Sebastopol Community Health Center: Innovation from every corner

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9.30.2011

At the Sebastopol Community Health Center in Sonoma County, some 50 miles north of San Francisco, California, a Care Team gathers around the speaker phone to sing happy birthday to one of their long-time patients, just turning 65 years old. A Nurse Case Manager prepares to make a home visit to one of her sickest patients, to look over his medications and ensure that he has the equipment he needs to move around his home. A front desk Care Representatives calls a patient that she has known for years in a "touch back," to check on how the person has been feeling since his visit two weeks ago. This is truly a place where Joy is evidence in the patients and the clinic staff!

History and demographics

West County Health Centers founded Sebastopol Community Health Center in 2008 to respond to high demand in emergency department use for non-emergency care at the local hospital. Recognizing the need for accessible primary care, the hospital offered space in nearby medical offices to open a clinic. Sebastopol Community Health Center (SCHC) serves the largely rural population of western Sonoma County.The vast majority of SCHC's patients have public insurance or are uninsured. In 2010, almost half (49%) of patients had Medicaid, County Medical Services Program, or Healthy Families (a state insurance for youth and pregnant women) and 17% had Medicare. More than a quarter of patients (28%) were uninsured.

Sebastopol Community Health Center has experienced dramatic growth from its inception in 2008. By 2011, the health center had 3,405 active patients (defined as patients with a visit within the last 18 months); of these, more than half (1,791) were new patients within the last 18 months. The Sebastopol health center has eightproviders (5 physicians and 3 nurse practitioners) who work between 40–100% time.

Team-based care

SCHC believes that the patients are at the center of the care team. A Care Teamlette works in collaboration with patient to provide medical care. Each teamlette includes a medical provider (physician, nurse practitioner, or physician assistant), a Care Team Medical Assistant (CTMA),

and a Care Team Representative (CTR). The same three people work with each other on a daily basis. For patients, this creates a "small practice" feel within the larger organization.

*Care Team Representatives*are responsible for all non-clinical communication with patients, including calling patients to schedule follow up appointments through the open access system, providing reminder calls, and conducting "touch backs." Touch backs are calls from the Care Team Representatives to follow up on a visit. For example, a provider might ask a Care Team Representative to call a week after an appointment to check on a new mother who just started breastfeeding, to make sure that labs were done, to check on a patient after an outpatient procedure or a medication change, or to send birthday greetings. Care team representatives may also assist with panel management by sending letters to patients to advise them to get preventive care such as mammograms or pap smears.

Care Team Medical Assistants are responsible for managing the office experience for their patients and the provider they work with, providing panel management for their patients, and helping to "create a common voice" and reinforce messages from the provider. When they are not assisting with the flow of medical visits, CTMAs have panel management responsibilities for their patient panels.

*Care Team Medical Providers*conduct patient visits and use the electronic medical record to provide timely preventive and chronic disease care, in additional to addressing acute concerns. Providers review labs and diagnostic tests returning on patients and assign them to the Nurse Case Manager or the Care Team Medical Assistant for follow up as needed. They are also responsible for quality oversight within their team, for reviewing the dashboard with their teams and identifying ways to improve care, for coordinating care for medically complex patients, and for working with other providers to approve algorithms for ordering laboratory tests, radiology services, and referrals for disease prevention and chronic disease management.

The Care Teamlette is supported by additional people who make up the larger **Care Team**. These people include the members of the Care Teamlette, as well as a Nurse Case Manager, a Behavioral and Mental Health Team, and a Navigator.

<u>Lessons learned</u>

SCHC works to create clear expectations and workflows for each of their team members. The organization's vision is encapsulated in a number of "living" documents that are continually being revisited and tweaked: the "Principles of Care" and "Care Team Roles." The organization turns to these documents both to orient new employees and to make hard decisions. For example, when I asked the medical director how they balance standardizing roles of team members with allowing teams to come up with their own solutions, he immediately turned to the Principles of

Care, asking, "What is in line with our belief that care is relational and team-based? What legitimately fits within the role of each team members?"

