

UMass Medical School/UMass Memorial Heath Care – Department of Family Medicine and Community Health				
Vision, Mission, Values and Strategic Priorities				
Clinical Services	Education		Research	Community Health
The Department will promote and provide innovative, high quality, evidence-based clinical care delivered to diverse communities	The Department will be a leading resource for addressing the primary care and public health workforce needs of the Commonwealth of Massachusetts <ul style="list-style-type: none"><i>We will train clinically competent, patient-centered and community-responsive clinicians and public health professionals to provide quality health care services to diverse populations</i><i>Our training programs will be based in clinical and community settings that reflect the health care needs of the Commonwealth, with emphasis on training for shortage area practice</i>		The Department will increase its national recognition for its research focused on health promotion and disease prevention and on innovative approaches to delivering evidence-based practice in primary care, with a particular focus on eliminating socioeconomic and racial health disparities.	The Department will distinguish itself and be recognized nationally for integrating CH into FM practice, training and scholarship
We will recruit and retain a Family Medicine workforce of a size and breadth to meet the needs of the diverse community of central Massachusetts	Our predoctoral training programs will ensure that all medical students graduate with a firm grounding in the principles of Family Medicine and of Community Health, and will include innovative curricula related to serving underserved populations	Our Preventive Medicine Residency will prepare primary care physicians to assume leadership positions in public health and preventive medicine. The Worcester-based MPH Program will prepare health care professionals and medical students for careers and leadership positions in public health and community health.	Our core research faculty will formally organize as a Research Group on Primary Care Quality, Access and Outcomes that will expand the productivity, visibility, and relevance of its research	We will serve as an academic partner with community agencies and public health entities in the development of community-responsive services to improve health equity and reduce health care disparities
We will support innovative systems and programs that support all Department practices in the care of patients across the entire spectrum of clinical settings	Our Family Medicine Clerkship will place students in dynamic teaching practices that are models for the provision of Family Medicine.	Our Behavioral Science Program will be a national model for training medical and psychological providers to offer integrated behavioral health services in primary care.	Working with community practices and partners, Medical School departments and Commonwealth Medicine, we will enhance our approaches to research collaboration that are bidirectional and responsive to community priorities	We will integrate training in population health concepts and the application of community health strategies within clinical training sites
We will implement practice improvements that increase the satisfaction of physicians and patients and improve quality and effectiveness	Our Family Medicine Residencies will be highly competitive, and will attract and sustain a diverse group of learners within supportive and innovative learning environments.	Departmental CME offerings will support our faculty via innovative lifelong learning practices.		
We will apply methods for the creation, measurement, and maintenance of a clinically superior healthcare workforce	Our Sports Medicine Fellowship will be a regional and national leader in the field of Primary Care Sports Medicine through education, research, clinical services, and community outreach.	Faculty development activities will be coupled with the recruitment of community-based preceptors and will focus on training and supporting expert teachers and excellent role models.	We will enhance the scholarly environment across the Department through strengthened efforts in the residencies, fellowships, and at each of our health centers	We will serve as an academic partner for Commonwealth Medicine and other departments to establish and evaluate innovative and sustainable models of health care for diverse and vulnerable populations
We will cultivate and encourage integration of clinical teaching in all of our practices as part of the culture of the department				
ORGANIZATION AND CULTURE: We will be a highly functioning academic and clinical Department:		The Department’s leadership and management infrastructure will be mission-driven, aligning planning and implementation, clarifying expectations, and supporting a culture of innovation and professional growth		
OUR VISION: Our Department will be nationally recognized for its innovation and impact in Family Medicine and Community Health			OUR VALUES: <ul style="list-style-type: none">AdvocacyCollaborationProfessional growthCommitmentInnovation	
OUR MISSION: Our Department sets the highest standards of patient care, education, and research in Family Medicine and in Community Health, and is committed to improving the health of populations, with special emphasis on those most vulnerable.				

A3 – Enhanced PDSA

A3

Plan • Do • Study • Act (PDSA)

Team Members: Linda Weinreb, Judy Savageau, Roger Luckmann, Alan Chuman, Ahmed Hussain, Tracy Kedian, Tina Runyan, Roger Luckmann, Nicholas Apostoleris and Kostantinos Deligiannidis

Problem Statement: The department is missing opportunities to partner with faculty practices to identify and implement innovative practice improvement projects with scholarship potential (i.e., regional/national meetings and/or publication in peer-reviewed journals).

Scope: Faculty practices including: Benedict, FHCW, HFHC, BFHC, FHCW, and Fitchburg

Background/ Current Conditions:

- Department strategic goal: We will enhance the scholarly environment across the department through strengthened efforts in the residencies, fellowships, and at each of our health centers.
- Faculty express interest in conducting mentored projects for dissemination.
- Limited time, resources and training to independently conduct projects that can be disseminated.
- Faculty have implemented innovative practice change efforts with limited dissemination plans.
- Faculty practices commonly rush to implement innovation without the necessary upfront planning that would allow for rigorous evaluation and dissemination.
- Department has been very successful in dissemination efforts related to research.
- Limited research/investigator faculty who can provide the necessary collaboration and support.
- Mentored projects on practice innovation have been limited.
- During 2012-2013, 2 publications and 10 presentations that focused on practice innovation in our department clinical sites.

Root Causes: Man: <ul style="list-style-type: none">•Unmotivated faculty<ul style="list-style-type: none">○Competing priorities○Inexperienced<ul style="list-style-type: none">▪Lack of training▪Lack of mentors to work with them▪Limited resources<ul style="list-style-type: none">➢Limited time (takes a long time)➢Competing time with obtaining funding by research faculty▪Lack of collaboration opportunities○Lack of scholarship champion at each site•Insufficient number of faculty investigators<ul style="list-style-type: none">○Those at practices not engaged in practice transformation evaluations at their sites<ul style="list-style-type: none">▪There for clinical work▪Limited opportunities to collaborate with colleagues<ul style="list-style-type: none">➢Clinical demands➢Too busy➢Not the same freedom of collaboration that would foster these efforts○Haven’t explicitly recruited clinical faculty w/career goal to do practice innovation projects	Materials: <ul style="list-style-type: none">•Limited number of departmental research investigators to pro-actively seek out projects in collaboration with site-based faculty•Limited number of departmental research investigators to support identified practice-based projects•Limited number of support staff to assist projects who are familiar with practice innovation efforts Methods: <ul style="list-style-type: none">•No well-defined process for identifying practice innovation project with dissemination potential<ul style="list-style-type: none">○Lack of time to think through all aspects of project and plan time demands/resource needs○Lack of training among practice-based faculty in conducting a needs assessment to identify projects○Lack of training among practice-based faculty to identify dissemination potential and outputs of projects
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Goals: Goals are based on specific activities which culminate in dissemination output(s)

- Identify 1-2 site-based practice innovation/improvement projects by September, 2014.
- Develop project design and implementation plan(s) by January, 2015.
- Implement/complete project(s) by June, 2015.
- Identify dissemination plan(s) by September, 2015.
- Disseminate results from at least 1-2 practice innovation project(s) by Spring 2016 (regional or national publication/presentation).

Countermeasures (Plan): What do you plan to do at a high level? What results do you expect to see? What could possibly go wrong?

Implementation (Do): Describe what actions you are going to take. Identify steps including who is assigned and when it is due. Carry out the change or test.

Results/Conclusion (Study): Collect data and begin analysis. What behaviors did you observe? What happened? What were the challenges? What did you learn? Did you meet your measurement goal listed in the countermeasures (show results)?

Follow-up Actions (Act): Are we ready to make a system change (if so: who, what, when, where)? Do we need to make revisions and test again in next PDSA?

A3 – Enhanced PDSA

Project Title: Improving Measures of Quality of Care
A3

Owner: Dennis Dimitri

Date: 04/07/2014

Plan • Do • Study • Act (PDSA)

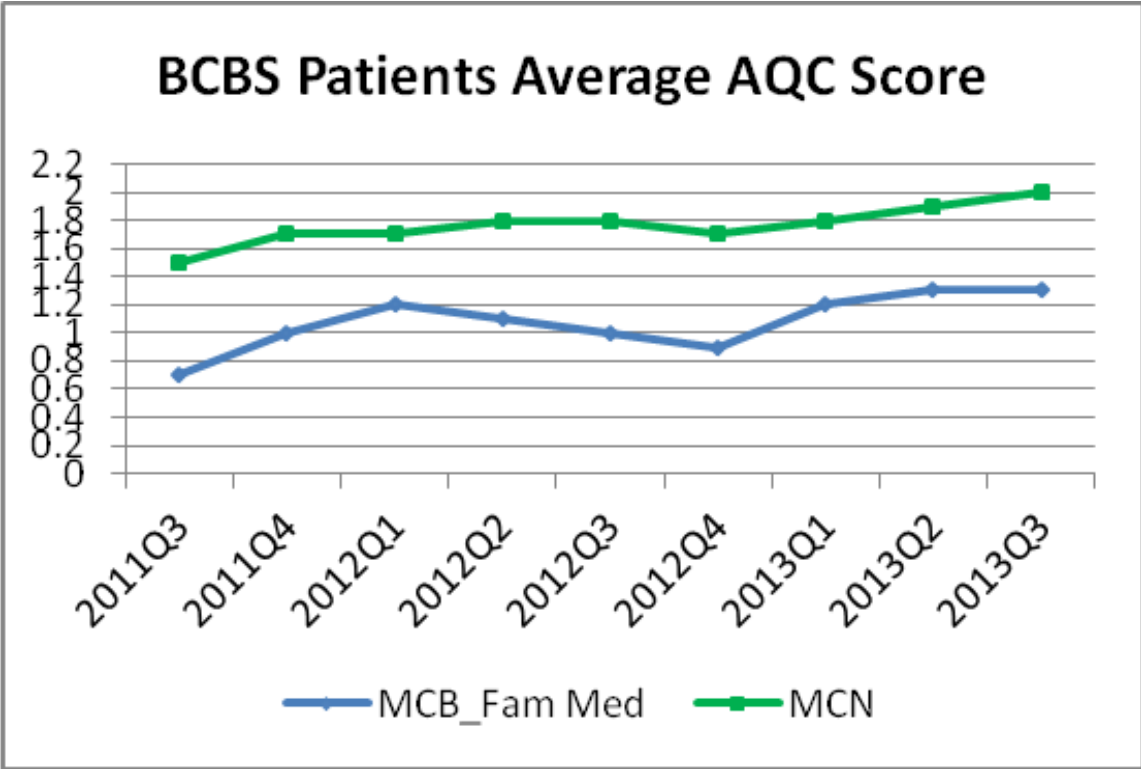
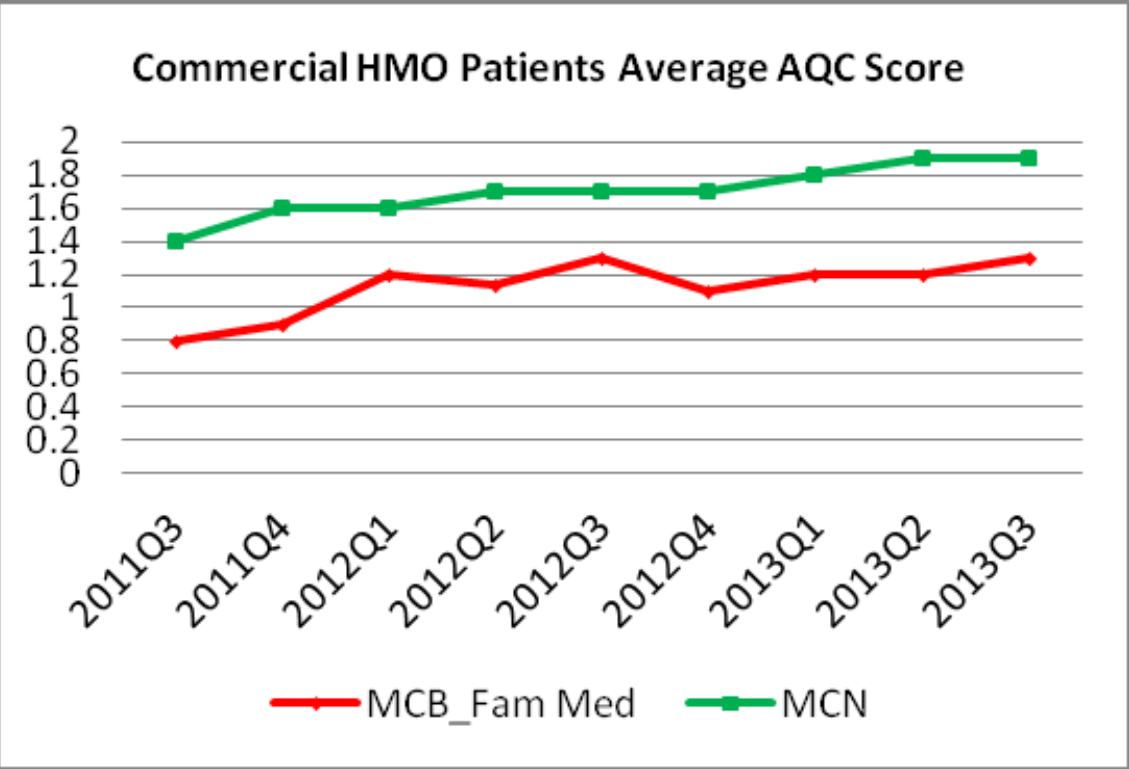
Team Members: Drs. Dimitri, Barnard, DiFranza, Earls, Gilchrist, Luckmann (or designee), Trish Kelly, Fancis Wanjau, Sue Begley, Colleen Bregman

Problem Statement: Quality measure scores for FM&CH have been known to lag behind the network mean for the last 3 years. This has resulted in loss of revenue for the department, reduced incentive payments to department clinicians, and an image of poor delivery of care by our department.

