CIN Partners Share:

Trends in Serving Patients Inside and Outside the Provider Office

Main Takeaway:
Organizations are improving primary care by providing convenient and coordinated health and wellness services through enhanced in-person and remote encounters.

The February 2016 meeting of the California Improvement Network (CIN) focused on innovative ways that organizations are providing care inside the provider office, as well as in people's daily lives outside the provider office through the use of new technologies and distributed care sites. Presentations were provided by Asian Health Services, Petaluma Health Center, the California School-Based Health Alliance, and Dignity Health.

Asian Health Services www.asianhealthservices.org

The CIN partners visited the newest clinic site of Asian Health Services (AHS), a Federally Qualified Health Center in Oakland. The Rolland and Kathryn Lowe Medical Center opened in fall 2013 at a busy intersection in Oakland's Chinatown, with many facility design elements and technology tools to serve its patients and staff, and the community. Of the 25,000 patients AHS serves at its three clinic sites, 75% are best served in a language other than English, and 20% are over 65 (compared to the national average for community health centers of 7%). Collectively, the AHS staff speaks 12 Asian languages.

Funding that became available through the Affordable Care Act and a 5,000-patient wait list spurred AHS to open this new clinic site, though finding a building in Chinatown was a challenge. AHS's ties to the community provided a solution.

> "On a tight timeline to find a neighborhood site for our new clinic, our community connections came to the rescue. The famous dim sum restaurant Silver Dragon was closing, and the owners wanted to contribute to the community after 30 years of business. They heard that AHS was looking for a Chinatown location for a new clinic site, and the deal was struck. AHS renovated and retrofit the three-floor, 17,000-square-foot building to house the Asian Health Services brand of community-engaged care."
>
> —Nghe Yang, MD, site director, Rolland and Kathryn Lowe Medical Center

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Photo courtesy Asian Health Services

The Expanded Care Team

The new clinic site was designed for a growing primary care team, which includes the following roles:

- **Primary care provider:** The clinical expert delegates and coordinates care with a newly expanded team.
- **Health coach:** All medical assistants complete a 12-month in-house curriculum to become health coaches to support preventive care and patient health management goals, and also reconcile medications. Each health coach is paired with a provider and escorts patients throughout their visit. All health coaches speak English and at least one other Asian language spoken by AHS patients.
- **Behavioral health clinician:** A licensed social worker or other clinician takes referrals and warm handoffs for therapeutic interventions, case management, or both.
- **Medical social worker:** A recent addition to the care team, the social worker manages care for a small group of patients with complex needs.
- **Single-point-of-care nurse:** This nurse focuses on the care and support needs of patients transitioning from hospital to home.
- **Floor lead:** Each floor has a lead — a licensed vocational nurse — to support visit flow and serve as a floating health coach.

Space for Expanded Care Teams

The second and third floors of the clinic contain exam rooms and workspace for the expanded care teams. Active physician participation in the facility design process resulted in a floorplan that supports team-based care and health coaching. Care teams are split between floors: The second floor is adult internal medicine with a focus on geriatrics, a reflection of the volume of senior patients served by AHS, and the third floor is family practice. This separation allows the teams to specialize. Color branding helps patients and staff distinguish the two floors.

"We see ourselves as not only a health clinic. We also address community health and do advocacy. We try to stay ahead of our time."

—Nghe Yang, MD, site director, Rolland and Kathryn Lowe Medical Center

On both upper floors, exam rooms surround an open pod design workspace for providers, health coaches, and other care team staff, which facilitates intra-team communication. This central workspace is separated from the path of travel by a five-foot-high cubicle-style wall with a transparent upper section, which allows team members to see when patients are escorted into exam rooms. These walls ensure the privacy of clinical conversations and keep noise to a minimum.

There are 10 exam rooms on each floor, with each provider-based team assigned two rooms. Additional rooms are used for health coaching and behavioral health visits. For urgent care visits, there is a nurse triage room on each floor with two doors: one for quick access for patients coming from the street, and the other for quick access for nursing staff from the team pod side. These rooms can be used for nurse-provider co-visits as well. Point-of-care tests are processed on each floor, minimizing delays and travel time.

Standard office visits last 20 minutes, which allows providers to complete chart notes as they close the visit. The productivity expectation is 17 visits per day, with the appointment schedule holding 20 appointment slots. The visit no-show rate stays around 10%.

