

Visit to Clinic Ole, Napa, California, February 28, 2011

Clinic Ole was founded in 1972 in a trailer in Rutherford, a town in Northern California's Napa Valley. In 1994, the clinic moved to a permanent facility in the town of Napa. Family physician Robert Moore was the medical director and chief innovator from 1995 to 2011. By 2011, the clinic had 15 physicians and 15 non-physician providers – nurse practitioners, physician assistants, and midwives. Clinic Ole, a FQHC, has expanded to 8 sites, providing medical, dental, and obstetric care to the low-income population of Napa County. Napa County, about 60 miles northeast of San Francisco, has 135,000 inhabitants, of whom 31% are Latino, an underestimate due to the population of undocumented immigrants. Clinic Ole cares for 20,000 patients each year. The clinic is financed 75% from Medi-Cal payments, sliding scale patient fees and other patient revenue, and 25% from grants and donations. 52% of the clinic's patients use Spanish as their primary language.

Empanelment and panel size

Clinic Ole has empaneled its patients to specific providers of care. Many clinics close the panels of providers when they reach a maximum panel size, but since Clinic Ole is the only safety net provider in Napa County, it is not possible to close all panels in the clinic, but specific provider panels can be closed once they reach 1300. Panels are weighted with a formula that includes age, sex, and diagnosis codes.

Continuity of care and access to care

The clinic currently measures continuity as the percent of visits by a patient that are visits to the provider (or team) to whom the patient is empaneled. Clinic Ole scores continuity at 72% for provider and 81% for team. In many clinics, a major challenge to achieving continuity is language concordance between patient, provider, and team. At Clinic Ole, almost every provider and staff member is bilingual in Spanish, which makes continuity much easier. Another challenge is part-time providers; at Clinic Ole, most providers work 4 days per week. One way in which Clinic Ole has persuaded providers to work at least 80% time is to offer benefits for providers and all employees only to those working at least 30 hours per week.

In 2010, Clinic Ole targeted access to care as a key improvement goal, and succeeded in reducing its appointment delay (third next available appointment) from 52 to 2 days. Providers are scheduled for 12 visits per half-day. In late June 2010, literally overnight, the clinic changed the scheduling and other systems to allow patients to be seen in the same day or next day. This was done in a relatively slow season and with one extra provider, so it allowed the previously scheduled patients and the same day/same week appointments to be seen simultaneously. The clinic stopped scheduling appointments after October 1, 2010, thereby achieving a completely open schedule for that month. Currently, half of appointment slots are available to be scheduled in advance, 25% are saved for the same day, and another 25% are saved for the same week. Morning slots

are used for same-week appointments, some afternoon slots are available for same day appointments. Visits are scheduled for 15 minutes except procedures. The clinic schedules three 15 minute visits for each hour, with the fourth 15 minute slot left open for drop-ins or for providers to catch up. Using the above access model, the clinic did not need to work down its backlog before changing the system. Capacity has been sufficient to meet demand, and the backlog has disappeared. As expected, no-shows have gone down as access has improved.

Care Teams

Clinic Ole has organized itself into care teams (pods) and teamlets. Teamlets consist of a provider and medical assistant (MA); patients are empaneled to the teamlet, and teamlets are measured for continuity of care, access, no-show rate, and cycle time. To allow teamlet-based continuity of care to be successful, three critical culture changes were implemented. First, patients must be taught to identify with a pod and with a teamlet so that they demand continuity. Second, personnel scheduling must prioritize the two teamlet members working together as much as possible. The clinic has succeeded in having the same provider and MA working together 90% of the time. Third, personnel making appointments must make clear to patients that – unless it is impossible to arrange – appointments should be with the teamlet to which the patient is empaneled. Patients receive business cards with the provider’s name, list of the provider’s days in the clinic, the MA’s name, the pod RN’s name, and the clinic phone number, in English and Spanish.

