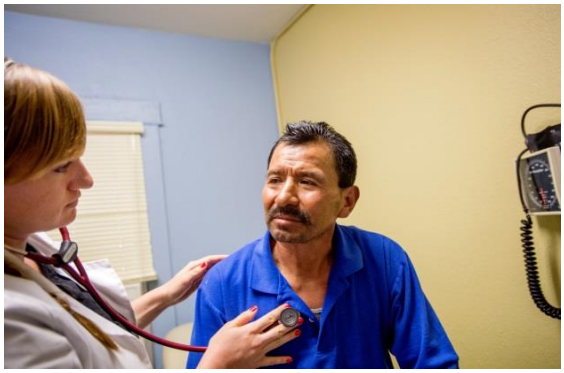
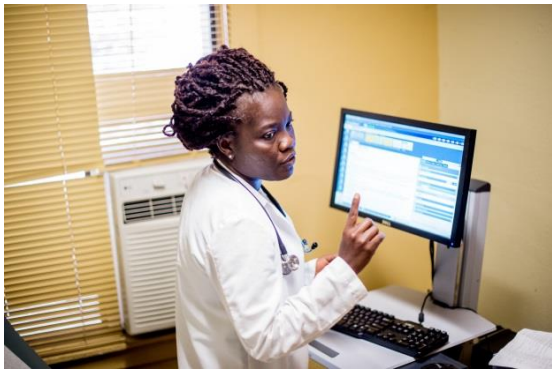




Blue Shield of California Foundation

Expanding Access through Team Care Program

Final evaluation report

Prepared by the
Center for Community Health and Evaluation

December 2015

Contents

GroupHealth

Executive Summary

In June 2014, Blue Shield of California Foundation (BSCF) launched the Expanding Access through Team Care (EATC) Program and funded 13 clinic organizations across the state to work on strengthening their team-based care model in order to increase access to care.

The EATC program effectively provided a package of resources that helped grantees both strengthen their care teams and improve access.

EATC grantees reported progress:

- **Strengthening and expanding several key care team roles** including medical assistants (MAs), front desk, nurses, flow coordinators and behavioral health staff. Changes made through EATC resulted in effectively distributing work across the care team, empowering team members to take on new roles, and increased the overall level of support provided to patients.
- **Increasing access** by empowering flow coordinators and front desk staff to more effectively manage the appointment schedule to optimize capacity. They also implemented alternate visits—other types of visits beyond an in-person, face-to-face visit with a PCP— which positioned clinical care team members to work at the highest level of their licensure and provide more direct support to patients.
- **Improving patient satisfaction** by keeping patients at the center of the team's work, ensuring more effective communication with patients, and providing them the care they needed in a timely way.
- **Tracking, reporting and using data for improvement**, as well as building infrastructure to engage in other change initiatives and quality improvement efforts**.**
- **Increasing staff satisfaction** by clarifying team members' roles and responsibilities, ensuring their skills and training are being utilized, and fostering relationships with patients, as well as other team members.

Most of the grantees indicated that **key changes would likely sustain beyond the program** and they would continue to build on the work done during EATC. Grantees reported that EATC's emphasis on strengthening team-based care and requiring grantees to track and use data for performance improvement better positioned them to obtain or maintain PCMH accreditation.

Grantees reported EATC effectively supported their work, and they highlighted the contribution of the grant funding, opportunities for peer exchange and learning, and access to individualized practice coaching from "experts." They indicated these types of resources and programs would be helpful in helping the safety net respond to ongoing changes and challenges in the health care environment.

I. Background

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. CCI engaged Coleman Associates, Dr. Carolyn Shepherd, and the MacColl Center for Health Care Innovation to provide technical assistance and content expertise related to improving access and strengthening team-based care models. Coleman Associates and Dr. Carolyn Shepherd also provided individualized practice coaching to grantees that requested additional support.

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)

What is team-based care?

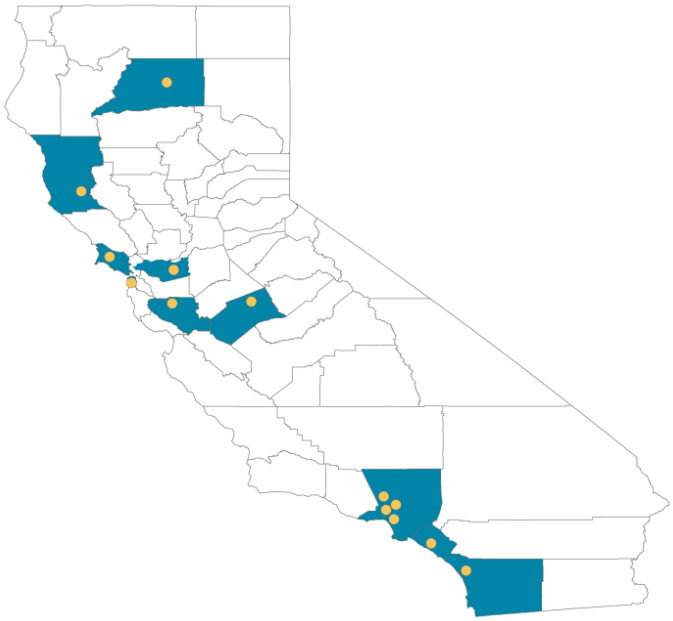
The provision of comprehensive health services to individuals, families, and/or their communities by at least two health professionals who work collaboratively along with patients, family caregivers, and community service providers on shared goals within and across settings to achieve care that is safe, effective, patient-centered, timely, efficient, and equitable.

Naylor MD, Coburn KD, Kurtzman ET, et al. Team-Based Primary Care for Chronically Ill Adults: State of the Science. Advancing Team-Based Care. Philadelphia, PA: American Board of Internal Medicine Foundation; 2010

BSCF contracted with the Center for Community Health and Evaluation (CCHE) to evaluate EATC. This report presents evaluation results for the EATC program overall. The evaluation also produced case studies of three clinics that demonstrated progress both strengthening their care teams and improving access as a result of participating in the program. These case studies can be viewed on CCI's website.

EATC grantees

EATC funded 13 primary care agencies across the state of California. Grantees were primarily community clinic organizations, as well as two entities operating within the local municipal health system. Grantees were required to have some level of team-based care in place prior to the program, typically at least provider and medical assistant (MA) dyads. Grantees ranged in organizational size and served rural and urban areas.



EATC Grantees:

- Coastal Health Alliance
- Hill Country Community Clinic
- Indian Health Center of Santa Clara Valley
- LA Christian Health Centers
- La Clinica de La Raza
- Livingston Community Health
- Mendocino Community Health Clinic
- North County Health Services
- Northeast Valley Health Corporation
- Olive View - UCLA
- San Francisco Health Network
- Share Our Selves
- Valley Community Healthcare

II. Evaluation Methods

In partnership with BSCF and CCI, CCHE developed a program logic model that informed the identification of outcomes and data collection approaches (Attachment A). The evaluation assessed grantee progress related to the following:

Grantee outcomes

- Access
- Team effectiveness
- Continuity of care
- Patient experience
- Workforce development
- Clinical outcomes

Process outcomes

- Implementation of EATC
- Relative value of program components
- Benefits & challenges to grantees
- Grantee engagement
- Work plan implementation

Data collection methods are summarized in the table below. The evaluation collected quantitative and qualitative data throughout the program. CCHE worked with BSCF, CCI, EATC technical assistance providers, and the grantees to identify a set of standard metrics to assess grantees' progress improving access.