Features of the exam rooms allow efficient, patient-centered, and complete care:

- There is a logical path of entry and exit for patients.
- Doors open in, with exam beds located behind the door, to allow privacy.
- Lights and faucets are triggered by motion sensors.

- Frosted glass windows in exam room doors offer simple visual cues to determine occupancy: Is the light on or off?
- Vitals sync to the electronic records system.
- Audiovisual equipment supports video interpretation for more than 12 languages spoken by patients.

On the first floor, staff who handle appointment registration and insurance eligibility sit at movable workstations to welcome patients to the clinic and support efficient wayfinding. In addition to these stations, the clinic plans to install several self-service kiosks, which patients can use to schedule appointments, receive health education, and access personal health information through the electronic records portal. The flexibility provided by the moving workstations and the planned kiosks allows the group floor space to be used for community events. Fixed private workstations in the rear of the ground floor are used by patient navigator staff to conduct care coordination and care management with patients.

Success and Spread of the New Site Design and Care Model

AHS is working to spread the care model and team-based pod design of its newest clinic to its other two sites. Providers report that the older clinics feel chaotic and lack privacy for patients, whereas the Lowe clinic feels much more peaceful and facilitates communication between staff and patients. AHS plans to renovate its original clinic site, just across the street from the Lowe clinic, to reproduce the pod seating, visit flow, and other features of the new site.

Measures of patient experience at the Lowe clinic, as documented by a recent Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, met AHS's Medi-Cal health plan benchmarks and were higher than other AHS sites. A recent comparison of visit cycle time across all three AHS sites found that the Lowe clinic's visits were the most efficient, at 44 minutes.

Petaluma Health Center www.phealthcenter.org

Petaluma Health Center is a Federally Qualified Health Center with two large sites, two school-based health centers, and a clinic that serves homeless patients. PHC serves about 25,000 patients, of whom 45% have insurance coverage by Medi-Cal, 8% by Medicare, and 16% by private insurance including Affordable Care Act insurance products. Most of the remaining 31% of PHC's patients are uninsured. PHC's provider staff is equivalent to 22 full-time providers, the majority of whom are family medicine practitioners. Dental care is also available.

In 2011, the main Petaluma clinic moved from a 15,000-square-foot building to one of 40,000 square feet. In this new space, PHC provides a range of wellness services, including group visits, group fitness classes, and a garden and demonstration kitchen to support healthy eating.

"We focused on developing a healing environment for our patients, more welcoming than the usual health care facility."

—Danielle Oryn, DO, MPH, chief medical informatics officer, Petaluma Health Center

All aspects of the building, from the entry to the front desk to the hallways, were designed to create a calm, warm environment. Colors were carefully selected, open spaces with high ceilings were included, and a café-style welcome area was situated by the front desk. A curved hallway connects provider visit spaces with spaces for dental and pharmacy and other services.

Care Team

Similar to the AHS site, the care team areas at PHC seat care team members together at workstations. Team members include four medical assistant and provider pairs (teamlets), nurses, one referral coordinator, call center staff, and a flow coordinator. Integration of call center staff into care teams has improved team communication and service. The flow coordinator is a specially trained medical assistant who manages the daily staff huddle and facilitates patient visit flow throughout the day.

Opportunities for Wellness

Petaluma Health Center's new facility supports patient and community-member health in more ways than traditional provider-based care services:

Petaluma Health Center's care teams include multiple provider-MA pairs, who share workstations in a "team room" served by a flow coordinator.
Photo courtesy of Center for Care Innovations

- In the demonstration kitchen, staff lead nutrition education and cooking groups for patients, including specific groups for those with pain management and weight management needs.
- The community garden on the clinic grounds is maintained by an intern and is managed in partnership with a community-based organization whose mission is to provide healthy foods to the community. The clinic nutritionist integrates the garden's produce into group visits, including the pediatric obesity prevention "Petaluma Loves Active Youth" program, which harvests vegetables and herbs to use in menus created in the test kitchen.
- Group visits include shared medical visits, pain management groups, and group acupuncture.
- The movement room holds group exercise classes, which are available to patients and community members for a small per-class fee. Classes include mindfulness-based meditation, Zumba, and yoga.