Scope: IN: AQC measures tracked in the patient registries for Benedict FM, Barre, HFHC, and PVHC
OUT: Other non-AQC measures of quality and other practices affiliated with but not managed directly by the department.

Background/ Current Conditions:

•Most recent (Q3 2013) department blended BC BS AQC score is 1.3 vs. MCN mean of 2.0.



- Recent progress reports indicate different rates of improvement at the 4 dep't HCs.
- Each HC is working with different approaches to improvement of AQC scores.
- Luckmann group is making outreach calls to patients to urge completion of certain QMs for 3 of the 4 HCs (not PVHC).
- Pre-visit worksheets are used to get QMs done at time when patients are seen.
- Staff (primarily MAs) are utilized in different ways at each HC to address the improvement of AQC scores.

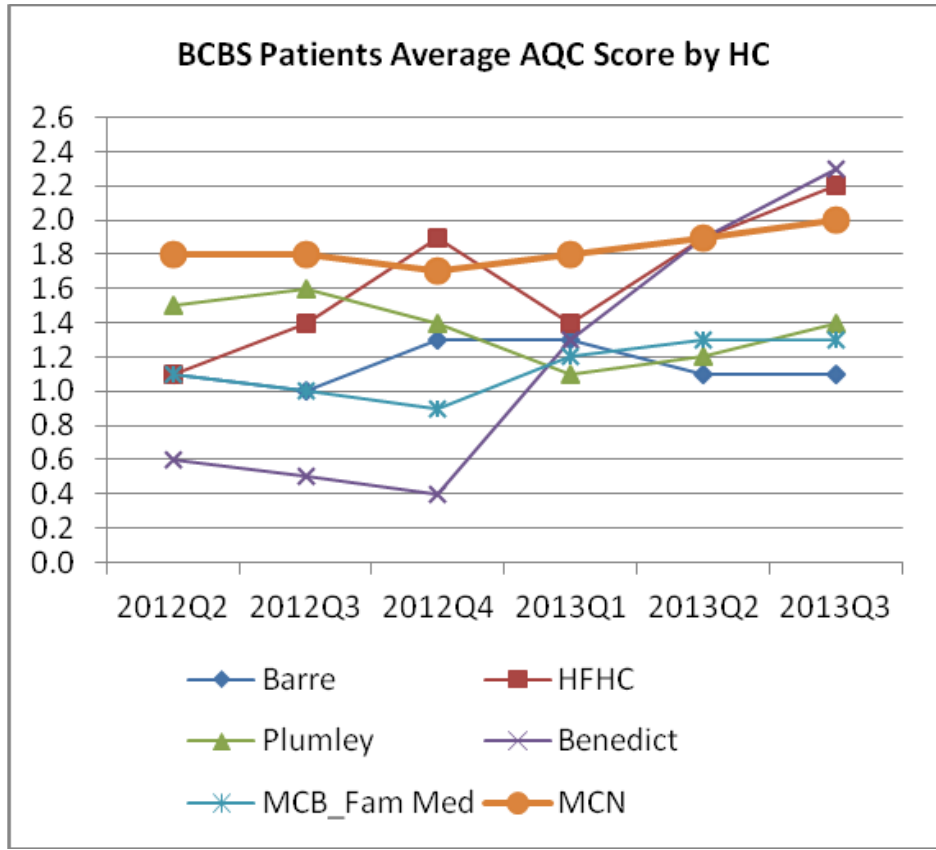
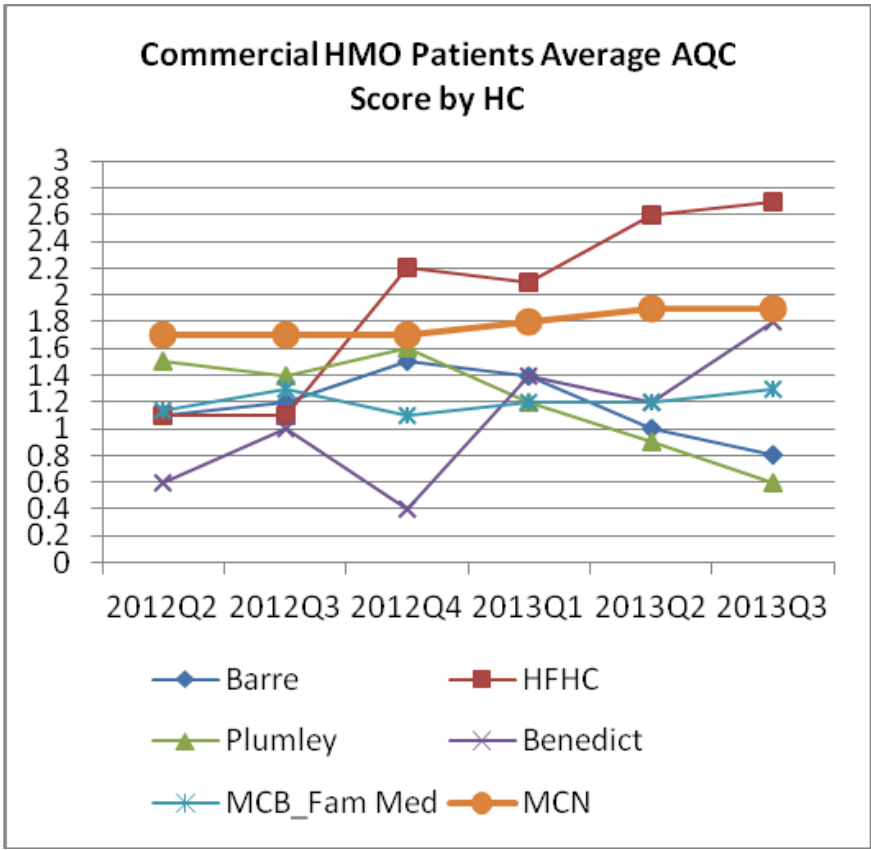
Root Causes:

- HC silos contribute to non-standard approaches and differential improvement rates.
- Limited idea sharing site to site across the MCN.
- Some faculty at HC's have balked at the use of AQC measures, challenging their validity.
- Little financial incentive to date to cause clinicians to prioritize improvement of quality scores.
- Variability of support services between the health centers.
- Poor patient engagement in improving health outcome measures.
- Top-down approach to improvement (Hospital system □administration/leadership □medical directors/POD leaders □providers □staff) with little incentive for staff to innovate or participate in quality-improvement work.
- Competing demands and priorities which distract clinicians and leadership from QM improvement work.
- EMR does not support real time reminders.

Goals:

- The department's blended AQC score for all commercial payers will be ≥ the MCN mean by end of CY2014.
- Each individual health center's AQC score will be improved by the end of CY 2014.
- A standard dep't of FM approach to improvement of selected AQC measures will be implemented by 2nd quarter CY 2014.

Individual HC Statistics:



Estimated Project Completion:

First milestone, April 2014
Department retreat poster presentation of A3 to date.
Second milestone, review of AQC score improvement at end of 2nd quarter 2014. Third milestone, successful AQC score improvement processes remain in place after end of 3rd quarter 2014. Final milestone, AQC scores at goal end of CY 2014.

Countermeasures (Plan):

- Standard workflow created for chosen AQC measures:
 - Comprehensive diabetes care.
 - Hypertension.
 - LDL measure in CAD.
 - Breast cancer screening.
- Develop sub-A3s at each health center to implement the workflows.

Implementation (Do):

What	Who	When
Plan 3 hour team meeting to review, share, and standardize approaches in use at all 4 health centers to improve these measures.	Dennis	3/18/2014(complete)
Map process of mammo scheduling at different HC's	All	3/18/2014(complete)
Map process of comprehensive DM care	All	3/18/2014(partial)
Obtain the mammo pt. ed. materials for front desk distribution	Carolyn	3/25/2014(pending)
Investigate the mammo center process for f/u on missed screening appointments	Dennis	3/25/2014(complete)
Investigate front desk staff access to Imagecast for scheduling mammos directly	Dave	3/25/2014(pending)
Create a common diabetes visit worksheet	Katharine & Dennis	3/25/2014(pending)
Standardize processes for comprehensive DM care	All	3/25/2014(incomplete)

Results/Conclusion (Study): Collect data and begin analysis. What behaviors did you observe? What happened? What were the challenges? What did you learn? Did you meet your measurement goal listed in the countermeasures (show results)?	Dave and Joe	After 3/25/2014 (complete)
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Follow-up Actions (Act): Are we ready to make a system change (if so: who, what, when, where)? Do we need to make revisions and test again in next PDSA?

Problem Statement

FHCW patients are not being seen when they are scheduled to be seen. When the appointment does not start at the scheduled time, it increases stress on patients, providers and staff. Resources scheduled for the time of the appointment s(interpreters, social workers, etc) become unavailable when the appointment is delayed

Scope

Primary care medical teams 1,2,3,4; April, May and June 2013; No capital funds available

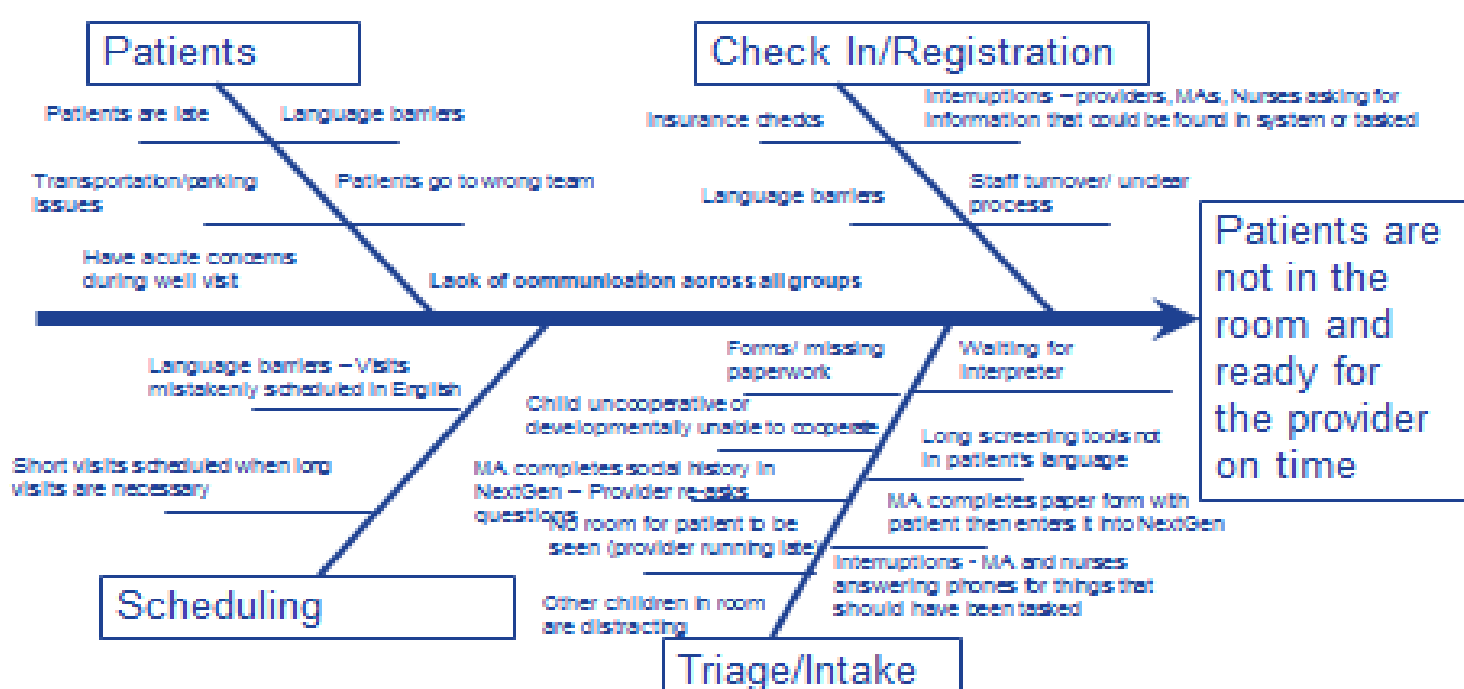
Background

Initial analysis (of January 2014)



Root Cause Analysis

Cause-Effect Diagram – Well Child



After reviewing our data, it seems that the majority of our patients arrive and are checked in on time. Well Child Visits take longer between Check in and Ready than other visits – supporting observations of longer triage process. There seem to be many redundant and non-value added elements in the triage process for Well Child Visits.