Common metrics:

- No-show rates
- Third next available appointment
- Missed opportunities
- Clinical measure: clinics selected tobacco screening, weight screening, **or** blood pressure control
- Patient experience

Data source	Data collection method	Sample
EATC participants – Individuals	Pre/post individual assessment survey	Pre: 61 (# of respondents per team ranged from 1-8) Post: 57 (# of respondents per team ranged from 1-8)
EATC participants – Clinics	Quarterly interviews with clinics teams—3 interviews per team	N: 13 teams (# of team members on call ranged from 1-4)
	Quarterly quantitative data reports on common measures (included one quarter of follow-up data after the program was complete)	13 grantees; 17 clinics[1]
	Pre/post clinic assessment survey (completed collaboratively)	Pre: 14 Post: 13
	Site visits with case study sites	N=3
EATC program staff & technical assistance providers	Interviews at end of program	N=6 (9 participants)
Program activities & documents	• Observation of webinars & learning sessions • Document review of grantee application summary	Webinars: 9 Learning sessions: 2 Document review : N/A

Qualitative data from interviews were analyzed thematically with the aid of Atlas.ti. Quantitative data were compiled and analyzed with Microsoft Excel and STATA where appropriate. The evaluation provided quarterly summaries on findings from interviews and results from clinical data reporting to BSCF and CCI.

[1] EATC funded 13 grantees; however, two grantees reported quarterly data on multiple clinics due to differences in their operations and process.

III. Results: impact of EATC

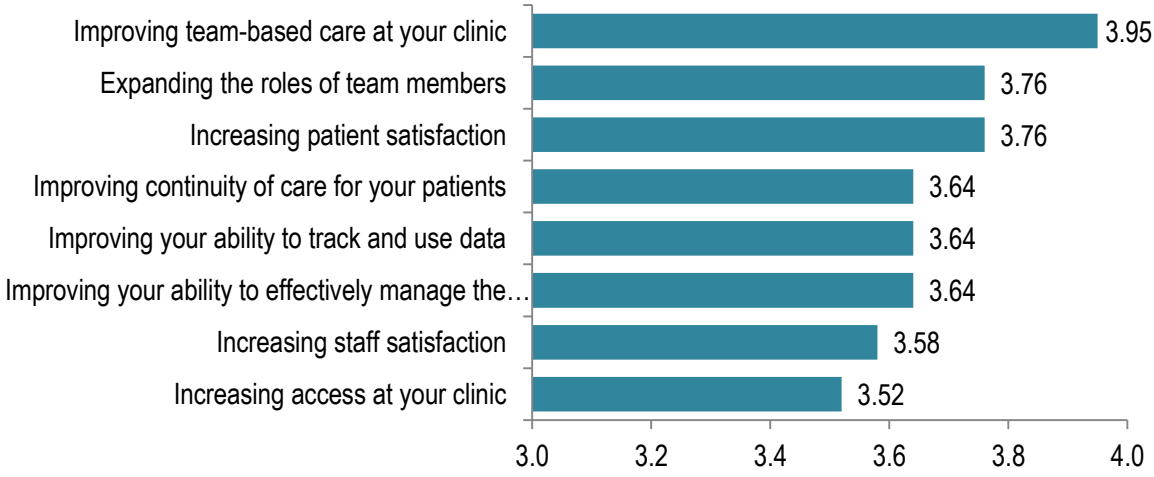
The EATC program effectively provided a suite of resources and support that helped grantees both strengthen their care teams and improve access.

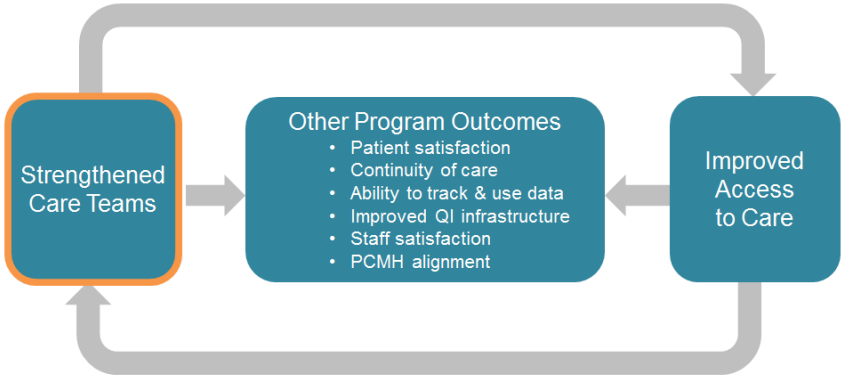
Grantees reported progress in several areas as a result of participating in EATC. Teams rated their progress the highest for improving team-based care and expanding the roles of team members. Teams also reported progress in their ability to effectively manage the appointment schedule, which resulted in some improvements in access. In addition to progress in the primary outcomes of EATC – strengthened teams and increased access – grantees reported improvements in several other areas:

- Patient experience
- Continuity of care for patients
- Ability to track and use data
- Staff satisfaction

Grantees reported that this progress contributed to an overall improvement in quality improvement infrastructure and helped them to be better aligned with patient-centered medical home objectives.

Average ratings of progress by EATC team members
(1=no progress; 5=outstanding) (n=55)





Strengthened care teams

All 13 grantees participating in EATC reported progress strengthening their care teams as a result of participating in EATC.

EATC team members rated *improving team-based care in your clinic* as the highest area of progress during the program—79% of team members surveyed indicated their progress in this area was *very good* or *outstanding.* All grantees made progress in this area and 11 of the 13 made notable progress. Grantees' work most often was related to:

- Strengthening care team infrastructure by clarifying roles and responsibilities and implementing or expanding huddles.
- Increasing the visibility of the care team through team branding, adding team members' names and credentials to exam rooms and after visit summaries, and increasing the use of "team talk" (e.g., "Your *care team* would like to follow up with you").
- Expanding care team members' roles and responsibilities.

We implemented a position called a lead MA, an MA that is responsible for a specific pod…With this experience, we're trying to get them working at the top of their license and give them things that are more exciting and rewarding.

Grantees worked to effectively distribute work across the care teams. Generally, this meant removing tasks from primary care providers while not overburdening other staff. Many of these efforts focused on ensuring that all members of the care team were working at the highest level of their scope of practice. About two-thirds of team members (65%) surveyed responded that their clinics' progress *expanding the roles of team members* was *very good* or *outstanding.*

Most EATC teams improved their care teams by focusing on five key roles: medical assistants (MA), front desk staff, nurses, flow coordinators, and/or behavioral health staff. Changes made to these roles allowed EATC teams to more effectively and efficiently address patients' needs and increase the overall level of support and interaction they have with patients, without relying on providers to do more.

Role	# of clinics reporting progress	Summary of work
Medical assistants (MA)	11	• Clarified and updated job descriptions • Expanded responsibilities to provide more patient support through standing orders (e.g., ordering labs and preventive screenings, prescription refills) and health coaching • Added or planned for more advanced MA roles (e.g., lead MA, health coach, patient navigator)
Nurses	8	• Positioning nurses to provide more direct patient care • Expanding nurse visits and implementing flip visits (see above) • Implementing standing orders for specific care processes
Front desk staff	9	• Inclusion of front desk staff as care team members • Giving front desk more ownership over the schedule, including communication about schedule changes • Integrating front desk representatives into care team huddles • Additional patient contact including phone intakes and reminder calls
Flow coordinator	7	• Added or strengthened this role to aid the overall functioning and efficiency of the care team • Positioned as the "hub" of the team to facilitate patient flow and communication
Behavioral health	4	• Integrated behavioral health staff into care team huddle • Established systems for warm hand-offs between the care team and behavioral health providers • Schedule changes for behavioral health staff to allow them to be more responsive to care team needs throughout the day (e.g., shorter appointments)

Role: Medical Assistants (MAs)

Grantees who made progress on team-based care all focused on maximizing the use of MAs—11/13 grantees made progress in this area. Teams expanded MA responsibilities to provide more direct patient support, which enabled MAs to take on care tasks previously done by physician and nursing staff. Several teams implemented standing orders for tasks such as: ordering lab work, some preventive screenings, and assisting with some prescriptions. In addition, a few clinics began to implement more advanced MA roles like lead MAs or health coaches.

