Blue Shield of California Foundation
Expanding Access through Team Care Program

Mendocino Community Health Clinic Case Study – Hillside Clinic's Pod C
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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

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.*

Mendocino Community Health Clinic (MCHC) participated in EATC with one primary care team at their Hillside Clinic. Hillside is their largest clinic, located in Ukiah—the county seat and largest city in Mendocino County. Like other community clinics, MCHC is grappling with increasing demand for services due to the implementation of the Affordable Care Act (ACA) and the expansion of Medicaid. EATC was well aligned with existing work occurring at MCHC to improve the functioning of their care teams, including maximizing their **flow coordinator role**—called a Patient Services Representative (PSR).

Geography: rural, Mendocino County, Northern California

Organization size: 3 family practice facilities

Team-based care: MCHC implemented team-based care in 2011 and divided adult medicine services into three pods. Implemented daily Medical Assistant (MA)-led care team huddles.

Care teams (i.e., pods): two primary care providers, MAs, one nurse case manager, and a patient services representative (PRS)

Other clinic services: Behavioral Health, Pharmacy, Dentistry, Women's Health Clinic, Internal Medicine Clinic, several other specialty services (e.g., dermatology, HIV care, orthopedics)

Quality improvement (QI) experience: A history of undertaking change initiatives and data-driven quality improvement efforts, including previous work with EATC TA providers Coleman Associates

Expanding Access through Team-based Care

MCHC selected Pod C at Hillside Clinic, a high performing and productive team, to pilot strategies to improve access by leveraging existing care team practices and structures. Pod C began its EATC work with a survey of pod members to assess current functioning—i.e., identify current strengths and uncover any challenges or areas of discontent. Results informed their work throughout EATC.

Clarifying the team: Clearer definitions of roles and responsibilities

Early in EATC, MCHC staff worked collaboratively to clarify the roles and responsibilities of the team members, particularly the MAs, nursing staff, and PSR. This resulted in changes made to the job descriptions for these positions across the organization. They communicated the team approach out to patients by changing the signs in the pod from being only the providers' names to including all of the team members with their credentials. This was received so well that all of the other pods in the clinic requested that their signs also be changed.

Elevating the patient-facing role of the PSR

The work that [the PSR] does and how she knows her patients and understands the needs of the providers is exceptional. She absolutely understands the panel of patients and makes sure people get in. Continuity numbers that I think are legitimate are almost 100%.

- *EATC technical assistance provider*

MCHC's philosophy towards its PSR role is that they are the "HOME—heart of the medical encounter." Its EATC work further positioned the PSR in Pod C to be a key patient-facing team member tasked with strengthening relationships between the care team and patients. She was given full ownership of the new, simplified schedule and brokered communication between patients and the rest of the care team. Pod patients were given a card with her direct line so they knew to contact her for any needs they had (bypassing the call center). Her desk sat in the middle of the pod, integrated with the care team and along the pathway of patients as they came and went. She connected with patients on their way out to ensure that they had all of the information they needed and next steps were clear.

Robust reminder calls by care team members

Reminder calls that had been done by the centralized call center staff were brought back into the pod. Generally, the PSR conducted these calls, which included not just a reminder of the appointment date and time, but an assessment of why the patient was coming back in and ensuring that the care team had the necessary information (e.g., lab or test results) to make the appointment worthwhile.

Access improvement strategies integrated into the team huddle

Given the PSR's real-time knowledge of patient needs through her ongoing communication with patients, she played a key role in the Pod C huddle to assist with identifying patients in the schedule who might not need an in-person appointment or have a history of no-showing. They were also working to modify the report they obtain from their patient registry to make it more comprehensive, in order to reduce the burden on MAs and the PSR to manually track down needed information.

Lessons for flow coordinator success

Earn the trust of the team. Keeping the patient at the center of the work and reinforcing that the whole team is working towards a shared goal can help build trust.

Show you care. A focus on connecting with and really getting to know your patients, their families, their barriers—"the better you know them, the better the results."

Be organized. Organization is the key to knowing and responding to what patients and the care teams need.

Outcomes and Impact of EATC

Increased patient access: Through the PSR's more effective management of the schedule, Pod C was able to ensure that appointment slots were filled with patients needing and ready for an appointment. In addition, the PSR acted as an advocate for patients, working to get them into the schedule as needed, while working with the care team to educate patients on what to expect from the appointment so that the team stays on schedule. The PSR paid particular attention to keeping patients with their assigned primary care provider to maintain continuity of care.

Decreased Pod C no-show rate from 15% to 7%: EATC team members reported that the work done to develop the relationship between patients combined with the robust reminder calls conducted by the PSR contributed to an 8 percentage point decrease in no-show rate during EATC.

Like a family, [patients] know who to go to […] They are very loyal to the providers and the team.

Increased patient satisfaction: Team members stated that the level of customer service provided and relationships developed by the PSR have resulted in patients being more consistent and compliant.

Increased staff satisfaction & improved team functioning: Team members reported improved communication, increased trust, and individual growth among members, including being empowered to "take the initiative and make changes."

Next Steps

MCHC stated that the alignment between their EATC work and their effort to obtain Level 3 Patient-Centered Medical Home accreditation across their organization will help them sustain and spread many of the changes made into other pods. They will continue to work to increase provider buy-in to help spread change, fully integrate this model of team-based care, and spur the culture shift needed to redefine how providers and other clinical support staff work together.

We did have the best pod in the clinic – hands down. We were innovative. We were productive. It was great for the team to have that validation and that confidence.

The flow coordinator position was well entrenched at MCHC, but by the end of EATC a few other grantees had successfully demonstrated the value of this position. Several additional EATC clinics were exploring the feasibility of implementing a similar role. Considerations for effective implementation of flow coordinator positions include:

- ***Shifting the culture of care provision.*** Historically, providers have been at the center of a primary care appointment. MCHC's team-care model positions their PSRs at the center—she sits in the middle of the care team and engages with patients before, during and after their visit with the provider. Leadership and providers have a role in communicating and reinforcing the value and role of the PSR and other clinical support staff in order to foster trust and empowerment.
- ***Determining what type of credential (if any) is needed for that role.*** Two of MCHC's PSRs were MAs, while the other two were not licensed clinical staff. EATC clinics struggled with what level of credential would be needed to effectively fill the flow coordinator role, both in terms of having the adequate skills to do the work and having the credibility needed in the organization.
- ***Care team structures that support and empower all team members, including the PSR, to work at the top of their ability.*** This will likely include clearly defining team members' roles and responsibilities, including potentially revising job descriptions, to ensure all team members know how they contribute to the team and what they can expect from their colleagues.
- ***Individual characteristics of care team members.*** Effective team-based care requires that all team members be willing to work in a collaborative environment. Furthermore, effective flow coordinators need to have strong interpersonal and communication skills and be organized and committed to improving the patient experience.
- ***The importance of trust and personal relationships.*** MCHCs model relies heavily on trust and personal relationships—both among the care team and between the care team and patients. This takes time and effort to develop. As a result, it is challenging for an organization to transition team members from one pod to another.