Goals

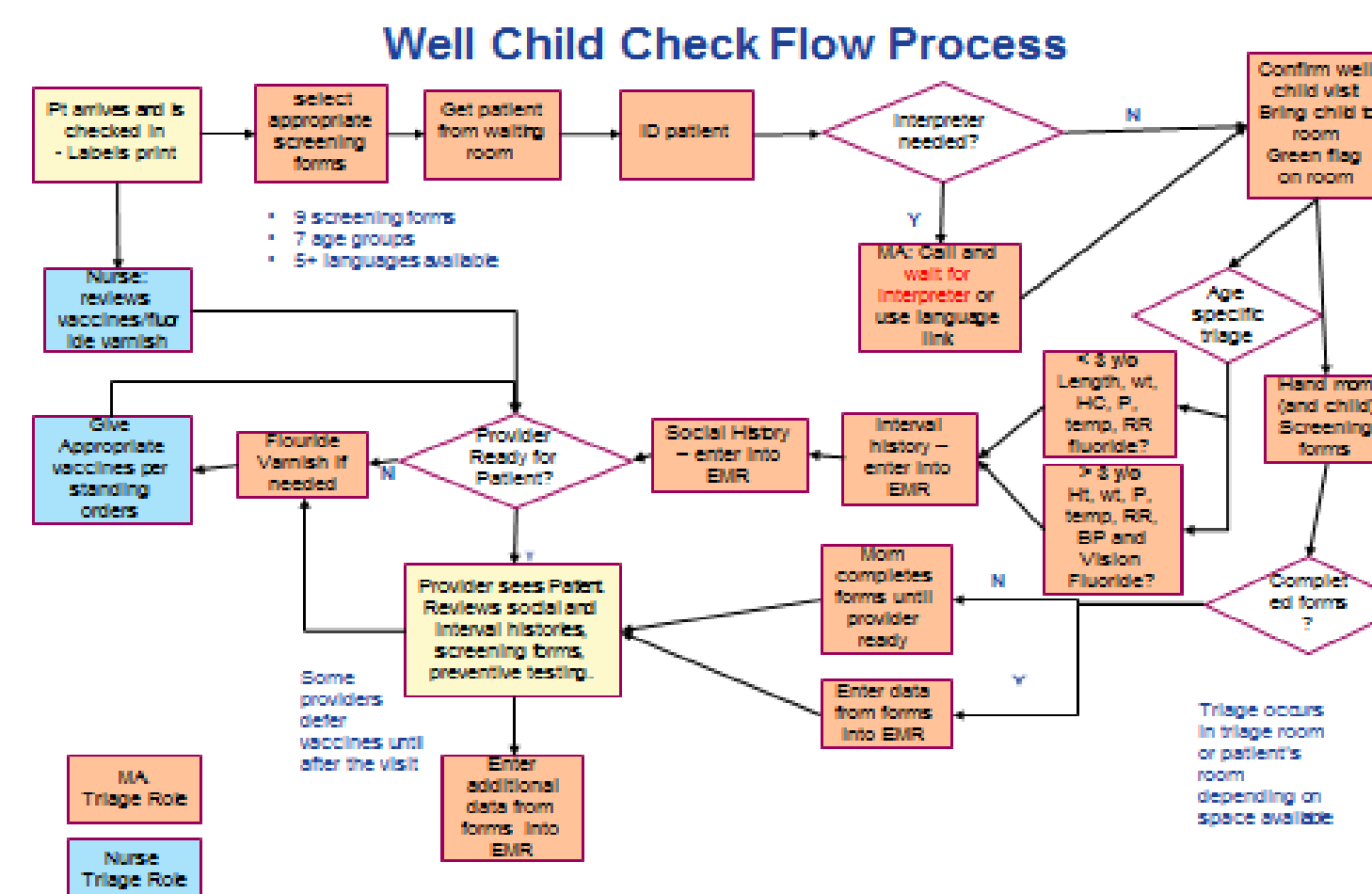
Increase the % of patients in the room, ready for the provider and within 5 minutes of the appointment time to 60%; for Well Child Visits, increase to 40%. Hypotheses #1 if we modify the Well Child Visit triage process, the time saved will make the overall visit shorter. This would open up a room, freeing up a provider and allow other patients to be roomed more promptly, decreasing time in the waiting room. This should shorten Check in to Ready and Appointment to Ready for other patients. Hypothesis #2, when patients are seen in a more timely way, patients and staff are more satisfied and more resources are available for each encounter

PDSA

- Plan: Reduce wasted time selecting and looking for well child screening forms by creating packets of forms appropriate to age and language
 - 0-15 m = Peds Response and Interconception Counseling (ICC)
 - 18-24 m = Peds Response, ICC and MCHAT
 - 3-5 y/o = Peds Response
 - 6-10 y/o = Pediatrics Symptoms Checklist (PSC)
 - 11-12 y/o = PSC, Youth-PSC, Guidelines for Adolescent Preventive Services (GAPS), Early GAPS child
 - 13 y/o = PSC, Y-PSC, GAPS, initial GAPS
 - 14-18 y/o = PSC, Y-PSC, GAPS, periodic GAPS, CRAFFT
- Do: Over 3 days on 2 teams will trial packets in English and Spanish
- Study: Review Check in to Ready time for Well Visits on those days. Give nurses and MAs brief survey: Did this make it easier? Did this make it faster? Would you continue this method?
- Act: If helpful, consider rolling out to other teams, other languages.

Future PDSA Considerations:

- For Well Child Visit triage:
 - Load grouped, language specific Well Child Screening forms onto EMR
 - Have medical records participate in preparing for well child visits
 - Have interpreters, Mas and Medical records work together to input data from forms
 - Discuss with Provider Group why each form is required and if there are (shorter) alternatives that perform screen equally well
- For all patients:
 - Evaluate OB and Well adult visit triage process in similar way
 - Evaluate Ready to Check Out to better evaluate if providers' visit time is part of problem of getting patients in room, ready, on time.



Establishing a Colposcopy Referral Service at a Family Medicine Residency Training Site

Ronald Adler, MD, FAAFP

Hahnemann Family Health Center, Worcester, MA

April 2014

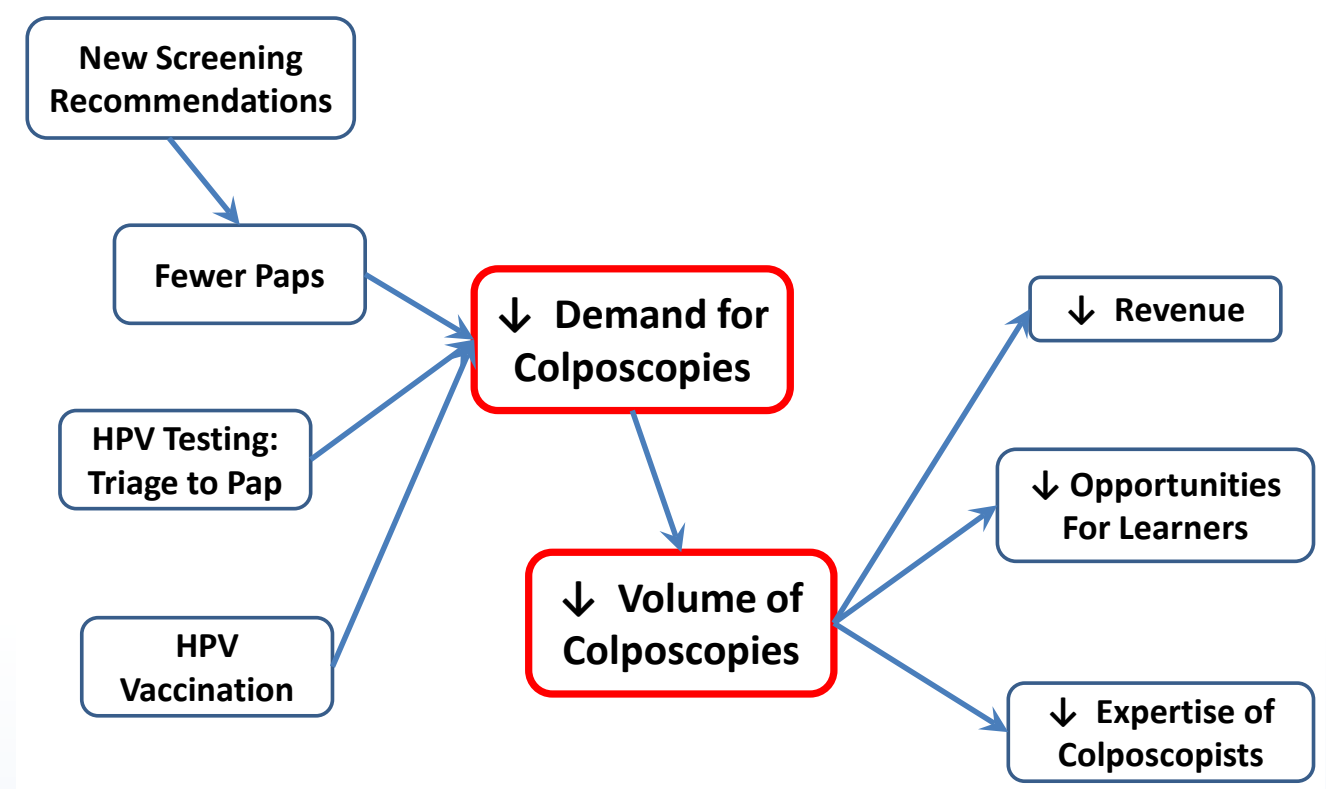


Problem Statement

In the near- and long-term, fewer colposcopies will be needed for a given population. This will present challenges for colposcopists to maintain their skills and expertise. It may also reduce training opportunities for learners. Substantial revenue opportunities are “leaking” out of the Department of Family Medicine and Community Health.

Root Cause Analysis:

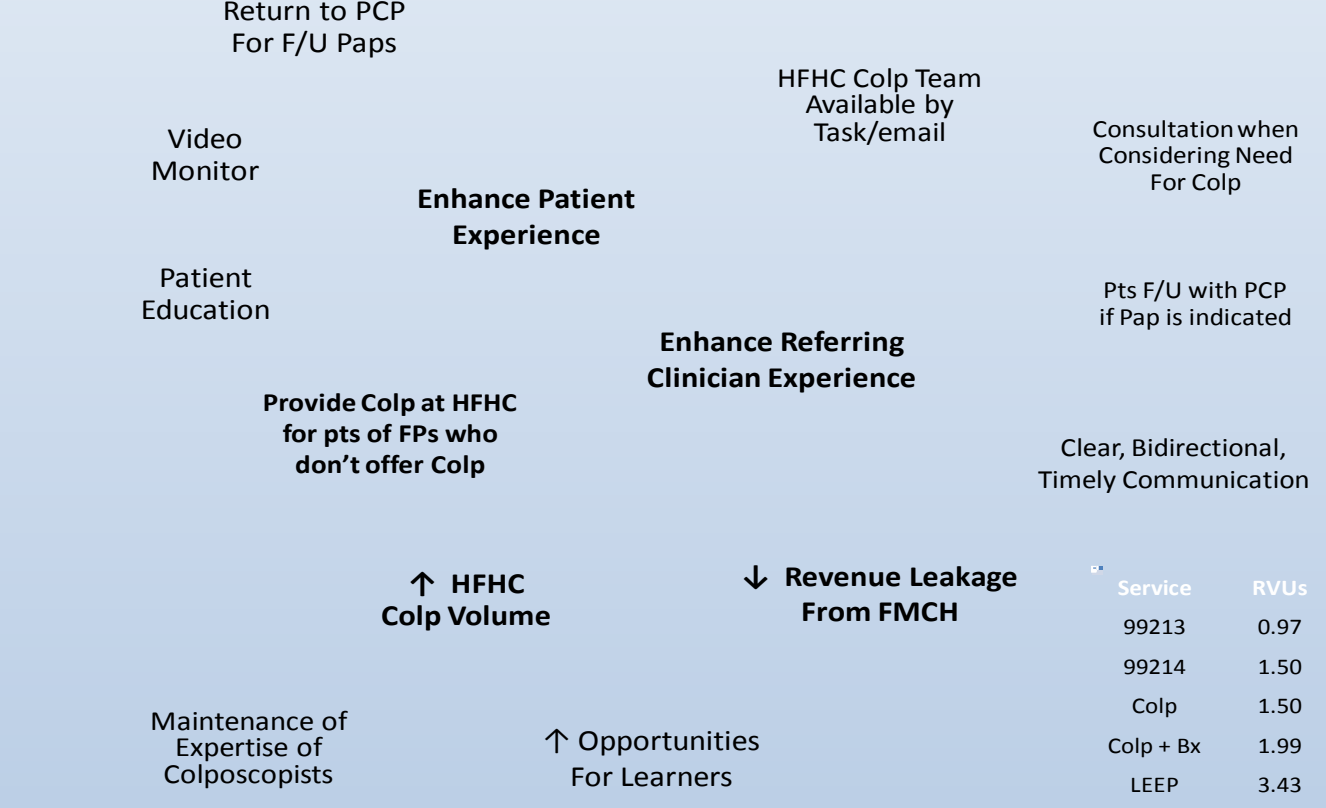
Current State: Drivers and Consequences



Scope – Includes:

1. HFHC colposcopy providers: Ron Adler, Katharine Barnard, Stephanie Carter-Henry, Jeremy Golding.
2. Family Medicine providers in or near Worcester who do not work in a practice that offers colposcopy and who use Allscripts as their EMR.
3. The patients of FM providers noted in (2), above.