Conducting training and skills checksis vital to institutionalize the agency's expectations and workflows. The agency lead MA pointed out that medical assistant schools generally prepare their students to do procedures, but they do less to prepare medical assistants to organize and proactively reach out to a panel of patients, or to manage the patient and the provider experiences.The team-based care model of SCHC puts great responsibilities on Care Team Medical Assistants to communicate with the provider and patients between visits. To support this role, SCHC provides detailed training in these "big picture" areas. Their orientation trainings include topics such as "Ways to help manage your provider's day," "Questions to ask in a huddle," and "Ways to improve the patient's experience."

SCHC has found it helpful to provide explicit instruction on how to use provider-MA huddles at the beginning of each shift. They dedicate time (5–15 minutes per shift) to huddles. CTMAs are asked to print out the schedule for day in advance. They discuss the anticipated reasons for visits with the provider, develop plans for cancellations, talk about patient personalities, and anticipate special needs (e.g., lab results, ER reports, supplies, interpreters, immunization routing forms).

Care Teams also meet monthly to check in with each other, look at their clinical outcomes together, and discuss how to improve patient care. This meeting provides an opportunity to troubleshoot issues that arise; for example, if one group feels overwhelmed by their responsibilities, other team members may decide to share the load or change tactics. Care Team meetings may also be used to coordinate patient care when there is a patient of concern. For example, a Care Team Nurse or Navigator may join the Care Team meeting to update the group on a particular patient.

Population-based management

Panel management

Outreach is the process of contacting patients between visits to alert them to preventive and chronic care needs. Care Team Medical Assistants perform outreach based on standing orders, scanned into the patient's electronic medical chart, for their patients with diabetes or HIV.For diabetic patients, they schedule office visits if the patient has not been seen in the last six months, set the patient up to get labwork that is out of date, refer patients for diabetic eye exams or foot exams, schedule visits for flu vaccinations, and screen for depressive symptoms. For HIV-positive patients, the Care Team Medical Assistant may schedule needed labwork and arrange for an office visit if influenza or pneumovax vaccinations are required.

Similarly, Care Teamlettes periodically run reports on patients who are due for cancer screenings, such as mammograms and pap smears. Each team conducts outreach to their panel in a different way, which might include the Care Team Representative or the Care Team Medical Assistants printing and mailing letters to those patients reminding them that they are due for the screening.

To ensure that panel management is sustainable, SCHC has found that there must be dedicated and protected time, that scope of practice questions be made explicit, and that staff performing panel management be trained in how to talk effectively to patients. Each Care Team Medical Assistant has an hour a day (or about a half day each week) dedicated to panel management activities. This time is not only dedicated, but also protected. Without an explicit plan to respond to staff absences, staff will naturally be pulled away from panel management activities and into filling in for missing staff. Second, the organization has found that panel management must explicitly address scope of practice of various team members. For example, as the organization develops Hepatitis C protocols, they are clear about the appropriate role for their Care Team Medical Assistant. For instance, as diabetes-related labwork or cancer screening results come in, Care Team Medical Assistants are assigned to send out letters for normal labwork, but all abnormal results go to Care Team Nurse Managers for review. Finally, SCHC has found that it is important to train staff that will be doing population-based management to ensure that they know how to talk to patients. The agency lead medical assistant found it beneficial to ask for training from an outside person, because the messages from an outside expert could help to validate their organizational practices.

Health Coaching

At SCHC, the *Navigator* serves as a bridge to resources, an advocate, and a coach. The Navigator is available to receive "warm handoffs" from providers through an in-person introduction and meet with patients for up to several hour-long sessions. These sessions may focus on creating goals around wellness areas such as healthy eating or social support, identifying and connecting to community resources, and providing emotional support. The navigator uses a strengths-based approach to help patients identify and build on their resources. The Navigator follows up via phone or in person to help support patient in working toward personal goals. One current project is to create a web-based resource that will facilitate more customized referrals, creating a list of resources specific to a patient's needs and interests. At end of a navigator session, the provider will join via videoconference to review the plan developed by patient and navigator.