➡ Livingston Health Center implemented an MA health coaching role, including training and support for the MAs, as well as a small pay increase. They built buy-in for the role and recognition that it was essential in providing necessary services to patients.

"The MA health coach piece is really looking at working at their highest level. Each of our providers has two MAs. They now have one MA plus an MA health coach. That is helping the teams work better together because [they are] working at their highest level."

Role: Nurses

Nine EATC grantees were able to strengthen the role of nursing staff in the care teams. They positioned nurses to provide more direct patient care by implementing expanded nurse visits and flip visits. Teams also implemented standing orders for specific care processes like diabetes care, depression screening, and iFOBT testing.

Flip visit

A primary care visit where a nurse provides a majority of care and the primary care provider comes in to review and approve the treatment plan.

➡ The San Francisco Health Network focused a majority of their EATC efforts on expanding and better utilizing the role of their Registered Nurses (RNs) and Clinical Pharmacists across four pilot clinic sites. They trained 18 RNs and two pharmacists in the network in health coaching for chronic disease management, and expanded RN chronic care visits. They also integrated a pharmacy representative into RN diabetes visits at one site. The team reported that these changes both improved access to and the quality of diabetes care at these clinics. The EATC work significantly lay the groundwork for ongoing team role development and expansion for diabetes and other chronic disease care.

Role: Front desk

A vast majority (9/13) of grantees made progress integrating front desk staff into the care team, which for many teams included a significant shift in the perception related to the role of the front desk staff. In practice, teams worked to give front desk staff more ownership over the schedule – empowering them to make changes in real time and establish systems to communicate changes to the rest of the care team. Several grantees also integrated front desk representatives into care team huddles to increase communication and collaboration. Some teams gave their front desk responsibility for conducting phone intakes and reminder calls.

➡ The EATC team from LA Christian Health Center's Joshua House clinic literally tore down walls to improve front desk staff's ability to serve and support their patients. Their front desk staff, called patient registration specialists (PRS), was redefined to give the PRS greater ownership of the schedule and more responsibility for managing the patient panel. The PRS was empowered to double book walk-in appointments in slots where patients had a history of no-showing. The PRS also worked to fit flip visits into the schedule and identify opportunities for patients to be connected with social work or behavioral health resources.

Role: Flow coordinator

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.

Over half (7/13) of EATC teams made progress implementing or strengthening a flow coordinator role. Three teams used the EATC program to pilot this type of role and reported that they successfully demonstrated the value of the position so that it will be sustained and in some cases spread after EATC. In general, this role was positioned to own the schedule. This included making changes in real time, moving patients around and fitting patients in as the day progressed, and helping scrub the schedule to ensure that all of the patients on the schedule needed and were ready for an in-person visit. In some cases, they helped do robust reminder calls. Where this role was successful, the flow coordinator was the hub of the care team and facilitated communication among the team and with patients.

The work [the PSR] does and how she knows her patients and understands the needs of the providers is exceptional…Continuity numbers that I think are legitimate are almost 100%"

- EATC technical assistance provider

➡ Mendocino Community Health Clinic focused their EATC effort on one pod within their main clinic to refine their already established flow coordinator role (called a patient services representative (PSR). The PSR was 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.

Role: Behavioral health

Many EATC grantees had behavioral health co-located with physical health the clinic site, but it was often a separate process for patients to access those services. Four grantees made progress integrating behavioral health roles into the care team, and it was a stated goal of several others.

To integrate behavioral health, clinics:

- Made changes to the behavioral health schedule (i.e., shorter appointment slots, slots blocked off throughout the day).
- Modified workflow to increase behavioral health providers' availability to primary care team members and allow for warm handoffs.
- Located behavioral health staff in the same area as the primary care team.
- Engaged behavioral health staff in care team huddles to increase communication between behavioral health and primary care staff and

give an opportunity to discuss which patients might benefit from behavioral health support.

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) were housed with medical services, participated in care team huddles and were available for warm handoffs. During the shorter behavioral health visits, the BHC conducted brief interventions (e.g. crisis, suicidal ideation, de-escalation), health coaching, or connected patients to longer term resources in the community that fit their needs.

They also collaborated with primary care staff to run group visits for patients with substance abuse issues and co-occurring disorders. Integration of behavioral health had strong support from both the behavioral health and primary care team members and clinic leaders suggested it has increased the clinic's positive reputation in the community due to the level of service they are able to provide.

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

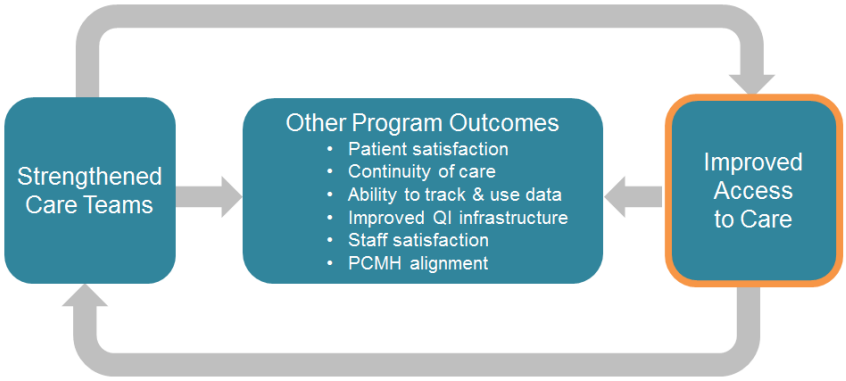
Factors in strengthening care teams

Grantees reported that strengthening their care teams resulted in empowering more clinic staff to be engaged in the work of the care teams. This helped improve relationships among care team members as well as between the care teams and their patients. Teams stated that the primary barriers to strengthening and improving the functioning of their care teams were:

- **Staff turnover/transition** – Grantees reported struggling to make progress in their efforts to refine and expand their team-based care model due to staff turnover and transition. They indicated that since team-based care relies heavily on relationships and trust, turnover could feel like "starting all over" with regard to team development. Furthermore, challenges with recruiting and retaining staff members contributed to some clinics being short staffed, which hindered their ability to focus on a program like EATC.

Thinking about the pyramid structure that was historically the case [in care teams], we are trying to tip that over…It's the job of the providers to start shifting that and empower the mid-levels.

- **Lack of provider buy-in** – Several grantees indicated that implementing team-based care required a shift in culture and mindset from how their providers were accustomed to working. Grantees reported that some providers struggled to let go of tasks and lacked trust that the other team members of the care team had the competencies necessary to provide high quality care. Due to the traditionally hierarchical structure of clinical settings where physicians hold a lot of the power, EATC efforts were stalled when providers were not bought into the team care model.



Improved access to care

EATC teams reported that access to their clinics was influenced by both internal and external factors, including significant changes in the health care environment such as health care reform and Medicaid expansion. External factors often resulted in demand outpacing the clinics' increases in capacity, but most teams still reported improvements in patient access to care as a result of participating in EATC.

The front office and back office are [jockeying] the schedule in an efficient way …If we have a patient who comes in early and have someone else no-show, we can move the early patient up. Then, we will have space later to accommodate walk-ins.