Surrounding the teamlets are larger “pod teams” with each team generally encompassing 6-7 teamlets. Each team has one RN, one behavioral health professional, 2 medical records personnel, and 2 front office staff. The word “pod” refers to the physical space in which each team functions; “team” refers to the people. Teams meet every 1 -2 weeks during lunch, which the clinic buys. On a given shift, 3 providers are seeing patients in each pod.

The process of creating stable teamlets took place in late 2010, with the clinic manager assigning which provider would work with which MA. In creating teamlets, it was decided to pair fast MAs with slow providers and vice versa. Two MAs left the clinic, unable to cope with the transition to stable teamlets. Providers expressed that always working with the same MA has been a major improvement.

In the process of rooming patients, MAs use a template on the electronic medical record (different MA templates exist for different types of visits), and performs the template’s orders based on the patient’s reason for the visit. If abdominal pain, the MA does a urinalysis, if asthma the MA does an O2 saturation and prepares a nebulizer treatment. The MA checks vital signs, allergies, medications, smoking status, last menstrual period and performs a universal screen for depression (PHQ2), anxiety and insomnia. Thus far, the MA does not do panel management. After the visit the MA may be asked to perform post-visit tasks, the most important of which is immunizations,

which they perform without provider input using physician-written standing orders. The clinic has decided not to have MAs do medication reconciliation, feeling that they have a difficult time doing it well. Some MAs have been trained in negotiating behavior-change goal-setting and action plans with patients, but do not perform this work on a regular basis due to lack of time. Behavior-change counseling is more often conducted by RNs, dietitians, behavioral health staff, and pharmacists.

In addition to the MA role as half of the teamlet, one MA serves as the lead MA, who has the function of flow coordinator, one on each pod. If a provider needs MA assistance and that provider's MA is tied up with another tasks, the lead MA provides assistance. If a patient arrives at the clinic 5 minutes after his/her appointment time, the patient is considered late and his/her appointment slot is gone. In that case the lead MA, consulting with the pod RN if necessary, decides whether the patient should be squeezed in or a new later appointment made. Having a consistent policy on lateness helps patients know what to expect.

Clinic Ole's leadership has insisted that each clinic session – morning and afternoon -- start on time, understanding that starting late disorganizes the entire session. The lead MA for each pod arrives at 7:30 and has the first patients ready to see their provider at 8:30. Clinic leadership comes to the pods to make sure that all providers are seeing their first patients on time, a practice called Quick Start. If someone comes late, that person hears about it.

The RN role oscillates from minute to minute between acute and chronic care. RNs answer triage phone calls routed by the receptionist and address many drop-ins when it is not clear if a provider visit is needed. They deal with phone calls and drop-ins and try to be available when providers need a dressing changed or a care coordination problem resolved. On the chronic side, they may have RN blood pressure visits, teach patients with diabetes how to use the glucometer or start insulin, or titrate warfarin for patients with atrial fibrillation. They regularly check their electronic medical record (EMR) in-box for patient phone calls or provider requests. When a provider is running behind, the RN may be contacted by the MA pod flow coordinator to assist the provider by taking patient histories and reviewing medications for patients on the schedule of the provider who is behind.

Another key RN function is prescription refills. Clinic Ole has instituted a standardized refill system with clear rules, allowing RNs to authorize certain refills without provider involvement. For example, the RN can refill hypertension medications for 6 months if the blood pressure was controlled at the last visit. If not controlled at the last visit or if the patient has not been to the clinic for more than 12 months, the medications can be refilled for one month and the patient is requested to come to the clinic. RNs do not change medication doses except for warfarin and insulin. RNs have little time for intensive patient education or behavior-change counseling. The time spent with chronic patients makes them less available when a provider needs immediate

assistance for taking a history or doing medication reconciliation. RNs' days can be more or less stressful depending on the hour-to-hour demands on their time.