Complex Care Management

Complex care management means identifying patients within a clinic's panel that are at high risk of medical complications and targeting special outreach and care coordination to those patients. Complex care management has been found to reduce unnecessary hospitalizations and improve patient care and well-being.

At SCHC,Nurse Case Managers providing complex care management. They manage patient transitions from hospitals and skilled nursing facilities and work with patients newly diagnosed with cancer or major illness. They are also beginning to conduct home visits with patients. Patients who may most benefit from home visits of Nurse Case Managers are people who are too sick to travel, who have repeat visits to the hospital emergency department, or who may have an unsafe home environment. Home visit activities include physical exams, review of medications, assessing how patients are managing their disease, providing education, examining the home for safety risks, assessing pain, and determining if intervention by other social services, such as Adult Protective Services, in home support services, or physical therapy, is needed. At the end of a home visit, the Nurse Case Manager teleconferences with the provider, with the patient present, to discuss the care plan for the patient and establish follow up appointments. Nurse Case Managers report that patients like in-home visits because it saves them time and travel and they feel attended to.

During my site visit, I observed one conversation that evidenced considerable skill in addressing with complex patients. One provider approached the medical director about a patient of concern to the hospital. The patient was chronically homeless, had severe psychiatric illness that included paranoia, and had developed ulcers on his legs. Although the patient had not been seen at SCHC before, the provider proposed that they take the responsibility for bringing him in to primary care by sending a Nurse Case Manager to track down the patient on the street and offer assistance with wound care and by instituting a policy that the patient could be seen at any time that he came into the health center (without an appointment).

Electronic medical record implementation and creating workflows

Sebastopol Community Health Centers uses an electronic medical record, eClinicalWorks. Medical Director Dr. Jason Cunningham felt that the implementation of an electronic medical recordwhen the center opened in 2008 was "an opportunity to transform medical practicetoward an new primary care delivery model, rather than overlaying an electronic medical record on top of our existing system."The goal of practice transformation made it necessary to think carefully about each process that they conducted.

In the process of implementing their EMR, SCHC used workflow mapping extensively. Workflow mapping, the process of visually representing a process and its steps, is an important tool in primary care redesign because it allows an organization to examine and tweak its practices and to identify variation that is ineffective. For example, the electronic medical record

offered various methods to enter smoking status. It was up to the health center staff to create consistent practices and ensure that smoking status would always be entered in one place in the same way so that searches could extract the information.

The workflow maps created during this period of EMR implementation and practice transformation are living documents that are frequently referenced and revised. For example, the team recently revamped a "Document Flowmap" that shows who is responsible for completing each part of common documents, such as prior authorization forms, disability forms, records release forms, durable medical equipment orders, etc. Revisiting these workflow maps allows the organization to streamline their processes.

Technology and access to care

Sebastopol Community Health Center is currently piloting a patient portal. Through the portal, patients can view selected lab and diagnostic reports, update their contact information, request appointments, and send messages to their doctor about medications or conditions. The portal also allows patients to create a list of questions for their next appointment. About 300 patients have signed up for the service to date, and the service has been popular because it may save patients a trip to the clinic. A patient advisory board has helped to design the portal and develop a process for registering patients.

Learning from Sebastopol Community Health Center

In merely three years, the Sebastopol Community Health Center has helped to reinvent primary care for the West County Health Centers system. How does the organization sustain their dizzying rate of innovation?

The answer, according to staff, is to create a culture of inventiveness and excitement at every level of the organization. Creativity and patient-centeredness is supported by clinic leadership. For example, front desk staff recently proposed handing out pagers to patients whose providers were running behind. In this way, the patients could go outside or even walk down the street for coffee while they waited; the pager would go off when the medical assistant was ready to take them back to the room. The idea was funded by the organization.

One key tool to spreading innovations across the organization has been to pilot it at one site (often SCHC) and then, after the problems have been worked out, to send ambassadors at each level of the organization to show their counterparts at other sites how the project can be accomplished. Talking to staff on the front line gives confidence to others that the new idea is achievable and allows them the opportunity to ask specific logistical questions. Additionally, when an idea simply does not work, they organization saves money by waiting to invest it across sites.