Twelve of the 13 EATC grantees reported progress in implementing access-enhancing strategies during the program. In addition, 11 out of 13 grantees reported improvements in operational metrics related to access.

Grantees made progress improving access to care by empowering staff members to take ownership of the schedule while expanding their care teams and clarifying roles and responsibilities. Empowered team members then implemented new strategies for maximizing capacity in the schedule, with guidance from EATC coaches at Coleman Associates. Almost two-thirds (64%) of surveyed team members rated their team's progress in managing the appointment schedule as *very good* or *outstanding*.

Most EATC grantees improved access to care by focusing on one or more strategies related to more effectively managing the schedule (strategies defined below):

- Simplifying the schedule template
- Jockeying the schedule
- Conducting robust reminder calls
- Scrubbing the schedule
- Strategic double-booking
- Scrubbing the schedule

A majority of grantees also worked to implement alternative visit types (e.g., group visits, flip visits). These strategies allowed EATC teams to more efficiently deliver care to patients, which was demonstrated by reported improvements in three access metrics:

Missed opportunities. The percent of unused appointments out of the total number of appointment slots.

No-shows. The percent of patients who did not keep an appointment out of the number of patients with an appointment scheduled.

Third next available appointment (TNAA). The number of days between a request for an appointment and the third available appointment slot for a regular return visit.

Strategy: More effective schedule management

Simplifying the schedule

Nine grantees reported simplifying their schedule templates. By reducing the number of visit types and visit lengths, care teams were able to work with a more flexible schedule and fit patients into the schedule more easily.

→ Valley Community Clinic implemented an advanced access scheduling system during EATC so that patients could call and get an appointment on the same or the following day. They reported this change keeps their TNAA at 1 and also reduced their no-show rates.

Simplified schedules helped some teams improve their TNAA metric and reduce the time patients had to wait for an appointment.

Jockeying the schedule

Jockeying the schedule

Making real-time adjustments to schedule changes that result from patient no-shows, walk-ins, phone triage, etc. to minimize the number of appointment slots that go unused each day.

Nine grantees reported implementing jockeying the schedule as a result of EATC, and front desk staff and/or flow coordinators were usually responsible for jockeying and communicating schedule changes to their care teams. Many grantees reported that jockeying the schedule was used to provide same-day appointments when possible. Most grantees that implemented this strategy also reported improvements in their missed opportunities metric.

→ At the Indian Health Center of Santa Clara Valley, MAs, front desk staff, and the newly added flow coordinator role were working together to jockey the schedule and maximize visits for walk-ins and phone triage.

Robust reminder calls

Most grantees (9/13) also reported implementing robust reminder calls, where the front desk staff or flow coordinator called patients before their scheduled appointments to confirm and make sure they have all the

necessary information ready for their appointments (e.g. lab tests and medication lists). If a patient was unable to confirm, the care team member could help reschedule or address the patient's needs. In addition, teams reported that a personal phone call helped build a connection between the care team and their patients.

→ The flow coordinator from Mendocino Community Health Clinic had built relationships with many of the team's patients and could encourage them to show up for scheduled appointments and provide support for their individual needs.

Robust reminder calls also helped some grantees reduce their no-show rates.

Scrubbing the schedule

When a member of the care team reviews the schedule a day or two ahead to check whether each scheduled patient really needs an in-person visit and that their charts are ready for an appointment.

Scrubbing the schedule

About half (5/13) of the grantees also reported scrubbing the schedule to ensure each patient really needs an in-person visit and that their chart is ready for an appointment. The flow coordinators or MAs were responsible for scrubbing the schedule in these clinics and the strategy may have helped reduce no-shows by removing unnecessary appointments from the schedule.

→ Northeast Valley implemented schedule scrubbing with robust reminder calls in an effort to reduce no-show rated. In addition, when they are scrubbing, when a patient is not scheduled with their assigned provider they look to see if there is a way to fit them into the assigned provider's schedule to improve continuity of care as well.

Strategic double booking

Three grantees developed systems to strategically double-book some appointment slots. In these clinics, the front desk staff or flow coordinator examined each scheduled patient's visit history to identify individuals who frequently no-show for their appointments and then double-booked their appointment slots with another patient. This strategy helped clinics reduce missed opportunities in their schedules.

Our clinical pharmacist sees patients with diabetes, HIV, medication adherence needs, and then will flip the visit over to the provider the patient is paneled to…it's working really well.

Strategy: Alternative visits

Ten grantees implemented at least one type of alternative visit, including: flip visits, group visits, behavioral health visits, or telephone visits.

Flip visits were most common (9/13) among grantees, building upon their work on strengthening care teams and expanding the roles of the nurse in patient care. Flip visits were successful among grantees who reported strong buy-in for team-based care, support from providers, and progress expanding the roles and responsibilities of nurses. Effective

Behavioral health visits

Where the primary care team either provides a warm hand-off to a behavioral health provider or integrates the patient's visit with a behavioral health provider into the primary care appointment flow.

Group visits

Visits that include group education and interaction as well as most elements of an individual patient visit, such as the collection of vital signs, history taking and physical exam.

implementation of flip visits also required effective communication between the flow coordinator/front desk and the rest of the team, to build flip visits into the schedule whenever possible.

→ LA Christian effectively implemented flip visits between the charge nurse and provider to give the nurse more responsibility in delivering patient care and create more time and efficiency in the provider's schedule. They also used flip visits to fit walk-in patients into the schedule when possible, with help from the front desk.

Group visits and behavioral health visits were implemented by about a quarter (4/13) of grantees. For example, Olive View reported using group visits for initial health assessments and diabetes self-management visits. And, as mentioned earlier, Hill Country started group visits for behavioral health patients with co-occurring disorder and for women being treated for substance abuse. Many other grantees reported an interest in implementing group visits, behavioral health visits, or both of these strategies in the future, if clinic space and resources allowed.

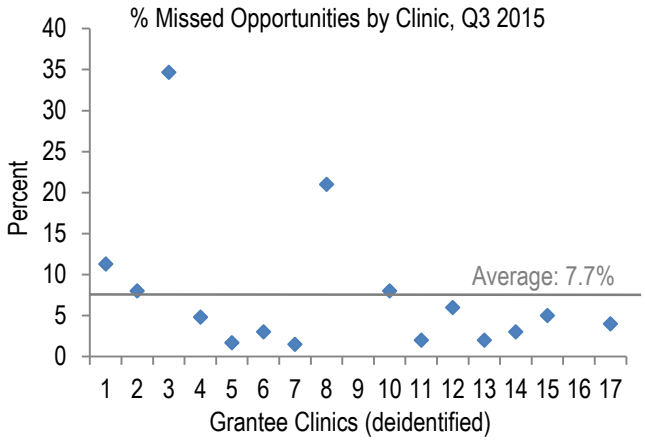
One grantee, Olive View, implemented telephone visits. When patients no-showed for a scheduled appointment, the provider used that open appointment slot for a telephone visit to try and reach the patient or follow-up with another patient. As a result, they reported improving its missed opportunities access metric.

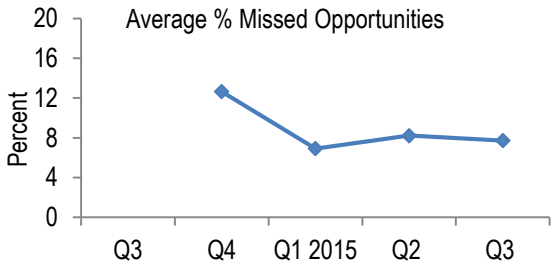
Outcomes: Improved access metrics

By implementing a combination of scheduling strategies and, in some cases, alternative visits, a vast majority of grantees (11/13) reported improvements in their access metrics. The majority of progress reported by grantees related to reducing missed opportunities, the operational metric that grantees had the most control over and could improve when empowering team members to more effectively manage the schedule.

