

Quality and Productivity Commission
29th Annual Productivity and Quality Awards Program
Champions of Change: Together We Make a Difference

2015 APPLICATION

Title of Project (Limited to 50 characters, including spaces, using Arial 12 point font):

NAME OF PROJECT: FRONTLINE TEAMS IMPROVE GATEWAY TO PRIMARY CARE

DATE OF IMPLEMENTATION/ADOPTION: OCTOBER, 2013
 (Must have been implemented at least one year - on or before July 1, 2014)

PROJECT STATUS: Ongoing One-time only

HAS YOUR DEPARTMENT PREVIOUSLY SUBMITTED THIS PROJECT? Yes No

EXECUTIVE SUMMARY: Describe the project in 15 lines or less using Arial 12 point font. State clearly and concisely what difference the project has made.

1 The implementation of Medi-Cal expansion and the Affordable Care Act meant many
 2 changes to Primary Care within our Ambulatory Care Network (ACN) in the Department
 3 of Health Services:
 4 - "Empanelment": Primary Care Providers (PCPs) can now see patients only in their
 5 own panel, assigned to them, to better manage patients' care, and
 6 - "Managed Care": Completely new processes became necessary to assess patients'
 7 financial eligibility for managed care Medi-Cal benefits.
 8 We took up the challenge, DHS working with SEIU 721, and implemented Care
 9 Improvement Teams (CITs): a partnership-based process improvement structure that
 10 engages frontline workers and managers to improve and transform patient experience
 11 and work culture. Our task was to change and standardize all business office
 12 processes leading up to the primary care visit to match the new policies, and to improve
 13 patient experience and access across the ACN. Humphrey was the initial "Gateway
 14 CIT" site where we formed CITs around three major process areas: appointment
 15 scheduling, financial eligibility & empanelment, and registration. Success of these teams
 continues as we expand to cover every facility in the ACN.

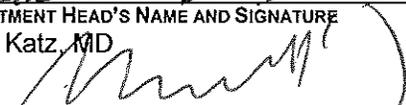
(1) ACTUAL/ESTIMATED ANNUAL COST AVOIDANCE	(2) ACTUAL/ESTIMATED ANNUAL COST SAVINGS	(3) ACTUAL/ESTIMATED ANNUAL REVENUE	(1) + (2) + (3) = TOTAL ANNUAL ACTUAL/ESTIMATED BENEFIT	SERVICE ENHANCEMENT PROJECT
\$	\$	\$	\$	<input checked="" type="checkbox"/>

ANNUAL = 12 MONTHS ONLY

SUBMITTING DEPARTMENT NAME AND COMPLETE ADDRESS Ambulatory Care Network – DHS 313 North Figueroa Los Angeles, CA 90012	TELEPHONE NUMBER 213-240-8094
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PROGRAM MANAGER'S NAME Nicole Moore	TELEPHONE NUMBER 323-309-1046 EMAIL nmoore@dhs.lacounty.gov
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PRODUCTIVITY MANAGER'S NAME AND SIGNATURE <small>(PLEASE CALL (213) 893-0322 IF YOU DO NOT KNOW YOUR PRODUCTIVITY MANAGER'S NAME)</small> Gerardo Rinedo 	DATE 7.9.15	TELEPHONE NUMBER <i>(213) 240-8104</i> EMAIL <i>grinedo@dhs.lacounty.gov</i>
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DEPARTMENT HEAD'S NAME AND SIGNATURE Mitch Katz, MD 	DATE	TELEPHONE NUMBER 213-240-8101
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Overall challenge: On January 1st, 2014, many of our patients in DHS became eligible for Medi-Cal with the Affordable Care Act (ACA). With Medi-Cal, patients have a choice to go to many health systems for their care. For our safety net system to survive, newly eligible Medi-Cal patients need to continue to choose DHS as their primary care provider; if they leave, DHS loses critical funding. In addition, Medi-Cal's transformation to a managed care system includes many new benchmarks and regulations that we need to meet to ensure new patients will be assigned to DHS.

So our challenges were three-fold: to improve patients' experience so they would chose to stay with DHS, to meet new standards for performance, and implement new processes to match brand new policies for primary care.

In October 2013, Humphrey, a large clinic with 19 primary care providers, became our testing ground. We formed Care Improvement Teams (CITs) for three of the processes impacted by the policy changes: appointment setting – including phone access; all eligibility requirement processes – including financial eligibility and empanelment; and the registration process. For each team DHS and SEIU picked a co-lead – one representing management, the other labor, respectively, then we chose a group of 6-8 people who represented all the people who do that process in the facility. We set up weekly meetings for each group – and started working on transforming, improving, and standardizing process, and implementing “small tests of change.” In April, 2014, we expanded to three additional facilities: El Monte, Roybal, and Mid Valley, and we've continued expansion through the present.