California School-Based Health Alliance www.schoolhealthcenters.org

Along with design and staff team changes within health care facilities, primary care is evolving to provide care outside of the office setting, to make care available where people live, work, and play. One of the most well-established examples of this is school-based health centers (SBHCs). SBHCs are dedicated clinical spaces that operate within, or in close coordination with, a school to provide primary care, health education, and other services. Common additional services include behavioral health, reproductive health care (in middle and high school settings), nutrition and fitness programs, and dental care. SBHCs are staffed by at least one provider who can diagnose and treat patients, and are distinct from a school nurse program (the two services generally work in tight collaboration). Many SBHCs provide care for community members and students' family members, in addition to students at the school.

Bus Drivers and Cafeteria Workers on the Care Team

A bus driver noticed a 6-year-old student stumbling to get on and off the bus. The driver reported the incident to school staff and helped the SBHC staff locate the student. A medical examination eventually revealed a brain tumor.

At another school, cafeteria workers noticed students' forearms covered in cuts and burn marks as they reached for food trays. The SBHC responded quickly with increased self-injury screening and behavioral health care.

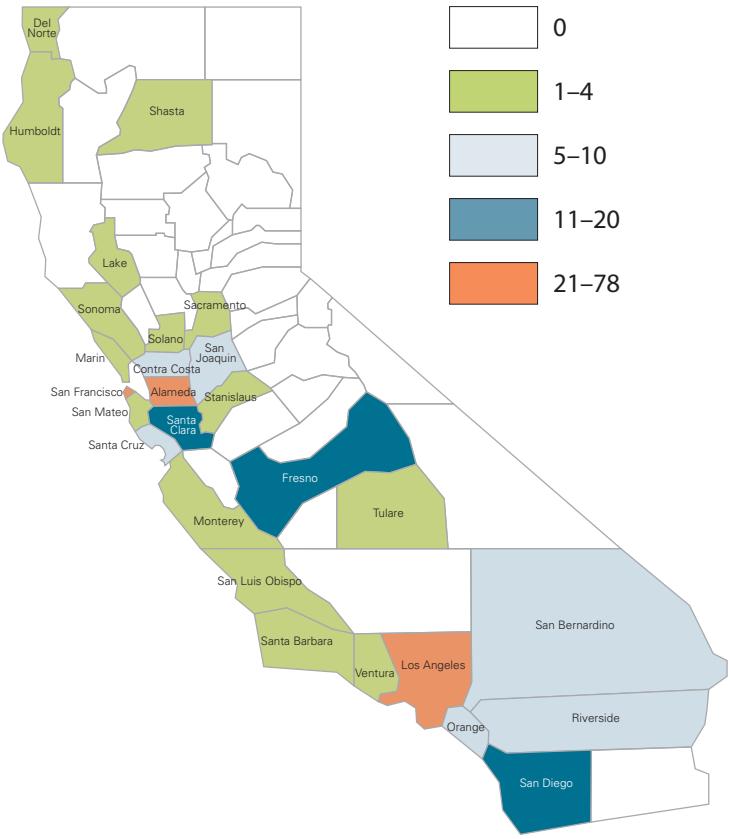
SBHCs are able to engage in population health work for the whole student body, such as schoolwide screenings for asthma or trauma. SBHCs are also able to focus on patients who need intensive support in managing behavioral health and primary physical health issues. SBHCs at the middle school and high school level use a model of youth engagement to develop cohorts of peer educators and advocates to address nutrition, exercise, intimate partner safety, and other population health issues.

In California, the number of school-based health centers is growing: from 108 in 2000 to 243 currently. SBHCs have varied business models and management structures. Some are operated by school districts; others are satellite sites of FQHCs or the county health agency. There is no dedicated state funding for SBHCs in California as there is in many other states. SBHCs are funded through a mix of state programs including the Child Health and Disability Program (a Medi-Cal program), Family PACT, and Medi-Cal insurance coverage, as well as school district contributions (including in-kind donations of facility space), grants, and sponsoring-agency subsidies.

California's 243 School-Based Health Centers

Number of school-based health centers per county

Alameda	27
Contra Costa	8
Del Norte	1
Fresno	11
Humboldt	1
Lake	1
Los Angeles	78
Marin	2
Monterey	3
Orange	8
Riverside	6
Sacramento	3
San Bernardino	7
San Diego	16
San Francisco	22
San Joaquin	7
San Luis Obispo	2
San Mateo	2
Santa Barbara	1
Santa Clara	13
Santa Cruz	6
Shasta	1
Solano	3
Sonoma	4
Stanislaus	4
Tulare	4
Ventura	2



Source: California School-Based Health Alliance

Being school-based allows health center staff to be in frequent — often daily — contact with students, school staff, and community members, which promotes open communication and is a key in building trust with the adolescent population. Students grow to become familiar with the SBHC care providers, who follow strict privacy rules: health care's Health Insurance Portability and Accountability Act (HIPAA) and the education system's equivalent, the Family Educational Rights and Privacy Act (FERPA). The relationships that develop between SBHC staff, teachers, and other school staff allow for proactive care for students that would not be possible without this clinic-school integration.