Strategy	# of grantees	Access metric(s) targeted
Simplifying the schedule template	9	Missed opportunities; TNAA
Jockeying the schedule	9	Missed opportunities; TNAA
Robust reminder calls	9	No-shows
Alternative visits		
• Flip visits	9	
• Group visits	4	Missed opportunities
• Behavioral health visits	4	TNAA
• Telephone visits	1	
Scrubbing the schedule	5	No-shows
Strategic double booking	3	Missed opportunities

Missed opportunities





Definition

The percent of unused appointments out of the total number of appointment slots.

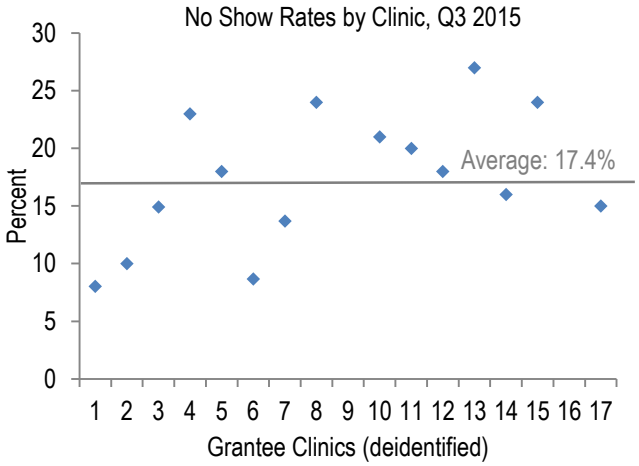
Improvement

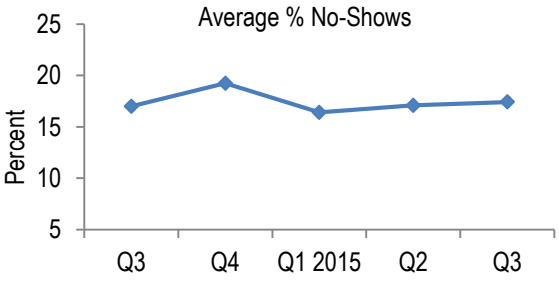
- 9 grantees improved their missed opportunities during the program.
- 5 of these grantees reduced missed opportunities by 50%or more.
- 7 grantees reported missed opportunities were at or below 5% (of their teams' total number of appointment slots).

Example of success

Share Our Selves significantly reduced missed opportunities by "letting the front desk staff…have more control over the scheduling and [doing] a really good job with [jockeying] the schedule."

No-shows





Definition

The percent of patients who did not keep an appointment out of the number of patients scheduled.

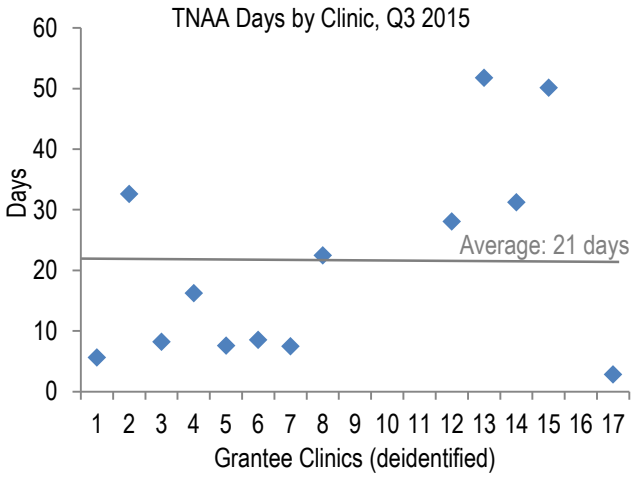
Improvement

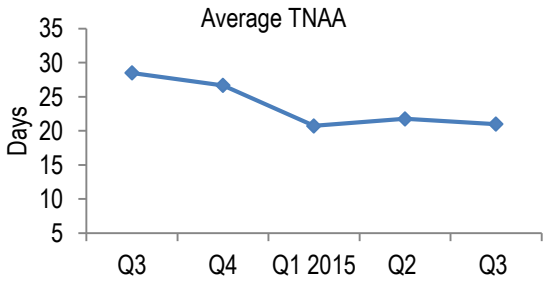
- 5 grantees improved their no-show rates during the program.
- 3 grantees reported no-show rates at or below 10% (out of the total number of patients with a scheduled appointment).

Example of success

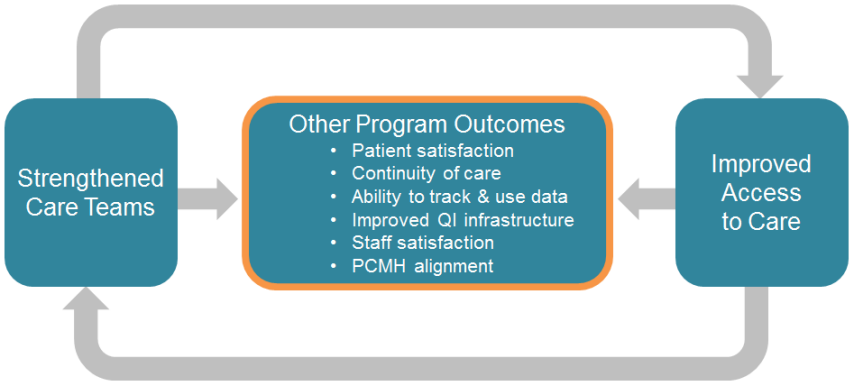
Northeast Valley Health Center implemented a combination of robust reminders and confirming appointments via text message to reduce no-shows.

TNAA





Access metric	Definition	Improvement	Example of success
Third next available appointment (TNAA)	The number of days between a request for an appointment and the third available appointment slot for a regular return visit.	• 3 grantees improved their TNAA during the program. • 4 grantees consistently reported strong performance on TNAA throughout the program, with wait times of 7 days or less.	Indian Health Center of Santa Clara Valley reduced its TNAA by 50 percent by implementing an MA flow coordinator who worked with the front desk to manage the schedule and jockey appointments.



Other EATC outcomes

In addition to strengthened care teams and increased access, EATC grantees reported improvements in several other areas—patient experience, quality improvement infrastructure and the capacity to track and use data, staff satisfaction, continuity of care for patients—as a result of participating in the program. Grantees reported that this progress aligned with and supported their patient-centered medical home (PCMH) objectives.

Improved patient experience

In general, patients at EATC clinics had high levels of satisfaction with the care they receive from their care teams. In the point-of-care survey implemented for EATC, a vast majority (over 90%) of patients from all of the teams consistently *agreed* or *strongly agreed* with the statement: “I receive exactly what I want and need from my care team exactly when and how I want and need it."

One patient pulled me aside and said that she noticed that her MA is more knowledgeable about her care in the questions she's asking and the time she spends with the provider is more productive as a result.

While patient satisfaction was high from the outset of the program, grantees reported that their progress in EATC positioned them to provide more timely and higher quality care, which resulted in improved patient experience. Specifically, care team members reported that they had improved their communication and relationships with their patients; their impression was that patients noticed and were happy with the changes they had made.

Improved data capacity & infrastructure for quality improvement (QI)

To implement the changes in team function and fulfill the quarterly data reporting requirements, team members had to test different practices, monitor results and make adjustments as needed. Teams reported that the program helped them “become more proficient in the use of data,” which improved their ability to collect, report and use data to make decisions.

To paint the picture in terms of access, before this program out TNAA was 9 months or more. Now we can see patients on the same day for walk-ins. It has been really great.