Future State: Benefits



Goals

1. Increase volume of colposcopy performed at HFHC by attracting referrals from local FM providers who do not do colposcopy. This will result in:
 - Maintenance of high levels of expertise among HFHC colposcopists
 - More and better learning opportunities for residents and medical students at HFHC
 - Enhanced revenue at HFHC
2. Establish standardized protocols that work effectively and efficiently for referring providers, patients, and HFHC colposcopists and staff. These will include the following:
 - A consultation service through which PCPs can receive answers to questions regarding appropriateness of colposcopy vs. alternative management strategies for abnormal Pap/HPV results
 - Facilitation of scheduling colposcopies
 - Communication of results and future management steps
 - Education of patients in plain language such that they can understand the significance of their results and participate in shared decision-making

PDSAs/Process

Conversations → email dialogs → meetings → repeated, iterative dissemination and review of evolving proposed workflows and supporting documents

Guiding Principles:

- Define processes that are clear and can be standardized
- Make it easy to do the right thing
- Consider the needs of the “customers:” patients and referring providers
- Identify exactly who will do each step
- Assign roles according to training, abilities, licensure

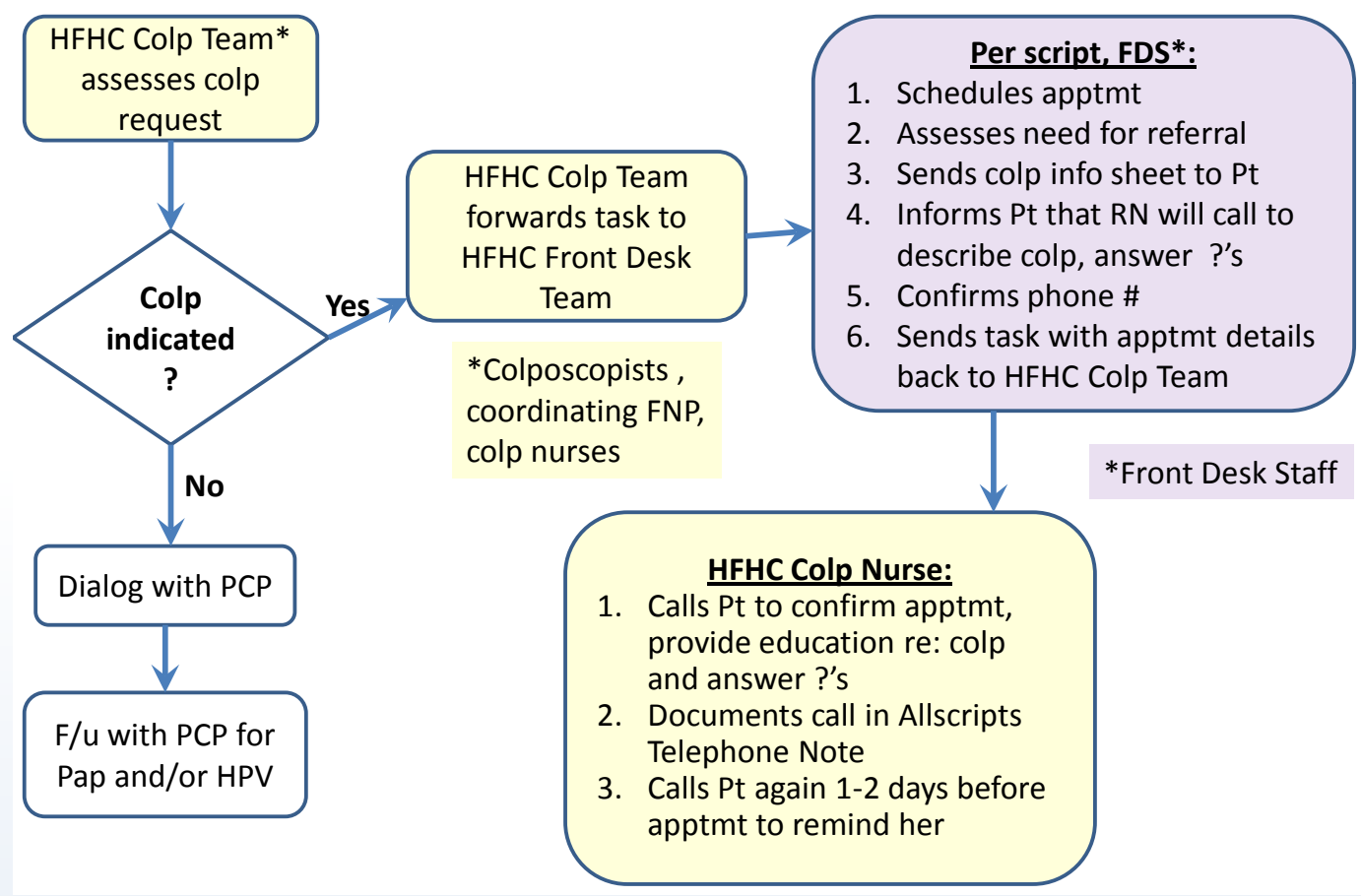
Supporting Documents and Work Flows

Supporting Documents:

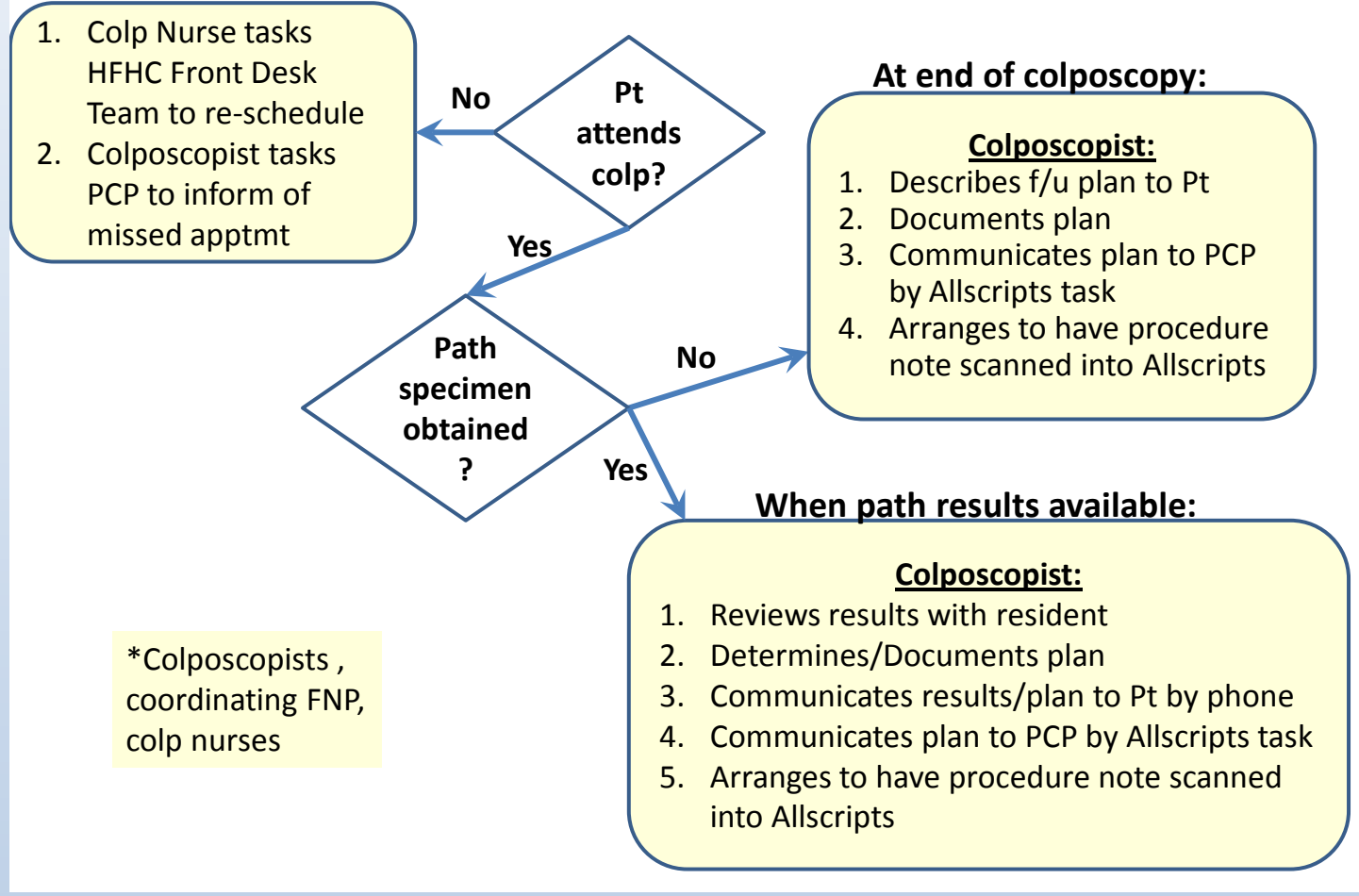
- Script for Front Desk Staff
- Patient Colposcopy Information Sheet
- Invitation letter to potential referring clinicians
- List of identified potential “customers”
- RVU data for specific colposcopic procedures

Work Flows:

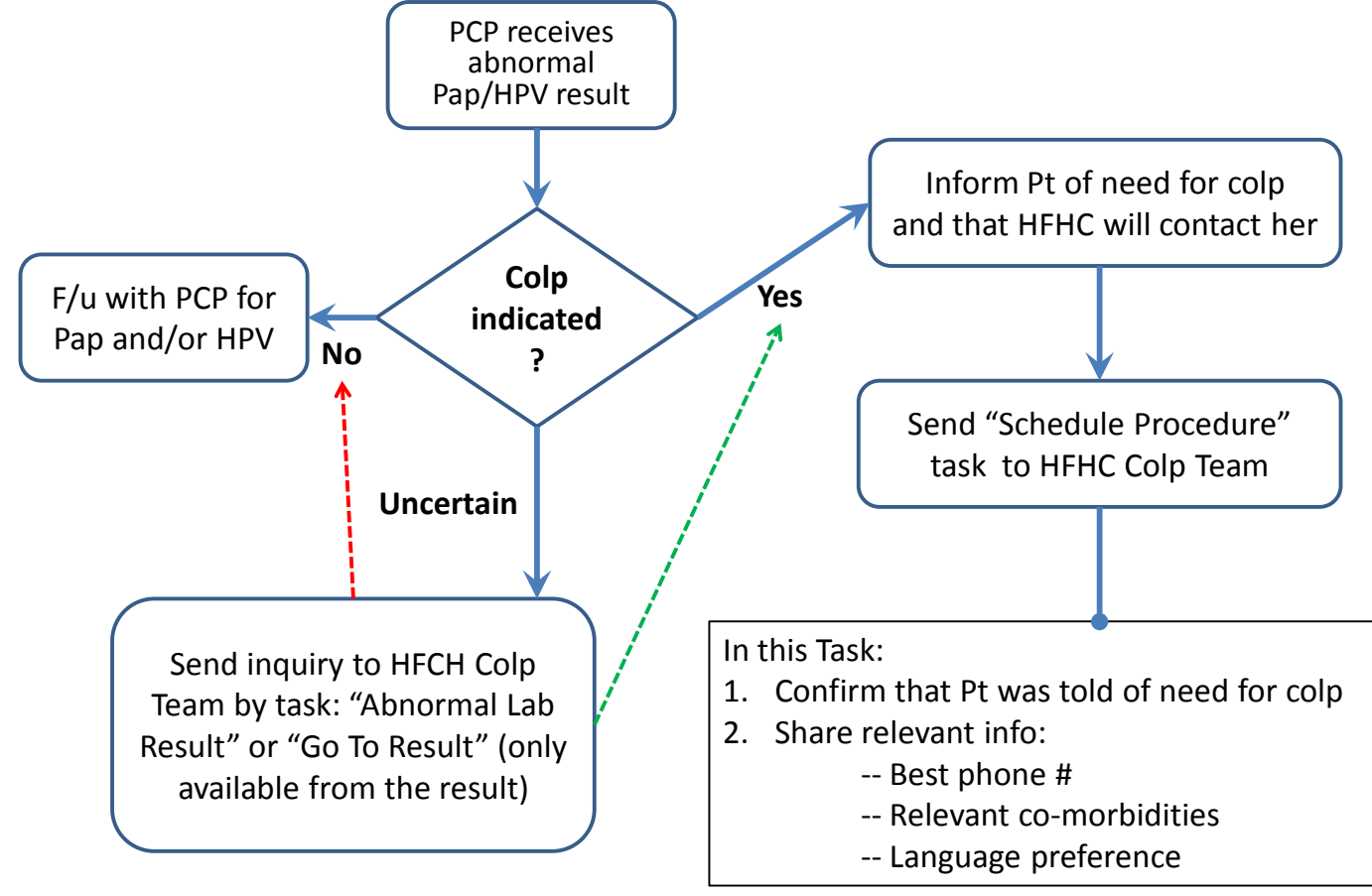
Colp Referral Process: HFHC, Pre-Colp



Colposcopy Follow-Up Process



Colp Referral Process: PCP



Next Steps

- As implementation proceeds, further refinements may be indicated.
- Data to be tracked:
 - HFHC colp volume (monthly and per session)
 - Referral colp volume
 - Referral colps as % of total colps
 - No-Show rates
 - Colp RVUs
- Consider expanding process to other procedures such as IUD insertion and EMB
- Establish monthly educational Colposcopy Case Conference (“3C”)

Acknowledgements

Stephanie Carter-Henry, Eileen Rafferty, Jeremy Golding, Katharine Barnard, and David Gilchrist participated in the development of this project.

Ronald.Adler@umassmemorial.org

A3 – Enhanced PDSA

Project Title: Securing Financial Stability for the Center for Integrated Primary Care

Owner: Sandy Blount

Date: 4/9/2014

A3

Plan • Do • Study • Act (PDSA)

Team Members: Sandy Blount, Ellen Endter, Ali Connell, Dan Mullin, Amy Green, Jodie Martineit, Melissa McLaughlin

Problem Statement: The Center for Integrated Primary Care needs to generate revenue sufficient to cover its costs, both incurred and assigned. It missed achieving this by about 33% this year.

Scope: Members of this team plus other Center faculty

Background/ Current Conditions:

- For many years the revenue of the training programs (which became the Center) increased every year
- In 2011-2012, the PCBH program trained 150 participants on contract for one entity, greatly boosting overall numbers.
- In 2012, the ICM program was developed on contract to CIHS for \$123k above tuitions
- In Spring 2013, the ICM program had 260 participants from one entity.
- ICM has gradually increased participation, if the one time windfall is removed.
- PCBH has gradually lost participation over the last two years.
- MI has gradually increased participation, but has small numbers and high overhead compared to the other two programs.
- During the “good years,” for the Center, when the Department was stressed financially, the Department began to account more of the Behavioral Science and behavioral health programs (e.g. the Fellows) onto the Center’s revenue. This led to the Center’s 400K in revenue being 200K short of expectations in 2013.
- The Center has not had a functioning budget to be used to inform spending decisions.
- Our financial difficulties have come as we may have used up the “early adopter” group, but integrated care is growing exponentially across the nation

Root Causes:

- Competing program is in Beta this spring offering similar training free.
- Four competing programs nationally
- We have followed two marketing approaches since we began, emailing to a list we have assembled and exhibiting at conferences. No other approach has been used to any substantial extent.
- The benefit from any one approach to marketing tends to attenuate (list gets used up, regulars at a conference have met us)
- We have not gotten the benefit of new large organizational contracts for the “stabilizing bump” we got in other years.