Clinic Ole has a 60% time clinical pharmacist, plus pharmacy students, who perform medication reconciliation following hospital discharges and for complex patients. Licensed pharmacists are authorized to institute some new medications and titrate doses for some chronic medications, using collaborative practice agreements. Each pod in the Napa site has a behavioral health professional, who receives warm hand-offs from providers for patients with depression, anxiety, and other psychosocial difficulties, and for referrals to community resources.

Group Visits

Clinic Ole has been offering group visits for Spanish-speaking diabetes patients for over 12 years, with group visit patients generally having better diabetes control than patients not participating in groups. Exercise groups are also offered throughout the community, coordinated by the clinic's Outreach and Education department. Many are led by volunteer community health workers (promotoras), who also assist with diabetes classes, nutrition education, and health fairs. The clinic's tuberculosis group involves Spanish-speaking patients with latent tuberculosis infection, providing education on latent TB and enhancing medication adherence.

Clinic Ole also offers chronic pain groups, led by the patient's regular provider so that the group is not separated from the remainder of the patient's care. Patients come once a month and are expected to arrive on time. Patients agree to a pain contract, medication use agreement, and unannounced urine toxicology screens. A social worker does patient education, group therapy and patient empowerment activities. Patients participate in physical and occupational therapy and other non-narcotic modalities. During this time the provider meets with each person for 7-10 minutes (seeing 8 – 10 patients in 2 hours). Patients who trust that they will receive their narcotic doses tend to lose the dysfunctional behavior that may characterize some chronic pain patients. Many patients bond with one another and over time begin to address depression, and social isolation. Clinic Ole does not use the traditional 0 – 10 pain scale, feeling that it is unreliable; instead it uses a functional pain scale developed at Kaiser Permanente which measures function; for example, can the patient get out of bed.

Panel management and complex care management

Clinic Ole has a panel management system which includes out-reach by a PAP/mammo case manager to contact patients overdue for breast and cervical cancer screening, but not yet colon cancer screening. A diabetes care manager provides panel management for patients with diabetes. Care management for complex patients with high utilization of emergency departments and in-patient services is available from the Medi-Cal managed care plan, Partnership Health Plan. The health plan has care managers to work with those patients. In addition, the health plan each day sends Clinic

Ole a list of patients who have been seen in the emergency department, who are followed up promptly by one of the clinic's RNs. The clinic receives a quality bonus from Partnership Health Plan, which includes a portion for keeping ED utilization and hospital re-admission low.

Creating workflows

The clinic spent considerable effort making over 100 workflow maps both before and after EMR implementation. Clinic Ole decided to fix dysfunctional workflows prior to EMR adoption so that the workflows were efficient, and then made the necessary workflow changes to move from a paper to a computerized practice. The workflows were mapped in the computer training room, discussed with the people involved in that workflow, re-done based on staff input, and used to identify duplication and missing steps in order to improve how the work was organized. Workflow analysis continues to be at the center of operational changes and quality improvement projects at Clinic Ole.

Performance data

Clinic Ole is a data-driven clinic, collecting and analyzing operational, financial, and clinical data on the clinic, each pod, and each provider/teamlet. Operational data includes metrics on continuity of care, access, no-show rates, and productivity. The data are shown on dashboards up-dated every Monday morning. On Tuesdays, the clinic operations team meets to discuss the dashboard and to plan how to improve in areas that the data show are not working well enough. Pods receive their dashboard every week and everyone on each pod is expected to review the data.

Leadership

Clinic Ole's executive team includes the executive director, medical director, chief of medical operations, and the dental director. The Optimizing Primary Care team is composed of the medical director, front office manager, scheduler, and data coordinator; this group decides on innovations to implement. Each pod has a pod liaison who guides the pod meetings; the pod liaisons meet with representatives of the medical operations team once a month. Dr. Robert Moore, Clinic Ole's medical director for many years, has played a leadership role at the clinic and with the regional clinic consortium – Redwood Community Health Coalition (RCHC). Seen by many as California's leading clinic consortium, RCHC initiated the Quality Culture Series to train the leadership of its 16 member clinics on such topics as meaningful use, patient-centered medical home, and data-driven quality improvement.