A vast majority of team members surveyed (84%) reported that they were either *somewhat* or *much more confident in engaging in QI projects as a result of EATC*. A few team members highlighted the benefits of the QI tools and approaches (e.g., PDSA cycles) they learned from EATC as key benefits to improving their work going forward.

Increased staff satisfaction

Successful team-based care is highly dependent on the buy-in and engagement of individual care team members and significantly impacted by turnover. One of the goals of expanding team member roles is to increase staff satisfaction and retention. EATC grantees reported increased staff satisfaction as a result of the changes made to team roles during the program, many of which gave members more responsibility for elements of patient care. One team lead summed it up this way:

> *One, providers are happier because they don't have to do clerical work anymore; they use that time to do telephone follow-up visits. They are more satisfied and also helped us improve access. Two, RNs are happier because they feel like they are involved in providing care to patients. They're so excited to do nurse visits and are happy to be doing blood pressure checks and medication*

adjustments. We took some things off their plate and gave it to the MAs. Three, MAs are happier because they are working with the providers more closely and are building a relationship with the patients. [They have] more contact with the patients because they are following up with labs or receiving the calls from the patients and screen them for appointments. They feel like they are part of the team, not just doing the same thing over and over again.

Improved continuity of care

A goal of EATC was to improve continuity of care for patients at participating clinics. One clinic anecdotally reported a significant increase in continuity rates to 70% as a result of some of the tactics they employed through EATC (e.g., schedule scrubbing).

However, teams qualitatively reported less progress in this area and, in general, indicated that they continue to struggle with continuity. They said that there is agreement across the clinic that it is an important goal, but reported that there is an ongoing tension between improving access—getting patients in as soon as possible—and ensuring continuity of care.

Alignment with PCMH efforts

Teams consistently highlighted the alignment between their EATC work and PCMH efforts, both in terms of building care team infrastructure and helping with increasing QI and data capacity. Most EATC teams had goals to obtain or spread PCMH status in their clinic organization and reported that they were better positioned with regard to PCMH certification. One team stated:

Our clinic was selected to start PCMH certification [out of several in their organization] because of the EATC knowledge we gained – the standing orders and how we strengthened team functioning. I consider that a very big benefit of the program and it wouldn't have happened without it.

NCQA Patient-Centered Medical Home (PCMH) Recognition

The patient-centered medical home is a way of organizing primary care that emphasizes care coordination and communication to transform primary care into what patients want it to be. Medical homes can lead to higher quality and lower costs, and can improve patients' and providers' experience of care.

Source: http://www.ncqa.org/Programs/Recognition/Practices/PatientCenteredMedicalHomePCMH.aspx

Sustainability & spread

EATC grantees reported high likelihood of sustainability for the changes they made during the program and anticipated they would continue to build on their work.

Grantees overall reported that they were confident that their work would continue beyond the grant period. They indicated changes that supported expanded care team roles like standing orders, flip visits, schedule management tactics, and huddles had been integrated into clinic practice and systems.

Furthermore, grantees anticipated that they would continue to build on their EATC work by spreading successful practices to additional care teams and clinic sites. Some grantees used EATC to pilot new roles or practices in one care team or clinic site to refine processes and build buy-in and support.

Northeast Valley successfully implemented a flow coordinator role in their Santa Clarita clinic and were able to demonstrate the value of that type of position to leadership. With leadership support, they were able to integrate funding for this role in the organizational budget going forward. In addition, they dedicated staff and developed a process to spread the role throughout the organization.

In addition to sustaining and spreading what they had implemented during EATC, some grantees anticipated that they would adopt promising practices that they were exposed to during EATC, but had not yet implemented—like alternate visits, flow coordinator role and advanced MA roles.

Factors influencing progress in EATC

EATC grantees were affected by a number of factors that supported or impeded their progress and impact. These factors are similar to what other practice transformation and quality improvement efforts have faced in the past, including both internal clinic factors and external influences.

A vast majority of teams reported that key factors that helped them make progress and be successful in their EATC work included:

I think [the work we did during EATC] is going to stick. I credit that to executive leadership – they are wanting to see it stay and are really enculturating it. It has become part of our language and how we take care of our patients.

- **A supportive work environment** – Teams reported that having colleagues who were mission-driven and focused on what was best for patients helped to implement and sustain positive changes.
- **Support from clinic or organizational leaders** – Grantees whose leaders understood the value of EATC, actively supported their clinic teams, and engaged in helping to manage change were able to make more progress and spread successful strategies more effectively. Leaders who saw alignment between EATC and other organizational priorities (e.g. PCMH) were particularly supportive.
- **QI infrastructure and clinic data capacity** – Teams who had an existing foundation of internal QI knowledge and data collection and analysis were able to make data-driven decisions during EATC and demonstrate their success to staff and leaders.

In addition, when clinic goals aligned with program goals, the evaluation found that engagement in EATC including accessing technical assistance resources contributed to teams' progress.

The challenges that impeded teams from making progress were mainly internal factors. The biggest challenges reported by teams related to **staffing**, including: turnover, transition (e.g. staff taking on new roles or leadership positions), recruitment (particularly for providers), and retention. These staffing issues are particularly challenging when working on team-building, where the team's success relies on the individuals involved, their knowledge of clinic operations, team dynamics, staff relationships, and personalities.

Other key challenges teams reported were:

- **Space** – Many clinic organizations did not have enough room to effectively implement a comprehensive team-based care approach. Clinics often had floorplans that did not facilitate effective communication and work flows because team members could not sit together. In addition, grantees reported not having enough exam rooms to move patients through effectively or big enough rooms to facilitate group visits.
- **Competing priorities and rapid growth** – Safety net clinics were balancing myriad demands while engaging in EATC (e.g., changes to Medi-Cal programs, PCMH, ICD-10 implementation) and overall these demands outweighed the capacity grantees had in terms of time, funding, staffing, and other resources.
- **Resistance to change and change burnout** – Initiating and successfully implementing changes was challenging on its own. Sustaining and spreading changes throughout and across teams and clinics was even more challenging. EATC grantees reported having to grapple with an unrelenting stream of changes and needing additional support on how to manage change and build staff buy-in.
- **Provider buy-in** – For some grantees, the shift to team-based care was a significant adjustment in how to deliver care. This shift extended deeper than staff workflows and required a culture change in how the people in the clinic work together. Grantees reported that providers were key to moving this culture change forward and cementing team-based care in the clinics. When there was a lack of buy-in from providers, then progress was significantly challenged and teams tended to stall.

We worry about overwhelming our staff. It's good to have change, but it's hard to have a lot of change. That's our main challenge. It's exciting, but it's hard work.

Some grantees also noted that the external environment of health care reform and Medicaid expansion made it difficult – if not impossible – for clinics to increase their capacity enough to meet the rising demand for services.

Participation in EATC

Overall, EATC grantees reported high levels of satisfaction with their participation in the program and the progress they made strengthening their care teams and improving access. A vast majority of survey respondents (94%) said they were *satisfied* or *very satisfied* with their participation in EATC. The program provided focus and momentum to change the way grantees delivered care—the "time and space to think about process improvements." Grantees reported the program structure and pace supported their efforts and increased their knowledge and confidence, which positioned them to move forward with broader clinic transformation goals (e.g., implementation of patient-centered medical home).