Goals:

- Generate 3000 qualified new email leads.
- Enrollment targets: Increase enrollment by 20% over 2013-2014 levels.
- Bring in at least 1 large (100 participants) organizational contract
- Generate \$650,000 in gross revenue

Countermeasures (Plan):

- Develop a marketing plan that includes a schedule of actions taken (project management structure) – Ellen
- Develop a budget to support decision making – Ellen
- Re-vamp brochures to better make the case briefly and graphically why people need our programs
- Re-do our website to be more user friendly, more informative with constantly increasing information about the field, more visually interesting, easier to use and more easily updated
- Open up businesses beyond the current 3 courses

Implementation (Do):

- Meeting with Mullin, Blount, Endter and Connell held in February to focus on potential markets for each program – who has taken it, who is likely to want it, who might want it for their employees.
- Ellen met with Bern and got initial numbers to give overview of our position
- Decided to send Ali to Case Management Society of America conference to present, and coached her in working the conference for leads, but canceled the booth rental, saving about \$2500.
- Decided not to exhibit at APA (save \$3500) and faculty will go using their professional funds (save \$2000 per)
- Submitted AG grant to fund 150 PCBH, 100 ICM per year for 2 years, plus developing two new courses.
- Previously wrote evaluation proposal for integration project in MD which was submitted to CMMI. Our section was for \$1,000,000. Awaiting award announcement.
- Wrote proposal for training for Value Options in Colorado which was funded. Expect 75 in PCBH and 75 in ICM over the next year

Results/Conclusion (Study): Collect data and begin analysis. What behaviors did you observe? What happened? What were the challenges? What did you learn? Did you meet your measurement goal listed in the countermeasures (show results)?

Follow-up Actions (Act): Are we ready to make a system change (if so: who, what, when, where)? Do we need to make revisions and test again in next PDSA?

Problem Statement

The phone service level for HFHC has been below the target of 85% for the past 9 months resulting in a poor patient experience.

Scope

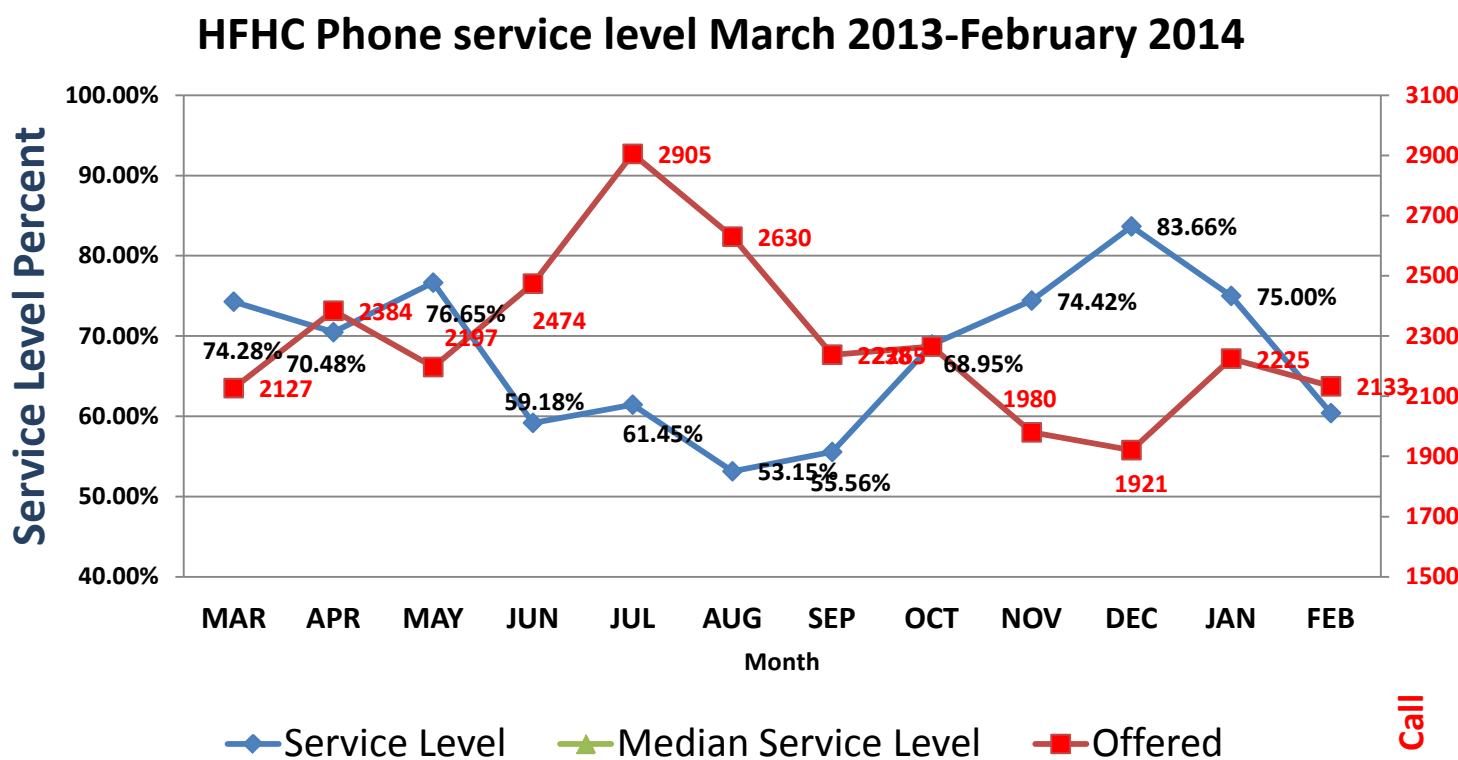
IN: Pt calls HFHC to request processed
OUT: Other family medicine clinics

Goals

- Attain phone service level of 90%
- Reduce number of phone calls to under 1900 calls per month

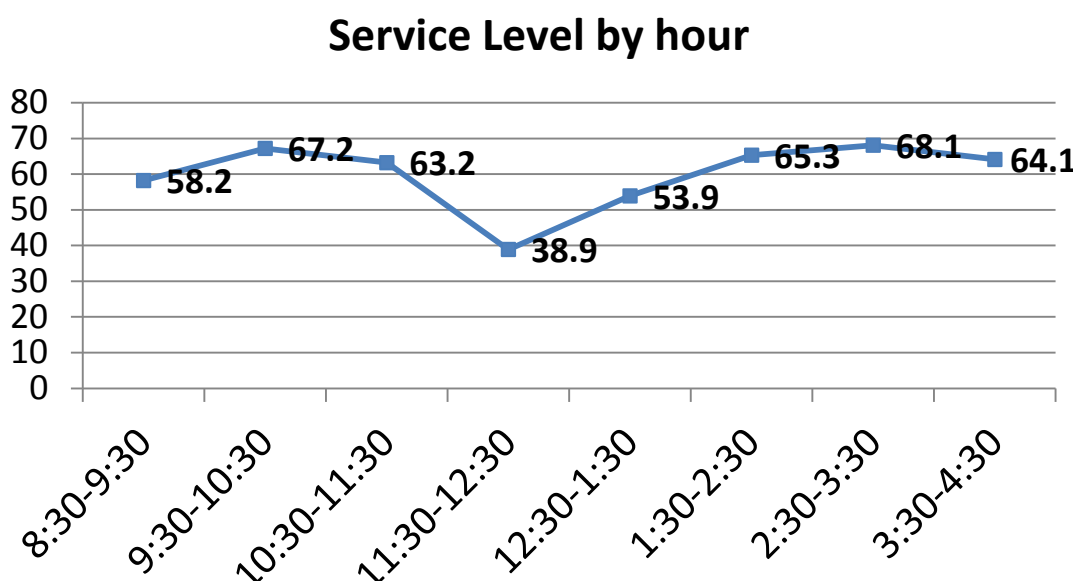
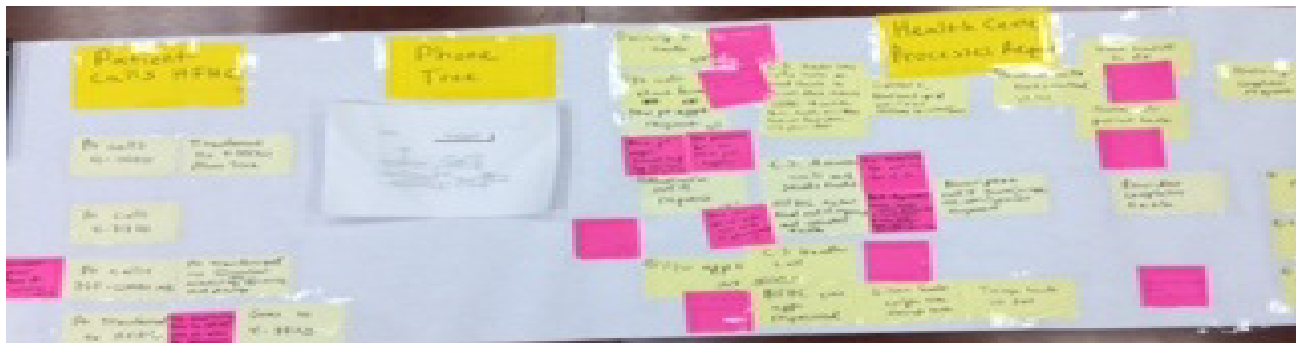
Background

- The phone service level for Benedict has been consistently above 95% for the past 8 months while the other sites struggle to keep the same level of phone service.
- 10% of calls to the health center are wrong number transfers
- Patient’s experience of ease of access on the phones to the practice has been 83-84% for the past three quarters

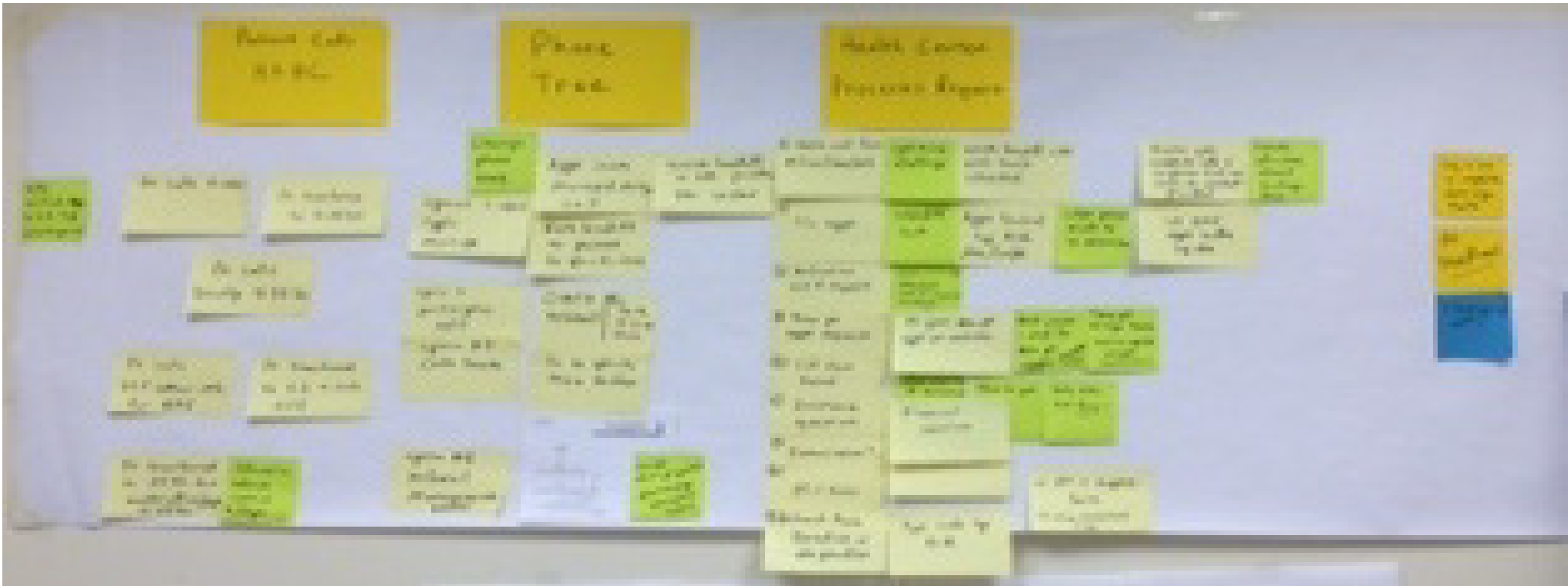


Root Cause Analysis

- Lack of standard processes regarding how to handle each patient call/request
- Phone tree is cumbersome
- No tracking of data on a daily basis to give feedback for continuous improvement
- Unclear expectations for ready status
- Difference of resources from site to site



PDSA



Countermeasures (Plan):

- Revise the phone tree and trim down to one menu
- Get schedule out further to reduce call backs for appointments (waste)
- Create policy around ready status for those answering the phones and other options when on the phone.
- Create policy around forms for patients and workflow to reduce call backs about forms
- Set up daily service level reporting
- Create tasking types
- Education with operators regarding correct

Implementation (Do):

What	Who	When
Ask phone tree folks to remap phone tree and eliminate all other steps	Zailee	May 1st
Get schedule out 3 months in advance	Lindsay	May15th
Create clear expectations about ready status, and other potential status on the phones	Lindsay and Massiel	May 1st
Create policy/workflow for forms coming into the office for improved turnaround and clarity for patients/staff.	Dave	June 1st
Set up daily service level reporting	Lindsay	May 1st

Study: To be done once countermeasure implemented

Act: TBD

Barriers/challenges: reductions in force at HFHC and central scheduling, lack of ability of central scheduling to take on overflow calls, new office manager

Problem Statement

Patients of PVHS wait too long in the waiting room, which contributes to patient dissatisfaction and creates stress for staff & providers. Waiting room time is directly affected by clinic flow.

