Creating a More Meaningful Clinical Discharge

HARRISONBURG COMMUNITY HEALTH CENTER

CHC LEADERSHIP INSTITUTE LEARNING PROGRAM 2016-17

CAPSTONE TEACHBACK: JUNE 6 & 7, 2017

THE VIRGINIA CHC LEADERSHIP INSTITUTE

1. Focus

HCHC focused on aligning our discharge process with goals of improving chronic disease outcomes as well as “well-child care” follow-up

- Providers questioned low volume of follow–up appointments
  - Felt they were ordering return visits for chronic disease management and well child checks

- Chronic Disease Management efforts suggested these patients were getting lost to follow–up

2. Team

List the team members who worked on the project:

- Erin Frazier, Clinical IT / Process Improvement Coordinator
- Dr. Jay Hotchkiss, Medical Director
- Luz Guzman, Front Office Supervisor
- Angie Whitmer, Practice Manager
- Beth Moseley, CFO
- Lisa Bricker, ED

3. Need

- **WHAT WE DISCOVERED**…..
- Patient Experience / Front office Workflow Concerns
  - Patients were not willing to wait in line to reschedule
- Front Office Staff with no clinical training, cannot address questions about Treatment Plan
- Loose compliance with printing and reviewing the Visit Summary
- Inconsistent Provider Work Flows re: Follow-Up Planning
- Need to Improve Clinical Quality Outcomes for Patients

Patient Centered / Meaningful Discharge Process

4. Objectives

Implement Creative Strategy to Overcome Barriers to Creating a Meaningful Discharge Experience

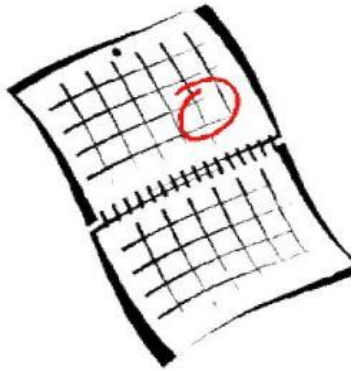
HCHC realizes that without effective Chronic Disease Follow-Up we will never achieve our Population Health or Well Child Care Management Goals

Support Safe Discharge through Patient Engagement with Clinical Staff and Follow Up with an "Intentional Visit"

- Patients are engaged in the process – selection of date / time that works best with their schedule
- Clear Understanding of the Importance of the Scheduled Follow-Up Visit

WHICH CREATES VALUE!

Clinical staff to Schedule Follow-Up Appointments / Create Meaningful Discharge



5. Assets

- Office Supervisor:
  - Supervises staff and oversees process management for scheduling follow up visits at project start.
- Clinical IT / Process Improvement Coordinator:
  - Able to evaluate data to confirm provider practices re: follow up planning.
- Practice Manager: Implement change strategy with clinical team members
- CFO - financial implication for missed visit opportunity and effect of outcome based revenue
- ED – make the case for process change, direct course for achieving change, support journey
- E-Clinical Works - reporting and scheduling functionality
- Patient Experience Team – evaluating patient visit
- experience from patient perspective

6. Action Strategies

1. Validate and Verify Barriers
2. Engage Team in Solution Oriented Thinking
3. Commit to Decision and Implement

   Clinical Staff to Complete Meaningful Discharge Process (Review Visit Summary / Answer Questions)

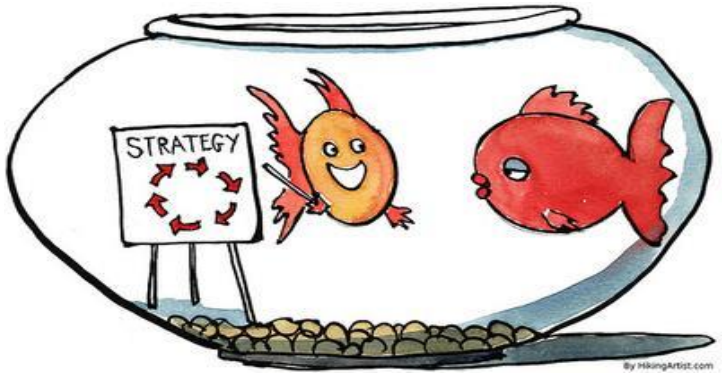
   Clinical Staff to Schedule Follow up Appointments if ordered, in exam room engaging patient / caregiver with date / time selection.