EATC consisted of:

- **Grant funding** ($50,000-$75,000)
- Two **in-person learning sessions**
- Monthly **webinars**
- **Training, technical assistance & individualized practice coaching** from Coleman Associates & Dr. Carolyn Shepherd
- **Training & resources** from the MacColl Center for Health Care Innovation
- **Support & technical assistance** from CCI
- **Site visits** to primary care clinics with exemplar practices related to team care (supported with additional funding from the Hitachi Foundation)

All of the grantees indicated that CCI effectively coordinated the program, including their organization, planning, and communication. The structure provided by CCI helped grantees feel well supported, while keeping them accountable and "on track."

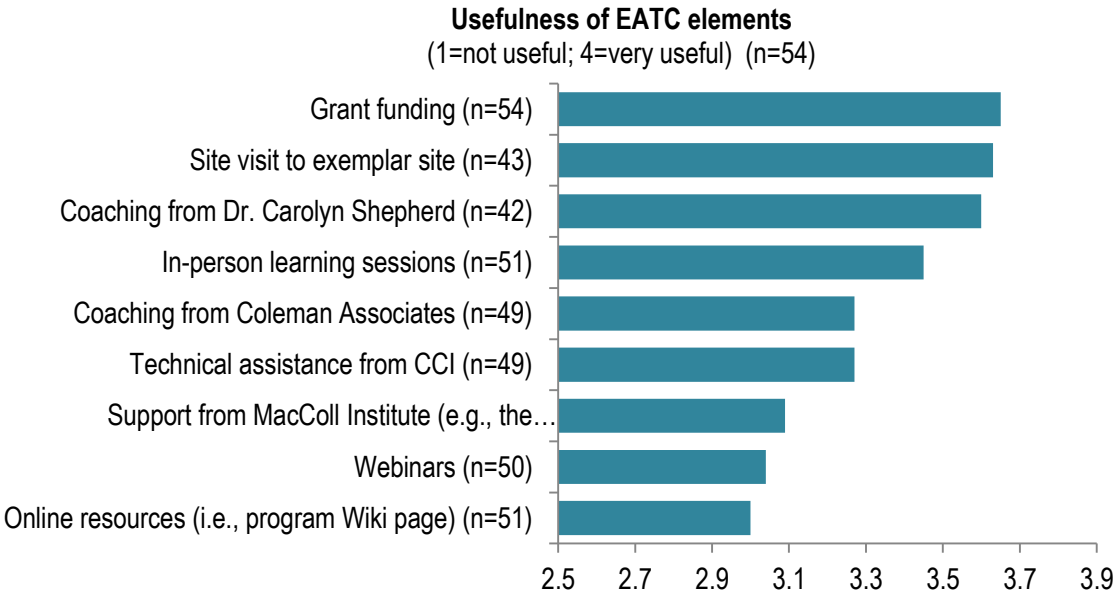
Relative value of EATC elements

Most grantees indicated that EATC provided a package of resources and support that worked together to foster engagement, facilitate learning, build capacity, and improve care team practices. Overall, there were not any components that grantees would suggest eliminating.

Here is [an exemplar] clinic that knows how to succeed and you get to witness that. [We] got to see how it works, and ask questions, and shadow the counterparts….the wealth of knowledge that you gain in two days is probably worth 100 hours of meetings.

When asked which program elements most contributed to their progress, grantees stated that the funding was essential for dedicating time and energy to the effort. They reported a preference for practical support that helped them to apply new ideas to their work, highlighting the in-person learning sessions, the technical assistance and practice coaching, and the exemplar site visits. Grantees appreciated how the program provided "access to experts" and facilitated peer idea exchange and networking. They indicated there was value in hearing about the work of other clinics, learning what has worked and what has not, and gathering ideas and tools to take back to their own clinics. Furthermore, a majority of grantees reported that the practice coaching provided by Coleman Associates and Dr. Carolyn Shepherd helped them to translate learnings to their clinical setting and make progress in key areas including improved access

through more efficient scheduling practices and continuing to build leadership support and investment in team-based care approaches. See Attachment B for additional detail on various elements of EATC.



IV. Conclusion

The EATC program effectively provided a package of resources and support that helped grantees strengthen care teams and improve access.

Grantees reported **notable progress in clarifying and expanding the roles of several key care team members**—MAs, front desk, nurses, flow coordinators, and behavioral health staff. They indicated that changes made through EATC resulted in more effectively distributing work across the care team, empowering team members to take on new roles, and ensuring team members were working at the full extent of their skills and competencies.

Shifts in care team roles contributed to process changes and efficiencies that helped increase access. Through EATC, teams gave the front desk or flow coordinators more ownership over the team's appointment schedule and implemented a variety of tactics that allowed them to **maximize the capacity in their schedules**—e.g., moving patients around on the schedule in real-time to ensure all the of slots were filled or conducting robust reminder calls. As a result, 9/13 EATC grantees improved their missed opportunities rate (i.e., percent of unused appointments out of the total number of appointment slots) during the program; five of those improved by 50% or more.

Grantees also implemented **alternative visits**—other types of visits beyond an in-person, face-to-face visit with a PCP—as a mechanism for

increasing access. Nine grantees leveraged the expanded nursing role by implementing flip visits to help increase the capacity and efficiency of the schedule and better meet the needs of patients in a timely way.

EATC grantees also reported positive impact in several additional areas, including improved:

- Patient experience
- Ability to track and use data
- Staff satisfaction
- Continuity of care for patients

Most of the grantees indicated that **key changes would likely sustain beyond the program** and they would continue to build on the work done during EATC. Grantees reported an ongoing focus on spreading successful care team practices to other teams and clinic sites. In addition, several grantees were committed to adopting promising practices—like adding group visits, a flow coordinator role, or more formal MA roles—that had been explored and planned, but not fully implemented during the program.

The PCMH team will be able to build on what we learned in EATC. We will have more champions and more buy-in for what we have already tried and what we can roll out. It serves as the foundation. It's the concrete and now we can start building.

In general, participation in EATC boosted grantees' quality improvement infrastructure. Evaluation results suggest that grantees were most successful when EATC participation aligned with and could be leveraged to support other internal priorities, particularly PCMH efforts. Grantees reported that EATC's emphasis on strengthening team-based care and requiring grantees to track and use data for performance improvement **better positioned them to obtain or maintain PCMH accreditation**.

Overall, grantees had high satisfaction with the EATC program and most indicated they would be interested in participating in a program like EATC again so they could work with another team or site on making improvements in team-based care and access. In particular, grantees benefited from the opportunities for peer learning and support, access to "experts" and resources, and individualized practice coaching and technical assistance.

Recommendations for consideration

Grantees appreciated the opportunity to participate in a program like EATC and indicated that ongoing investments would help clinics respond to the continuous changes and challenges in the health care environment, including strengthening the patient-centered approach to increasing capacity to meet the growing demand for services. They had the following suggestions for optimizing support to the safety net going forward:

- **More robust support around strengthening teams.** Grantees were committed to the team care approach, believed their future success

relied on high functioning teams, and talked about needing practical support around how to this effectively. Several grantees commented that they needed additional support around the "soft skills," instruction on team building, improving team dynamics and building trust.

- **Provide additional structure around the available technical assistance/practice coaching.** All of the EATC clinics accessed TA in some way and satisfaction with the support provided was high. However, some clinics suggested that they did not know how to best utilize the available TA resources until later in the program.

- **More focus on change management, leadership, sustainability, and spread.** Grantees reported these ongoing challenges at the end of EATC. Several of the clinics were struggling with how to build on the progress they had made and continue to facilitate changes in other areas of their organization.

- **Continue to foster peer exchange and learning.** EATC grantees stated that change work is ongoing that they are "always going to be leaning on somebody" and highlighted the benefits of learning from their peers. Grantees requested ongoing forums to continue to connect and obtain support from other clinics, as well as "experts."