Scope

(In) All patients with scheduled appointments at PVHS. Time from check-in to being called into exam room. (Out) Walk-ins.

Goals

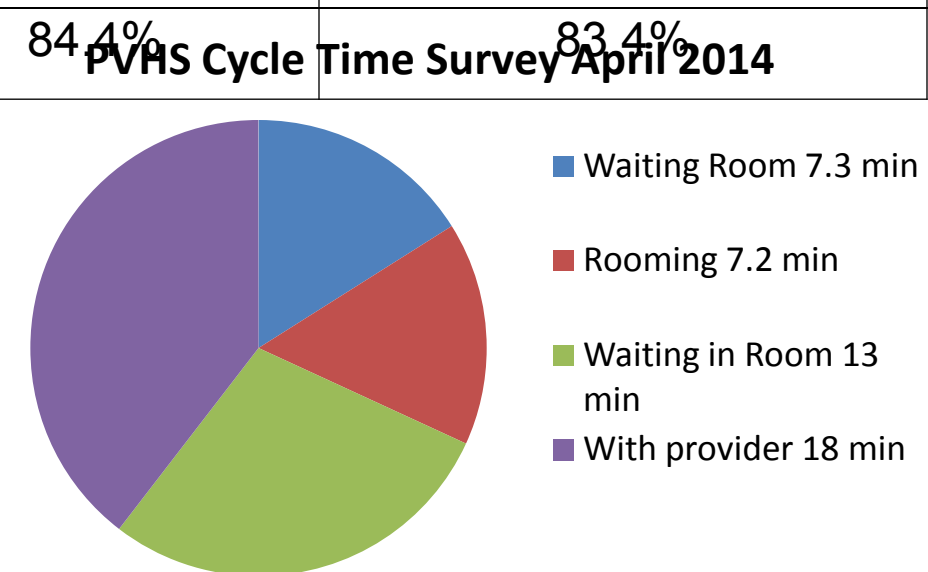
5% increase in patient satisfaction scores about waiting by Oct 2014 to reach ambulatory mean, without reducing satisfaction in other areas. Reduce “sentinel events” (waiting > 20 min) to ≤ 4 per day by Oct 2014.

Background

- National average waiting room time = 20 minutes. PVHS avg waiting room time = **7.3 min**, though with longer waiting time when clinic is busier.
- Patient satisfaction scores re: waiting are consistently lower than scores for our clinic in other domains. Clinic and hospital system place importance on patient satisfaction scores.

Internal Patient Satisfaction Survey for: 2014Q1 Department: PLUMLEY VILLAGE HEALTH SERVICE

Question	Replies	Mean Score (Dept)	Mean Score (Amb)	Mean Score (Amb Prior Qtr)
4. Waiting time in the reception area	26	79.8%	86.2%	85.8%
5. Waiting time in the exam room	27	78.7%	84.4%	83.4%



- transformation.
- Financial situation of institution affects availability of resources for clinic.
- Balancing priorities: Need to maintain access, as well as meet revenue & volume goals.
- Other clinics working on same problem, can share best practices.

Root Cause Analysis

- Scheduling outstrips ability to move patients through clinic, creating a backlog.
 - Many patients require more than 15 minutes of exam room time (complex patients, well child checks, patients needing nursing interventions). Average room occupancy time is **40 min**.
 - Rooming process occupies **7 min** of allotted visit time; slowed by IT issues.
 - Providers overbook their schedule (to preserve patient access).
 - More than 2 providers booked for patients during clinic session, without staffing or number of exam rooms to support flow.
- Patient behavior affects efficiency, ie: late patients disrupt flow, patients expect to add on family members, patients delay registration process by engaging in questions/talk with receptionist.
- Visit agendas become overfilled due to both patient expectation and PCMH/clinic processes.
- Patient perception of acceptable wait time may be different from clinic's; in fact, some wait time is perceived to be “too short”.

PDSA

Countermeasures (Plan):

1. Cycle time survey x 1 week all patients. To include data on day, time, provider, satisfaction with wait time. Repeat in 3 months and 6 months.
2. Ensure complex patients are designated in IDX to be scheduled for 30 min visits.
3. Schedule WCC as 30 min to allow for appropriate time in room (or 45 min for two siblings).
4. Capacity study re: panel size, ability to take on new patients.
5. Tuesday morning 1st patient should not be scheduled at 9:30 (exact end time of practice meeting).
6. Conduct process map to gain better understanding of clinic flow issues and areas to focus.

Implementation (Do):

1. Create cycle time survey (KB). Gather materials (clip boards, stop watches) and educate front desk staff (MR), educate clinical staff (JW) and providers (KB). Choose week and conduct survey. (KB, MC)
2. Front desk staff to check with provider partner about list of complex pts, enter in IDX. (MR + FD Staff)
3. Change WCC scheduling template (MR). Educate front desk (MR), nsg (JW) & providers (KB).
4. Gather data on current panel, visit #s, provider availability, new pt waitlist #s, and use data to complete capacity study. Survey providers about acceptable rate of new pts to be scheduled. (KB)
5. Change Tues morning template to start at 9:40. (MR/YD)
6. Extended staff meetings (March & April) to work through process map and find UDI's to prioritize. (MR, KB)

Results/Conclusion (Study):

1. Analyze cycle time results to identify (1) average waiting time, (2) patient perception of waiting time and (3) areas of inefficiency or mis-match. (KB)
2. Check in with providers about ability to care for complex patients. Monitor access (lag days) and volume (ability to see 10 pts per session). (MR)
3. After 1 month verify result of change in WCC template time. Is it working? How are providers using the “extra” time? Monitor access (lag days) and volume (ability to see 10 pts per session). (MR)
4. Determine ability & rate to accommodate new patients. (KB)
5. Verify schedule change on Tues mornings, check with providers about improved start timeliness (MR)
6. High freq, high impact UDI's can be compiled as next steps. (Team)

Follow-up Actions (Act):

1. Enter data into “background” (KB), identify new areas for countermeasures. (Team)
2. Check in with providers about ability to care for complex patients. Need to increase or decrease # of patients specified for 30 min visits? (MR)
3. Standardize WCC template time, or make new plan. (MR + Team)
4. Make plan for accommodating new pts on list, disseminate plan to FD staff. Check status of list and plan in 1 month. (KB, MR, MC)
5. Standardize Tues morning start time (MR)

Problem Statement

Diabetics should have a hemoglobin A1C (HgbA1c) blood test performed at least twice each year to monitor their blood sugar control. The proportion of diabetic patients in the Benedict Family Practice who meet this quality standard is below the state average.

Background

Blue Cross is basing payments on quality performance.

To meet the minimum quality standard, testing should be complete on 72% of diabetic patients.

Two years into our efforts to improve performance on this measure, testing is complete on only 58% of our 801 diabetic patients.

Scope

Diabetic patients with Blue Cross insurance (n=73).

Root Cause Analysis

1. Patients don't make and keep appointments.

2. Providers forget to order the test.

3. Patients do not go to the lab ...
because they forget,
because they can't wait, or
because they don't want to know.

PDSA

1. Get patients in the door

Providers

Ask all diabetics to book an appointment to return in 3-4 months.

Set refills on one diabetes medicine for one month beyond the next appointment to alert us if they cancel their appointment and do not come in.

Forward all No Show notifications for diabetics to scheduling for automatic rebooking.

RN

Generate a list every month of Blue Cross diabetics who are not up to date and call them to book an appointment.

Scheduler

The scheduler will indicate on the schedule that the next appointment is for diabetes so the rooming nurse will know to perform an HgbA1C.

Triage Nurses

When patients call, the nurse will identify those diabetics who have not been seen for 5 months and book an appointment.

Prescription Refill Specialist

When patients call for medication refills, she will identify those who have not been seen for 5 months and book an appointment.

2. Identify patients who need testing at the time of their appointment

A secretary will generate a list for the nurses and providers of booked patients who need testing.

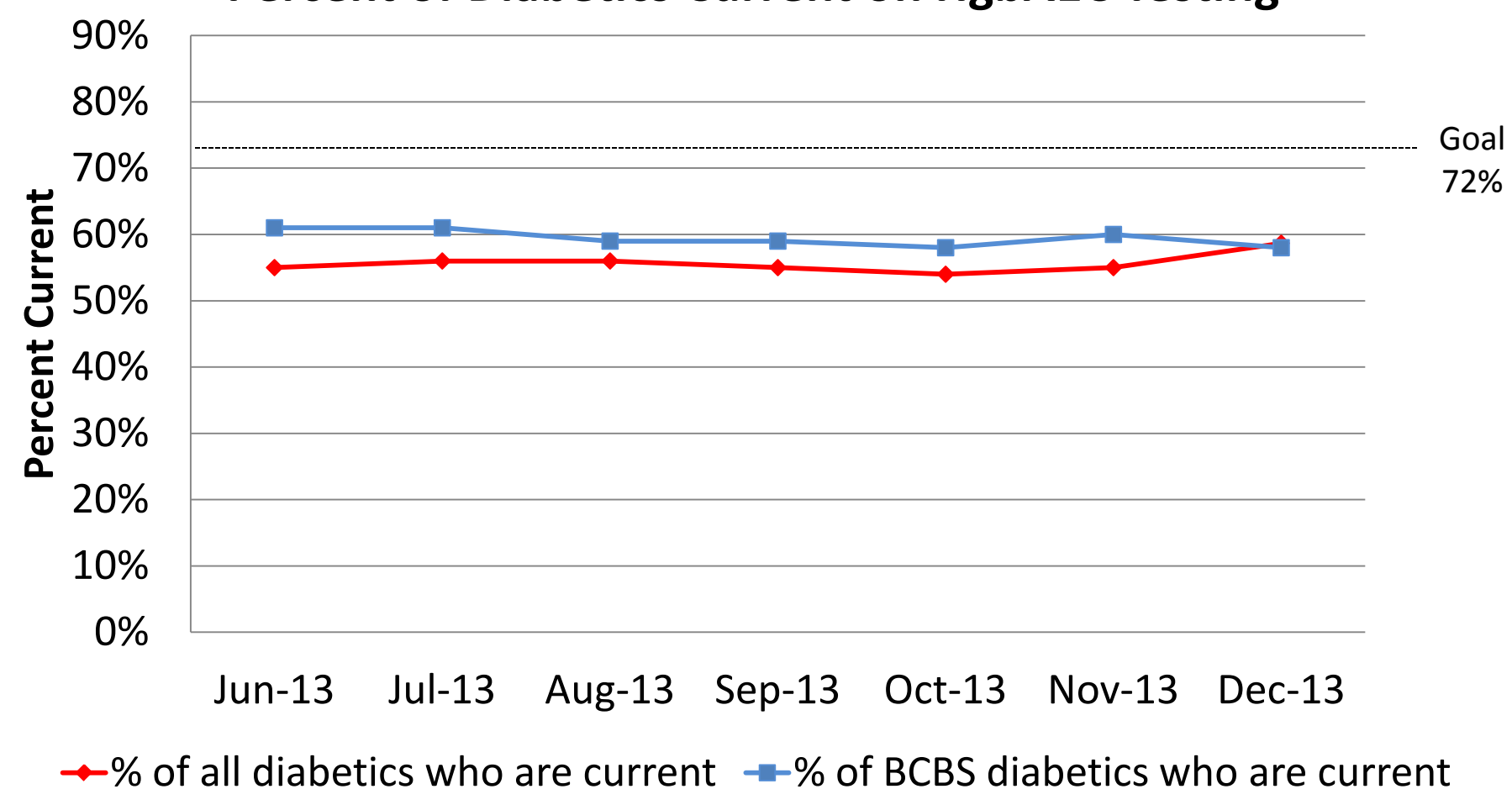
3. Obtain a Point of Care HgbA1C machine

Train the staff to use it.

Nurses will perform the HgbA1C test before the provider sees the patient.