4. Review Results and Revise Strategy

7. Team Development

Team Building / Team Engagement

- Engagement of Patient Ambassadors, Clinical Staff, Providers in baseline follow–up visit scheduling process
- Gain team consensus regarding desirable results
- Discuss Alternative Solution(s) and Implementation Strategy



Team Training

New Process Development

- Clinical Staff: Train on Scheduling Process / Provider Template Management
- Providers: Discuss role that best practice guidelines plays in the ordering of follow–up care

8. Testing & Refinement

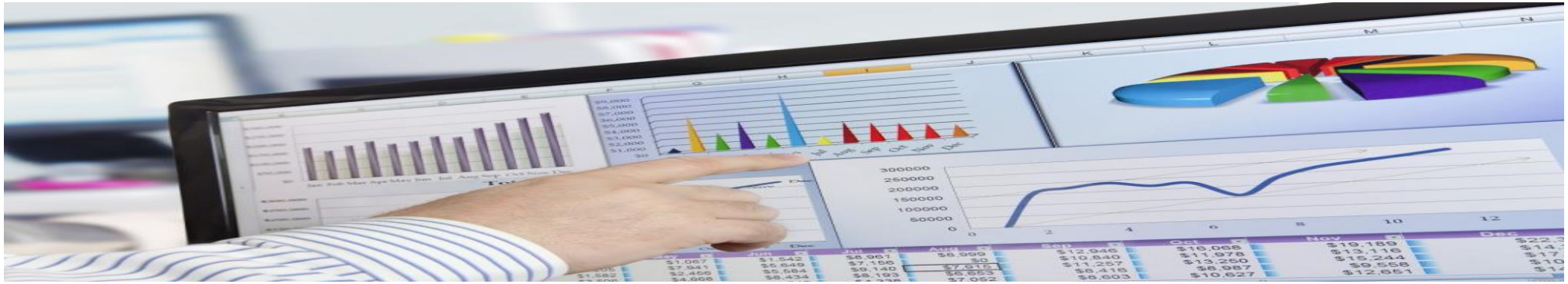
Initial training held with Clinical Staff

- Results fell far short of desired outcome
- Re-training and more Re-training performed
  - Written guidelines provided as reference for staff

Training held with Providers re: Best Practice Guidelines for scheduling follow–up care

- Data analysis reviewed as providers engaged in consistently ordering follow-up care

Systemically aligned team based success sharing goals with successful implementation



9. Results to Date

Data on two providers who were both at HCHC in 2016 and 2017 (One full time / One part time)

Increased their follow up visit scheduled rate by 8% over two months : 2017 as compared to 2016

- **Full time provider increased overall visit volume by 3.5%**
- **Part time provider increased overall visit volume by 13%**

Clinical Staff Scheduling Follow-Up Visits – Staff Starting to "By-In"

Remains a struggle, but improvement finally being seen after repeated training sessions

Philosophical Change in task management – in progress

Heart of Virginia: results starting to come in - HCHC recognized as

Managing BP / Heart Disease well - Improved by >10% on BP measure

Next Steps:

Hardwiring Process Management

Supporting Culture Change

Tracking Data and Clinical Improvement Measures

10. Lessons Learned

Describe your key lessons learned:

- This change is more difficult that it appears at face value. Even so, creating “by-in” from team is challenging. Patient “by-in” is the easy part.
- Preventing patients from standing in another line when they are “done” with their visit is greatly appreciated and alleviates bottlenecking in facility
- Adopting philosophy that next visit begins with current visit, represents culture change and as such needs to be managed with this in mind.
- Implementing strategies that require staff to engage in work flows markedly different than they perceive as their role, is challenging and requires a lot of repeated training.
- Provides for a safer discharge, facilitates patient engagement in treatment plan through “safe” questioning and allows team to cement primary care relationships!
- Shift in Philosophy re: Efficiency in Practice (exam rm. turnover vs. improved pt. engagement with Treatment Plan and valuing follow up visit)