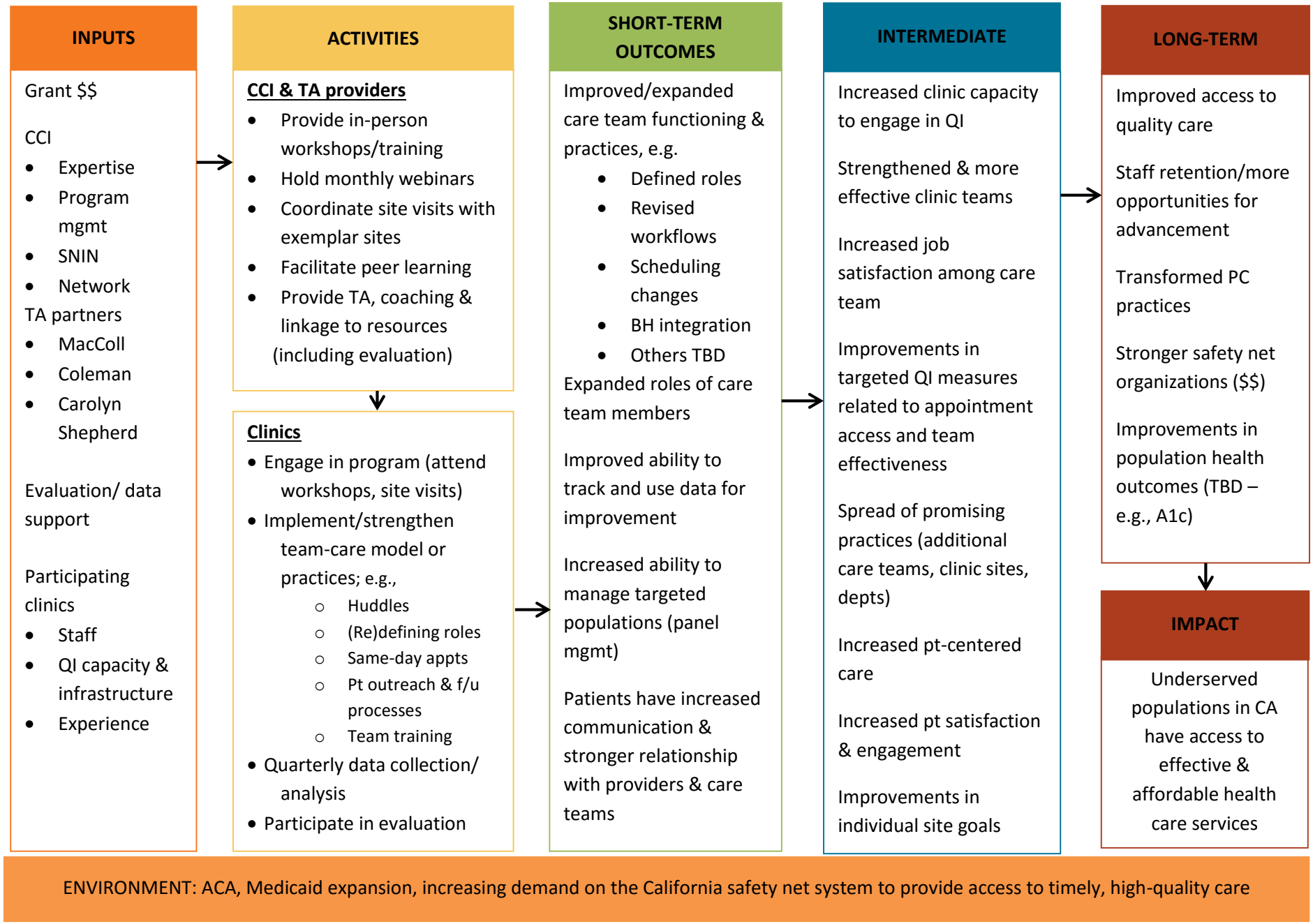
    - ***Support clinics with opportunities to site visit other high performing organizations.*** Although resource intensive, grantees highlighted the usefulness of site visits because attendees could efficiently connect with staff members at the site who are experienced in doing the work and gather practical knowledge and resources.

- **Situate workforce development as a core component of a program.** All of the EATC clinics were struggling with demand that outweighs capacity and exploring ways to maximize supply—i.e., freeing up provider time by shifting responsibilities to other care team members and recruiting and retaining providers and staff. There identified the following for digging deeper in these areas.

    - ***Helping clinics better understand California scopes of practice.*** There was a lot of confusion among EATC clinics related to what is allowed and not allowed when it comes to other care team members delivering patient care.

    - ***Support clinics in exploring opportunities for MA advancement.*** By the end of the program, several EATC grantees were thinking about the career ladder for MAs within their organization and potential changes to ensure that appropriate incentives are aligned with roles and expectations.

Attachment A: EATC Logic Model



Attachment B: Benefits and challenges of EATC elements

EATC element	Reported benefits & challenges	Grantee quote(s)
Funding	Funding primarily contributed by supporting: • A few grantees to hire key support staff to advance their EATC work (e.g., project coordinator, clinic staff) • Staff time and travel for EATC events—in-person sessions and exemplary site visits	*"The funding allows you to do things that you normally cannot do…[it's] not a significant amount of money, but it does make a difference."*
Exemplar site visit	Exemplar site visits were useful to: • See a clinic that is successful in action and talk to the staff who are doing the work; the experience was "eye opening" for many clinics • Identify resources from the clinics site visited (e.g., scheduling templates, training curricula, standing orders) Challenges included: • Difficulty translating what was observed and learned at the site visit to the reality of the grantee clinic • Timing—grantee needed to be far enough along to have goals and not be overwhelmed, but some thought it would have been beneficial to do earlier in order to leverage the EATC TA in helping them operationalize what they learned	*"Here is a clinic that knows how to succeed and you get to witness that. [We] got to see how it works, and ask questions, and shadow the counterparts….the wealth of knowledge that you gain in two days is probably worth 100 hours of meetings."*
In-person learning sessions	In person sessions were highlighted as having: • Shared useful content, tools and resources • Facilitated peer exchange • Strengthened teams—including engaging clinic staff typically not involved in these types of efforts • "Inspired" and built momentum Grantees highlighted potential challenges in taking information back and applying it	*"We brought a provider to one workshop, [and it], changed her mindset about why we do things."*

EATC element	Reported benefits & challenges	Grantee quote(s)

Technical assistance (TA) & practice coaching	The aspects of TA & practice coaching that were perceived to be the most useful were:
	• Access to "experts"
	• Individualized, practical TA
	• Support received from Coleman Associates and Dr. Carolyn Shepherd:
	  ○ Dr. Shepherd: site visit was most useful; she gave recommendations related to her observations and effectively communicated to various clinic staff, particularly leadership
	  ○ Coleman: effective strategies to improve access; specificity in the "playbook" was helpful
	Suggestions for improvement included:
	• Establishing more structure around ongoing TA (e.g., regular mentorship calls)
	• More specific instruction related to team-based care models
		"We've been doing a lot of work in team-based care and have a lot in place, but have a hard time taking it to the next level. Access to experts is helpful."
		
		"*Dr. Shepherd came here and was able to talk to us and give us specific ideas. That was worth wheelbarrows of gold."*

Webinars	Webinars were useful for: • Sharing content, tools and resources • Accountability and keeping grantees on track, particularly at the beginning of the program • Facilitating peer sharing Suggestions for improvement included: • More topic-specific sessions with additional focus and in-depth instruction • Altering the format or facilitation of the discussion, which was difficult sometimes and grantees struggled to engage	*"There's always a little something to learn when hearing how other clinics talk. Something to take away. [The webinars] keep you engaged, too, in the project."*