Setting Appointments Correctly: Challenge #1:

Before ACA and managed care Medi-Cal, anyone could call a clinic and schedule an appointment with our primary care providers (PCPs). After ACA, all patients seeking a primary care appointment would need to be empaneled to the PCP they were seeing and if they had managed care Medi-Cal, they would need to be screened to ensure their benefits were assigned to the correct DHS facility.

Solution: The CIT was formed and included the full call center team, plus representatives from the front desk and clinic, who also make appointments. Most team members had never checked financial eligibility or empanelment for scheduling appointments, so we had a lot of work to do. We had a series of projects that resulted in our success:

1. *The “Pop Up” Project:* A new computer window, affectionately called “the pop up”, showed financial and empanelment information for most patients: in order to ensure proper empanelment and financial clearance, we needed to know how to identify empanelment and financial eligibility. The team worked together and trained everyone how to use the pop-up and troubleshoot issues with the new window.
2. *Standardize the Process Based on New Policies:* New flow-charts outlined new ACN policies: we needed to turn it into step-by-step processes. What's the process if an unempaneled insured patient assigned to our facility wants an appointment? What if someone empaneled to another facility wants to come here? What if the

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pop-up is blank for someone wanting an appointment? We established processes for each of the possible situations. We developed a CERF (Change of Empanelment Referral Form) that allowed clerical staff to change empanelment at the patient's request, without making the patient go to another office to wait in line for the change.

Benefits: Patients experienced more efficient flow and fewer visits to other offices as the result of our paper-based CERF. The data we used to ensure appointment setting was being done according to our new standard processes was measuring the percent of patients empaneled to the PCP they were seeing at the time of their appointment. By April, 2014, four facilities were engaged in the project, and our baseline number improved by 50%. Increasing this measure ensures better continuity of care and patient bonding by empaneled providers who "get to know" their panel of patients.

Facility	Baseline 4/2014	10/2014
Humphrey	56%	93%
El Monte	72%	92%
Roybal	73%	90%
Mid Valley	31%	76%
Total Avg.	58%	86%

Facility	Baseline	By 7/2014
Humphrey	12:30	2:20
El Monte	7:43	5:30
Roybal	3:00	2:04
Mid Valley	1:44	2:30
Total Avg.	6:14	2:45

Patient Phone Access: Challenge #2:

For these new process changes to work, patients need to be able to call in to schedule their own appointments. Busy signals, long waits were standard. A new call routing system was installed in October, 2013, and we finally had empirical data to see how we were doing. At Humphrey, baseline numbers showed patients waiting an average of 12 minutes and 30 seconds just to make appointments! We had standardized the appointment process, but now we needed to make sure patients could reach us to make those appointments.

Solution: In the weekly CIT meeting, we began focus on efficient Call Center practice. Operators identified multiple issues, and we took them on one by one: the phone tree for people dialing in was incorrect, so many people who should have been routed elsewhere were ending up on the Call Center line; we were able to identify high volume times and other times we needed additional coverage, and were able to put extra operators on during those times; and we practiced scripts the team wrote to improve how we handled – and how quickly we handled – complex situations.

Benefits: As a result of our small tests of change, phone wait time for our patients improved significantly, and quickly. We went from a 12 minutes 30 second average wait time in October 2013, to a 2:20 average wait time by June of 2014, a more than 80% decrease in wait times. Call Center CITs also expanded to the other locations. Call Centers became a solution for other facility areas to give patients regular, dependable access to appointment setting. We have continued CIT work in Call Centers, working through challenges such as increased call volume and new Electronic Health Records.

Register Patients on Time: Challenge #3:

"Did you see your provider within 15 minutes of your appointment time?" is a critical question asked our patients as part of the national Consumer Assessment of Healthcare Providers and Services (CAHPS) survey. Maintaining a high score helps ensure that patients are assigned to DHS. If patients are registered quickly and efficiently – by the

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time of their appointment – Registration helps achieve this goal. When we started at Humphrey, only 41% of patients were being registered by the time of their appointment. We set a goal to achieve 95%.

Solution: In the Registration CIT we worked to get as much off of the registration clerk's plate as possible so they could focus on fast and efficient registration. The team implemented a pre-registration team, that took care of empanelment and financial clearance issues before the actual appointment. We also implemented a standard process for registration and pre-registration. Posting the data to registration staff on a weekly basis was also helpful in motivating everyone to accomplish our goals.