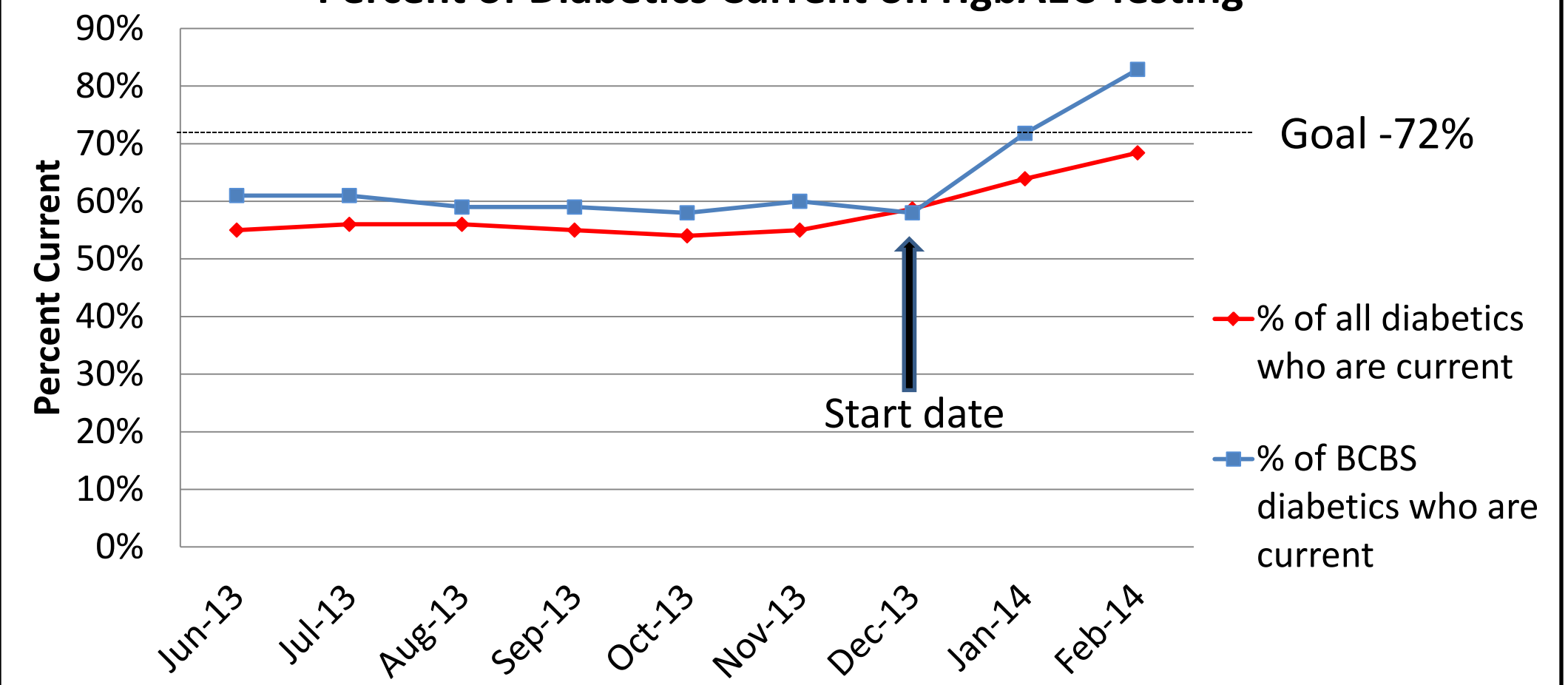
Goals

Percent of Diabetics Current on HgbA1C Testing



Increase the proportion of BCBS patients who have had at least two HgbA1c tests in the past year to 72% by June 2014.

Percent of Diabetics Current on HgbA1C Testing



Problem Statement

There is little consistency to resident scheduling. This makes continuity and consistency difficult for both residents and their patients. Further the sporadic scheduling causes significant flux in preceptor scheduling as well impacting the entire health center staffing.

Scope

Will impact health center schedules and central residency curriculum schedule.

Goals

Implement a more consistent resident continuity of care schedule

Background

As family physicians, continuity of care is essential to the work that we do.

Currently, resident schedules at the health center are based on the rotation templates from the central residency office. These templates are designed to maximize the educational benefit of the rotation but often have some flexibility.

Given that the templates are not coordinated across residents there is great variation in the number of residents in the health center at any one time. This impacts preceptors as well as availability for patients.

Idea developed at curriculum retreat in 2013, proposal delayed in action secondary to multiple other changes in the curriculum in 2013. Idea again discussed at curriculum retreat in 2014.

Root Cause Analysis

Schedules are based on rotation templates instead of health center, patient, or resident needs.

Educational opportunities happen at certain times and health center experience generally more flexible.

Service demands require resident schedules to attend to those needs

PDSA

PLAN:

Design a scheduling system that promotes the value of continuity of care through more consistent resident scheduling and teams of care. This will promote more consistency for patient availability and preceptor requirements.

Develop a concrete scheduling template to discuss with schedulers at each health center.

Recognize challenges that will be barriers to implementation and propose solutions to overcome those barriers.

Develop list of exceptions that will be necessary to maintain balance with other service requirements such as night float weeks, off service rotations (PEDS, OB, ED).

DO:

Curriculum meeting held April 1 to discuss details of plan

Scheduling meeting April 10th with HC schedulers and central residency staff

STUDY:

Will need to develop measures for resident scheduling consistency with specific goals. (i.e. Residents are present in health center for 75% of set sessions)

ACT:

Plan to develop draft schedule by May 15

Start date for new schedule July 1

Measure consistency with set schedule monthly with quarterly reports

Recognize deficiencies and reanalyze root causes

A3 – Enhanced PDSA			
Project Title: Defining Faculty Roles		Owner: Bob Baldor	Date: 04/10/2014
A3		Plan • Do • Study • Act (PDSA)	
Team Members: Chuman, A; Dimitri, D; Weinreb, L; Gilchrist, D; Potts, S.		Countermeasures (Plan): <ul style="list-style-type: none">Define faculty roles (e.g. core residency faculty, health center preceptor, medical student educator, medical manager, academic manager)Define alternative tracks for faculty jobs	
Problem Statement: Because of the varying duties of the Department’s clinicians, there are no clearly defined faculty roles.		Implementation (Do): <ul style="list-style-type: none">Problem presented to Leadership Team and to gain perspective on the problem, back ground and root causes (Feb/March 2014)A3 team met to clarify problem, scope and discuss background/root causes. The following basic principles were felt to be important (April 2014):Position descriptions will recognize that all clinicians are working in and contributing to an educational environmentPotential roles could include: Core Residency Faculty; Clinician-Educator; Research-Clinician.It is understood that there is a need for certain specific leadership roles (e.g. Residency Program Director) as wellAction items:Given the new RRC guidelines for ‘core residency faculty’ we will use those requirements to develop a specific ‘Core Residency Faculty’ position description, as a template to work from as we consider specific faculty roles and responsibilities (Potts)Report back to the LT in June with a plan	
Scope: Clinically active salaried members of the Department		Results/Conclusion (Study): Collect data and begin analysis. What behaviors did you observe? What happened? What were the challenges? What did you learn? Did you meet your measurement goal listed in the countermeasures (show results)?	
Background/ Current Conditions: <ul style="list-style-type: none">Each of our practices include clinicians focused on differing aspect of the Department’s multiple missions (Graduate Education, Undergraduate Education, Research, Medical Care, etc)While we have a ‘minimal expectations of faculty’ document, our present faculty job descriptions do not clearly define roles for the various expectations of our diverse faculty“Making practices work better” has been identified as a Must Do/Can’t Fail priority for this yearThe RRC has clearly defined needs for ‘core’ residency faculty needsThere are limited (and decreasing) financial resources to support non-clinical workA key strategy to stabilizing the Department’s finances is through increased clinical productivityA Department goal is to grow and enhance the role of clinically focused facultyClinically active faculty need to feel good about working in an environment where many of their peers may be running off to the medical school, to meetings or precepting residents – while they are ‘left to cover the practice’ and take call.We have finite support (and a finite need) for teaching. As we grow our practices, the support for teaching time remains constant, and we either spread the teaching across larger numbers of faculty (everyone does less), or we need to hire clinically-focused faculty.Recent attrition of more clinically oriented faculty, has highlighted a sense they felt a lack of support for their clinical roles, and they needed to work in a place where clinical practice was more of a priority.		Follow-up Actions (Act): Are we ready to make a system change (if so: who, what, when, where)? Do we need to make revisions and test again in next PDSA? <ul style="list-style-type: none">Identify faculty roles/positionsDevelop specific position descriptions	
Root Causes: <ul style="list-style-type: none">We are committed to multiple missions and our practices have significant histories, structures and missions as teaching programsIn the past, the education and research missions have been co-equal drivers, both trumping clinical practice. We developed clinical practices that serve learners or faculty first, patients secondWe have created multidimensional faculty roles– mostly all part time clinicians, with significant portions of time devoted to teaching or scholarship, often off-site, which contributes to dysfunctional practices.These faculty roles are ingrained and coupled with the lack of clarity around specific expectations of ten creates frustration in meeting all of our missions (e.g. who is going to teach a workshop, student session, evening clinic, etc)In the current academic environment there is more prestige to being ‘scholarly’ focused, than clinically active and our departmental promotion emphasis has been for scholarly work			
Goals: <ul style="list-style-type: none">Develop new faculty position descriptions that clarify and recognize the various faculty roles (e.g. clinician, educator, manager)Refine our compensation plan to reflect the financial contributions of clinically focused members of the faculty Timeframe: December 2014			

A3 – Enhanced PDSA

Project Title: Feedback for Change

Owner: Alan Chuman

Date: 04/10/2014

A3

Plan • Do • Study • Act (PDSA)

Team Members: Alan Chuman (lead), Judy Savageau, Kate Sullivan, Dan Lasser, Mary Sullivan, Mary Lindholm, Stephanie Carter-Henry

Problem Statement: Previous Department climate surveys and the Morehead Surveys conducted for the Medical Group have found DFMCH faculty overall to be satisfied with their faculty roles, but very dissatisfied with their clinical practice environment. This survey data is echoed in discussions in faculty meetings and in anecdotal accounts of problems in practice. This dissatisfaction threatens our ability to retain faculty, and negatively impacts on quality, clinical productivity, and patient satisfaction.

Scope: Clinical faculty in the DFMCH (i.e., BFHC, HFHC, Benedict Bldg, Fitchburg, and FM Hospitalist Group); does not include non-clinical faculty, nor faculty who practice in non-UMass sites

Background/ Current Conditions: We know there is significant faculty dissatisfaction with many aspects of the clinical practice environment, and we have made improvement in the way our practices work a priority. We have also instituted a new Lean strategy to create a culture of openness to change and continuous improvement. We have, however, no means of providing departmental leadership with timely feedback regarding these efforts. The only current means of obtaining anything other than anecdotal feedback regarding faculty satisfaction is through the implementation of two surveys which either are conducted only every three years (Morehead) or, in the case of the departmental climate survey, every two years and more focused on overall faculty roles than on clinical practice satisfaction.

- Practices receive data on a monthly basis which highlight basic problems in practice operation, such as poor phone service to patients, and patient dissatisfaction with important aspects of practice (e.g., access, and waiting times in waiting rooms and exam rooms).
- Availability of adequate staff support is often cited as a significant problem by faculty.
- Unhappiness with the EHR is very high; dissatisfaction with the EHR and IS support were the areas of greatest dissatisfaction highlighted in the Morehead survey.
- The Department has begun a process utilizing Lean approaches to change, including multiple A3s, all targeted at improving the practice environment and faculty satisfaction with their work.

Root Causes:

- Practices are organized in a way which makes effective change difficult and which leads to physicians and staff feeling like victims of the process rather than active participants.
- The EHR, and lack of support for the EHR, have led to great increases in the time required for documentation.
- Physicians spend too much time in work that could be done more effectively by others.
- Previous surveys have highlighted physician unhappiness with various aspects of clinical practice, with little in the way of effective response.

Goals:

- Implement an easy-to-complete survey (of less than 5 minutes) through Survey Monkey which will solicit feedback from DFMCH clinical faculty on a monthly basis regarding their satisfaction with their clinical practice environment and their sense of efficacy regarding their ability to participate in the change process.
- Disseminate trend data from these surveys to the faculty and to departmental leadership to utilize in assessing progress and planning future initiatives.

Timeframe: Survey initiated in May, 2014, continued monthly for an initial period of 6 months, then evaluated for continuation or revision. Trend data presented at regular leadership team meetings.

Countermeasures (Plan):

- Implement an on-going survey process which is easy to administer (via SurveyMonkey), easy to complete (< 5 minutes), and easy to analyze.
- Review current survey documents such as the Morehead survey and department’s climate survey, and solicit input on survey content from department leaders and clinical faculty.
- Decide (using the project team) on the most helpful, targeted questions which will be used in monitoring trends in physician satisfaction and provide useful feedback to departmental leadership on success in the Lean initiative.

Implementation (Do): Describe what actions you are going to take. Identify steps including who is assigned and when it is due. Carry out the change or test.

- Implement monthly survey starting no later than May 1.

Results/Conclusion (Study): Collect data and begin analysis. What behaviors did you observe? What happened? What were the challenges? What did you learn? Did you meet your measurement goal listed in the countermeasures (show results)?

Follow-up Actions (Act): Are we ready to make a system change (if so: who, what, when, where)? Do we need to make revisions and test again in next PDSA?