In SBHCs where community members are served as well as students, people who find this care location most convenient are parents and siblings of students as well as close neighbors of the school. SBHCs who serve community members must manage these two populations carefully, to retain the student-focused and student-friendly culture of the clinic while also providing a good care experience for the nonstudent patients.

Dignity Health www.dignityhealth.org

Nonprofit Dignity Health (formerly Catholic Healthcare West) owns and operates hospitals in three states. Its ancillary care sites, such as specialty care provider offices and urgent care clinics, are in 20 states. As Dignity Health transitions from being hospital-centered to addressing more outpatient care needs, it is focusing on ways to support health care consumers to take action before entering a Dignity facility.

Extending Services Through Strategic Partnerships and Digital Solutions

The wide range of new options for consumers to engage in care services through technology-enabled tools is what Dignity Health calls "the digital front door." For example, Dignity has partnered with Airstrip (www.airstrip.com), a mobile

patient monitoring and team communication platform for obstetrics, and is exploring a partnership with Doctor on Demand (www.doctorondemand.com) to provide video visits for medical and behavioral health needs.

Dignity is also pursuing partnerships that would expand its services to the community. For example, it has a partnership with naviHealth (http://navihealth.us) to provide post-acute care and is exploring partnerships with One Medical Group (www.onemedical.com) to extend primary care access and GoHealth (www.gohealthuc.com) to extend urgent care access.

As it launches new services, Dignity and its partners use a structured three-step process called: "Run, Run, Jump." The first "run" is a one-site pilot; it is followed by a second run pilot in a significantly different site (e.g., if the first run was urban, the second could be rural). The "jump" is the anticipated full implementation across all Dignity facilities or services after two successful pilots. To select which new products and services it will test, Dignity requires the innovation to have a Dignity champion identified at three levels: executive, management, and frontline-provider.

Dignity is engaged in a long-running pilot program with Propeller Health (www.propellerhealth.com) to support patients with asthma.

Dignity Health's Partnership with Propeller Health

Dignity Health began its partnership with respiratory health management company Propeller Health in 2012. Dignity was seeking new ways to track the health status and symptom management of the growing number of patients with asthma and respiratory allergies seen in their Woodland (Sacramento area) specialty care clinic, and to support these patients' self-management. The Propeller Health product is a sensor that sits atop an asthma medication inhaler and sends data on medication use to a smartphone app for personal symptom monitoring, and to a provider-based data analysis platform.

This population-level data on symptom management that the Propeller device provides allows providers to focus their attention on those patients who need more education and support in managing their illness. "We can see this information for someone who is 400 miles away," said Rajan Merchant, MD, the pilot program's lead physician. Avoiding unnecessary visits for those patients whose asthma self-management is going well helps keep appointment slots available for the patients who do need to see a provider. For patients, the mobile app sends messages about medication use as it happens, providing important interpretation of inhaler use as well as encouragement.

Dignity Health is using the Propeller product and app with 500 patients (age 6 to 75) in rural Woodland. Patients without smartphones were given a hub device to keep at home that uploads data to Propeller. Dignity Health has not found any falloff in app use after the initial engagement phase. While return on investment is not yet established, several elements of the Propeller product have been recognized as contributing to cost savings:

- Cost and efficiency savings result from using provider visits more wisely.
- Little to no provider time is required to support patients through the app, which Dignity is able to do for patients whose symptoms are well managed.
- Pharmacy savings: Previously, providers would often change a medication that appeared not to work for the patient to a more expensive second or third option. Now providers can see if the current medication is being used properly before making that change.

In addition to asthma, Propeller's app is also being used to monitor chronic obstructive pulmonary disease (COPD). Similar technologies exist for remote monitoring of conditions such as blood pressure, blood sugar, and weight.

California Health Care Foundation

California Improvement Network Better Ideas for Care Delivery