was also able to address some structural and process challenges at the front desk.

Expanding Team Roles and Strengthening Communication

The LACHC team revised job descriptions and mapped workflows to clarify each team member's role and responsibilities. Standing orders were developed for the MAs to provide HIV and diabetes care, which offloaded some work from the charge nurse and provider. The process resulted in the team creating a new Lead MA position at the clinic to oversee the MA activities.

The charge nurse role was also expanded to include **flip visits**, where the nurse provides a majority of the patient care to free up provider time. Flip visits are being used to give the charge nurse more responsibility for seeing high-risk chronic case management patients.

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.*

To implement these expanded roles, strong and consistent communication was needed between team members. Communication among team members was supported through morning huddles and discussions of tests changing workflow at staff meetings each month.

Elevating the role of the Patient Registration Specialist

We just did a focus group and we learned that compared to other [LACHC] clinics it was easier to be seen as a walk-in [at our clinic]. Our wait times are the lowest – less than 30 minutes for walk-ins – and it's also easier to make an appointment. It shows improvement in access.

The role of the front desk staff, called patient registration specialists (PRS), was redefined during the EATC program to give the PRS greater ownership of the schedule and more responsibility for managing the patient panel.

- The PRS implemented a new strategy called "grading the patient" where each patient is assigned a grade (A-F) based on no-show history. Patient grades were used to see where the clinic could strategically double-book walk-in patients.
- The PRS also looked for opportunities to fit flip visits into the schedule with the charge nurse and clinical pharmacist, which increased patient access to care with minimal time from the providers.
- When a patient would benefit from additional support that the social workers or behavioral health team could address, the PRS made a note that the patient needed a provider referral and looked for opportunities for a warm hand-off. When warm-hand-offs were not possible, the PRS would schedule a follow up appointment for the referral. Schedule changes and referral/warm hand-off requests were communicated to team members via walkie-talkie

in real time and through notes in the clinic's electronic health record (EHR).

- The primary care schedule template was also redesigned and simplified as a result EATC. All appointment slots became uniform—20 minutes per patient. There was also time built in after morning and afternoon visits for providers to finish charting. The new template eliminated restrictions on which appointment type fit into which appointment slot, giving the PRS more flexibility and further increasing access.

We have a patient that used to only go to urgent care because he didn't want to try to [schedule an appointment] or wait in the line at the front desk. But he's back now.

Lessons for expanding the role of the front desk staff

Empower the front desk staff, giving them the opportunity to take ownership of the schedule and letting them feel comfortable revising the schedule to prevent unused appointment slots.

Integrate the front desk as part of the care team. Communication between the front desk and the rest of the team is essential to keep everyone informed of schedule changes and help the team adjust in real-time.

Expand the roles of other care team members, such as introducing flip visits to the role of nurses, so the team as a whole can help increase the capacity of the schedule. This will help the front desk improve access even more and maximize flexibility in the schedule.

Redesigning the lobby and front desk

The Joshua House clinic faces significant space challenges in its current building, which was formerly a hotel and has three levels and narrow hallways. The lobby and front desk area was a particular bottleneck before EATC, with only two check-in windows. The practice coaching they received through EATC encouraged LACHC to renovate. They expanded so that the front desk now has five check-in windows. This improved patient access to the PRS, patient navigator, and enrollment and retention specialist and improved overall security since the entire waiting room is now in view of the front desk.

Our patients don't always know what they need. So, 'let's figure it out and I'm going to help you' has to be the mindset.

LACHC also created a new Lobby Attendant position to help facilitate the patient check-in process, monitor patient flow, and help with building security. They hired an attendant with experience working with the Skid Row community. He provides an exceptional level of customer service to patients that are sometimes agitated, in pain, confused, or needing additional guidance. He also helps patients use the computer in the lobby to access LACHC's online patient portal.

Outcomes and Impact of EATC

LACHC was well positioned to excel in the EATC program due to its prior work in Patient Care Team Redesign and experience with Coleman Associates to improve scheduling access. The LACHC team benefitted from leadership buy-in and a strong, proactive team leader who actively engaged in the program. Through EATC, the LACHC team at Joshua House was able to almost eliminate missed opportunities (i.e., unused appointment slots), make it easier for patients to get an appointment, effectively implement flip visits, and improve team communication.

Key Outcomes

- The care team is a more cohesive group, coordinating to maximize workflow efficiency and stay nimble as the schedule changes over the course of the day.
- The role of the PRS has become central to the care team functioning efficiently by anticipating where the schedule will flex and keeping appointment slots filled.
- The care team's capacity to see patients has increased to match the improved access the PRS has created in the schedule.
- The care team maximizes the services received by patients during their appointment slots, through standing orders, flip visits, and warm hand-offs. This is especially important for the homeless patient population at Joshua House where no-shows are common and patients often come to the clinic needing multiple services.
- As a result to the changes to how the schedule is managed, LACHC's missed opportunities dropped from 21 in the third quarter of 2014 to only 1 in the second quarter of 2015.

People are thinking more about proactive changes and thinking about the big picture and how their work contributes to the clinic and how they can improve clinic efficiency.

Next Steps

To maintain and spread the progress made at Joshua House, LACHC plans to review the changes made and the Continuous QI Committee will select the most successful workflow improvements to roll out across the organization. The LACHC team hopes to implement a new patient registration workflow so that all patients will go through eligibility and financial screening before seeing their provider.

LACHC is also preparing to implement behavioral health integration where they will build on the work done in EATC. They will be hiring a new behavioral health coordinator, integrating behavioral health scheduling into the PRS activities, coordinating care between primary care and behavioral health with more warm hand-offs, and implementing co-visits where a social worker and behavioral health provider see patients at the same time. LACHC credits the EATC program with preparing the clinic for the behavioral health integration grant they received.