Benefit: Humphrey went from registering 41% of patients on time in October 2013, to 90% in July of 2014. As the other facilities joined, we established an April 2014 baseline of 73%, and all four facilities had achieved an average of 90% by July 2014. CITs continue to work to improve the entire registration process, especially with implementation of ORCHID, our new electronic health record program.

Improve Work Culture: Challenge #4:

LA County Health Services must transform and secure change on multiple levels to meet the requirements of ACA and preserve our safety net health system. Resistance to change and change exhaustion are recognized as big barriers to improving the healthcare and patient experience we provide. Given the enormous changes we have to make, how can we sustain improvements?

Solution: When we began piloting Care Improvement Teams on other projects in 2012, we knew we had a model that had power to meet our "change challenge" in big ways. CITs give front-line workers and managers

- first-hand knowledge of department-wide strategic goals and challenges;
- license to try out their own ideas and innovations to achieve those goals;
- access and skills to use data and other process improvement tools to analyze results of changes they implement;
- opportunities to develop as leaders of change in their departments, and
- a mandate to work together, listen and respect each other, regardless of position or rank.

Benefit: While we don't have empirical data on culture change, teams across DHS have communicated in multiple ways that CITs are improving our work culture and our collective commitment to improving our services. A few quotes from a debrief conducted at Humphrey in Spring, 2014:

- "This is my first time in 35 years of being in a group where I had input.... We usually don't have a voice. And they LISTENED."
- "I honestly believe that because of this process, I've learned to be a better supervisor. It's easier when you rely on your staff and really listen to them."
- "The staff here now are thinking twice before they make an error – they know what the process is, and the thinking and reasons behind it. Knowing the reasons helps us think about the best way to treat the patients too."

These examples capture the essence of our continued commitment to the CIT model of change in the Ambulatory Care Network of DHS.

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LINKAGE TO THE COUNTY STRATEGIC PLAN (DETAIL IS REQUIRED FOR COUNTY DEPARTMENTS): Use Arial 12 point font

Goals accomplished by the Gateway CIT Project are closely tied to both LA County Strategic plan as well as the Department of Health Services – Ambulatory Care Network goals.

LA County 2014 Strategic Plan: GOAL 3: INTEGRATED SERVICES DELIVERY:

Strategic Initiative 1: Launch of Health Care Reform

Support continued transformation of the health delivery system with the goal of improving quality of care, access to care, and patient experience while safeguarding long-term fiscal sustainability of County services.

Focus Areas:

- Enhance Primary Care and Continuing Care Outpatient Clinics
Further develop the capabilities of the DHS Patient Centered Medical Homes (PCMHs), focusing specifically on fine-tuning empanelment, increasing capacity for panel management, facilitating transitions in care, and refining team member roles and responsibilities.

DHS - ACN Goals for 2014-15:

Goal 5, Strategy 4:

Partner with labor union leadership in order to improve staff satisfaction and engagement, enhance patient experience, and accelerate DHS' overall transformation.

Goal 1, Strategy 2:

Enhance outpatient experience through improvements in clinic flow (e.g., evaluation of front-desk registration functions), cycle time, physical environment (e.g., signage, focused facility improvements, waiting room Wi-Fi), customer service training, and by tracking and responding to input from patient comments, satisfaction surveys, and grievances.

- By June 30, 2015, 95% of scheduled patients, who are on time for their primary care appointment, will be registered by the time of their appointment.
- By October 31, 2104, analyze staffing for each ACN call center and provide recommendations for adjustments in scheduling and/or hiring.
- By June 30, 2015 80% of all ACN call centers will demonstrate and three month rolling average wait time of 2:00 or less.
- By June 30, 2015, all ACN call centers will have established quality control mechanisms for monitoring calls for customer service standards and accuracy of information.

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COST AVOIDANCE, COST SAVINGS, AND REVENUE GENERATED (ESTIMATED BENEFIT): If you are claiming cost benefits, include a calculation on this page. You must include an explanation of the County cost savings, cost avoidance or new revenue that matches the numbers in the box. Remember to keep your supporting documentation. Use Arial 12 point font

Cost Avoidance: Costs that are eliminated or not incurred as a result of program outcomes.

Cost Savings: A reduction or lessening of expenditures as a result of program outcomes.

Revenue: Increases in existing revenue streams or new revenue sources to the County as a result of program outcomes.

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