A3 – Enhanced PDSA

Project Title: Idea System Utilization and Sustainability in Family Medicine
A3

Owner: Melissa McLaughlin

Date: 04/10/2014

Plan • Do • Study • Act (PDSA)

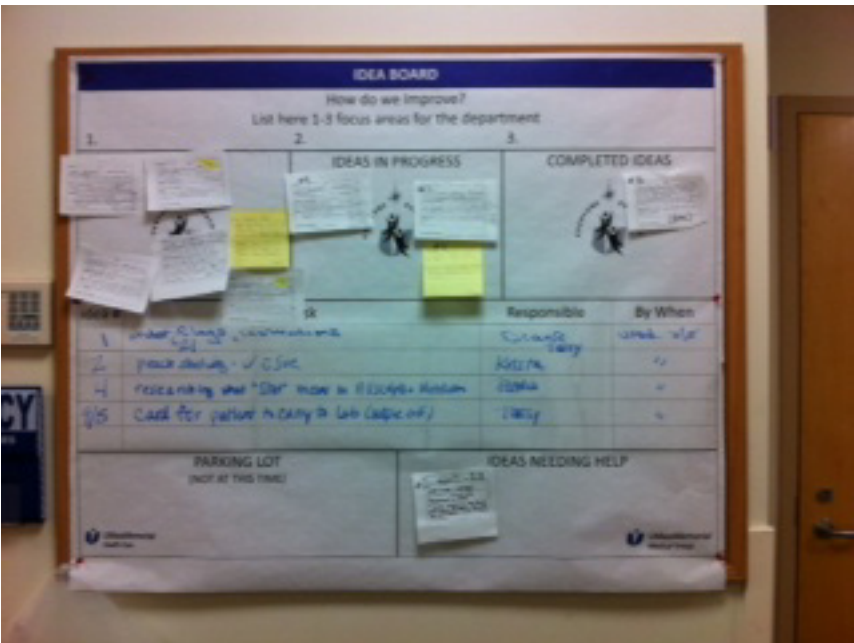
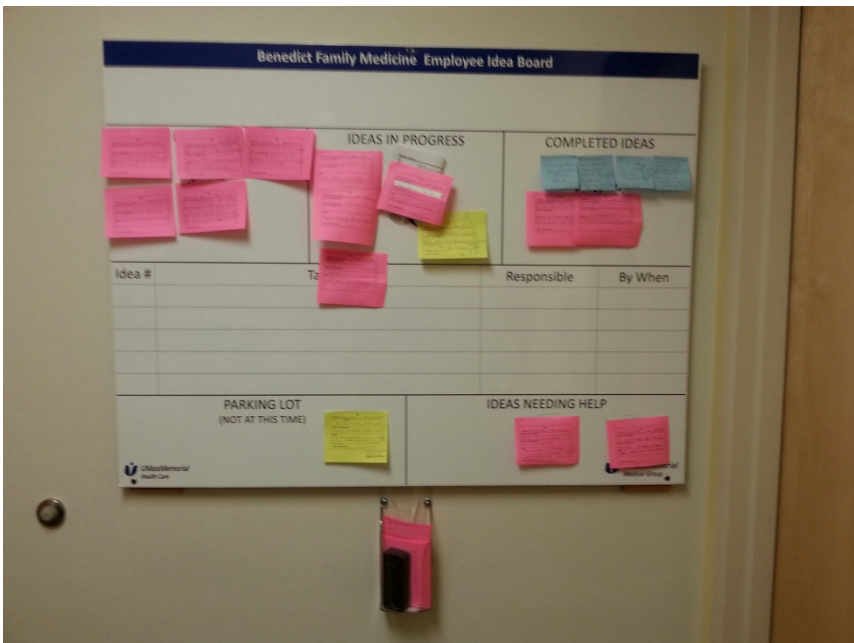
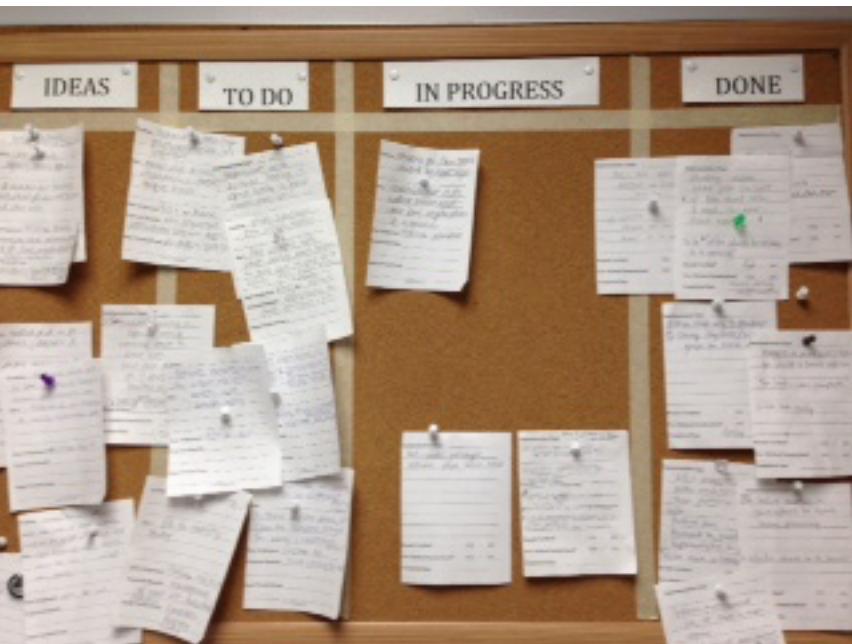
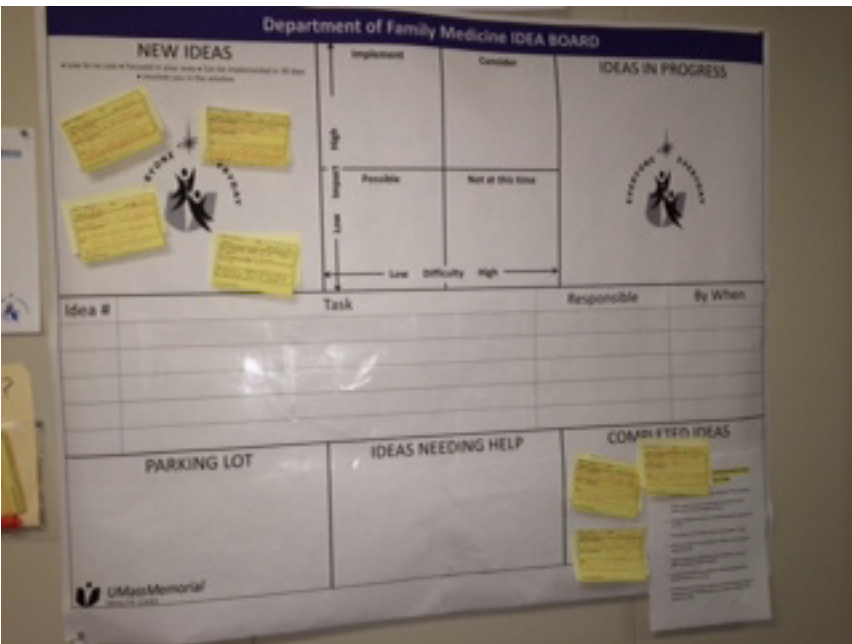
Team Members: Melissa McLaughlin Recommended team members: Colleen Bregman, St Patrick’s Blanche, Lauren Fletcher, Plumley?, Fitchburg?

Problem Statement: Although almost 100% of our practice sites have implemented idea boards we are not sure that they are being utilized consistently or facilitated appropriately resulting in variation of success and uncertain sustainability across the Department; administration and leadership are just getting on board. Implemented ideas are not being shared across sites or regularly being uploaded to the clinical system’s idea database.

Scope: All family medicine clinical/administration sites including: Barre, Plumley, Hahnemann, Fitchburg, Benedict clinic, Benedict administration and Benedict leadership

Background/ Current Conditions:

- Idea systems consist of more than just an idea board; requires available idea cards, a committed facilitator and regular team huddles - not sure this is standard practice across Dept.
- Idea systems are most effective when there is a set agenda and established ground rules and ongoing usage
- Staff were scared off by being asked to bring 1 new idea every month
- Idea boards are in currently displayed/in use at Plumley, Hahnemann, Benedict, Barre and Fitchburg and Benedict Administration



Root Causes:

- Too busy to huddle
- No one has the necessary time to commit to the required follow-up needed to implement an idea
- Lack of training (or awareness of offered training) on how to be an effective idea system facilitator
- Lack of knowledge about an idea database
- Practices are not being exposed to other ideas within the medical group that have worked and that could possibly be adapted to their site in solving a similar problem

Goals/Objective:

- Visit each FM site identified in the scope above to review the idea system being utilized and participate in a team huddle
- Distribute a short idea system assessment vi a email to practices in order to gather information on the current utilization of the idea board (3 star idea system by end of year)
- Increase the likelihood that idea systems can be sustained in our Department
- Increase amount of idea sharing across practices within Department – process for doing so
- Successfully track 1 implemented idea per FMCH employee

Metric(s) to track progress of this A3:

- # ideas implemented to the UMMHC idea database : system goal is 12,000 implemented ideas; UMMM Family Medicine goal is 87. **Currently - 9/87**
- Practices within this project’s scope will achieve a 2/5 star designation within the first 6 months and move to a 3star designation by the first quarter of 2015 – data collected by pre idea system assessment and conducted again by March 2015
- # people trained as idea board facilitators (as of today): 0/1???
- # sites having implemented complete idea systems vs. just the posting of an idea board (i.e. board, regular huddles and idea sheets available for people to use)

Countermeasures (Plan):

- Providing just in time training to facilitate idea systems
- Circulate information to practices about idea facilitator training; lessening the burden of one individual feeling responsible for the movement of an idea
- Share best practices of other clinical/administrative units which have learned how to huddle successfully and efficiently (monitor huddle times currently; huddles can be as short as 5-10 minutes)
- Circulate and advise the practices on the idea database and train them how to upload an implemented idea
- Establish criteria and clarification for which ideas are to be credited to the medical group and not the hospital

Implementation (Do): Describe what actions you are going to take. Identify steps including who is assigned and when it is due. Carry out the change or test.

Results/Conclusion (Study): Collect data and begin analysis. What behaviors did you observe? What happened? What were the challenges? What did you learn? Did you meet your measurement goal listed in the countermeasures (show results)?

Follow-up Actions (Act): Are we ready to make a system change (if so: who, what, when, where)? Do we need to make revisions and test again in next PDSA?

A3 – Enhanced PDSA

Project Title: Working Effectively in Family Medicine

Owner: Dan Lasser

Date: 04/10/2014

A3

Plan • Do • Study • Act (PDSA)

Team Members: Baldor, Robert; Chuman, Alan; Dimitri, Dennis; Weinreb, Linda; Ferguson, Warren; Gilchrist, David; Potts, Stacy; McLaughlin, Melissa

Problem Statement: With increasing pressure to transform practices, improve performance, and demonstrate accountability, our department needs a more effective and nimble approach toward problem solving which engages faculty and staff within a “can do” culture fostered by its leadership.

Scope: Members of the Department’s Leadership Team

Background/ Current Conditions:

- Under health care reform, and with increasing fiscal pressure from both parent institutions, we need to respond to major challenges to transform the way we do our work
- Faculty climate surveys indicate that faculty are not engaged, and feel that the practices are “broken”
- As we become more data driven, we have been confronted with several challenges. For example, our quality metrics are unacceptable, and we are experiencing increasing faculty attrition:
- Two “Must Do/Can’t Fail “ priorities for this year include “Making practices work better” and “Changing the culture from “I am a victim” to “I can make things better”
- Experience shows we are not very nimble, do not respond to change rapidly, and do not spread success
- The clinical system is modeling the use of Lean performance improvement techniques as an approach toward problem solving, and early experience with them in the Department has been positive
- While Lean is a bottom-up approach, relying on the empowerment of front line staff to call out problems, it also requires a culture with support and direction from leadership

Fiscal Year	Faculty Attrition
00-01	1
01-02	1
02-03	1
03-04	2
04-05	2
05-06	3
06-07	3
07-08	3
08-09	6
09-10	6
10-11	5
11-12	14
12-13	7
13-14	8

Root Causes:

- The decentralized and matrix structure of the Department has fostered a culture that relies on problem solving that is an acquired skill, based at the local level, with little formal training or support
- The matrix leadership structure can lead to confusion regarding roles, responsibilities + accountability
- There is little standardization across programs or services
- Staff in the health centers work for different parts of the organization, complicating the matrix
- Problem solving in the past has not made use of data

Goals/Objective:

- Develop the Leadership Team’s problem solving skills to incorporate Lean approaches to innovation and improvement, resulting in a Department culture that supports a highly effective, standardized approach to improvement and managing change that is measurable and holds people accountable
- Develop familiarity with the A3 approach, using and modeling it for a series of projects focused on making the practices work better.

Estimated Project Completion: December 2014

Countermeasures (Plan):

- Each LT member develops and implements an A3, using suggestions from the 10/13/13 faculty retreat
 - David: Improving phone waiting times
 - Alan: Developing an ongoing survey of faculty engagement in their clinical practices
 - Beth, with Warren: Transition of care from inpatient to outpatient
 - Dennis: Improved quality metrics
 - (projects put on hold – POC testing, standardized rooms)
- Identify additional priority areas that will improve practices and build Lean-oriented culture, develop and implement A3s
 - Melissa: Establishing idea boards at each site
 - Bob: Designing faculty tracks to support faculty according to their clinical role
 - Linda: Leveraging practice improvement to increase faculty scholarship
 - Stacy: Improved resident scheduling
- Use visual management to track strategic goals and A3’s
- Learn and use the A3 process, PDSA (integrate coaching from CITC)
- Encourage and model standardized work
- Use Idea Boards to stimulate/facilitate everyday improvement at the frontline
- Institute SLT gemba walks involving all major sites and programs
- Encourage involvement in projects across sites, and spread of successful projects when appropriate

Implementation (Do):

- Ongoing coaching from CITC team
 - Visit with Eric and his Visual Management Room 2/13 (SLT) 3/7 (LT)
 - Assist in developing visual management
 - Obtain feedback from Eric on FM Working Effectively A3
- Problem Statement, Team members, Scope, Background Complete by March Leadership meeting. Root Causes started at least.
- Meet with Leadership Team in March
- Report out at least on A3 at each SLT and LT meeting
- Encourage interdisciplinary meetings
- Lean/A3 Training session and kick-off event in February
- Further ongoing opportunities throughout the year for faculty, staff and residents
- Meet with entire Faculty in April at a faculty retreat with a “Gallery Walk”

Results/Conclusion (Study):

- Number of people trained
- Number of completed A3s owned by members of the SLT/LT, including A3s devoted to teaching, research, service, and Dept organization and development
- Number of spinoff A3s, including A3s devoted to measurement of faculty attitudes and engagement and to implementation of idea boards
- Formal Lean projects engaged by faculty, residents and staff

Follow-up Actions (Act): Are we ready to make a system change (if so: who, what, when, where)? Do we need to make revisions and test again in next PDSA?

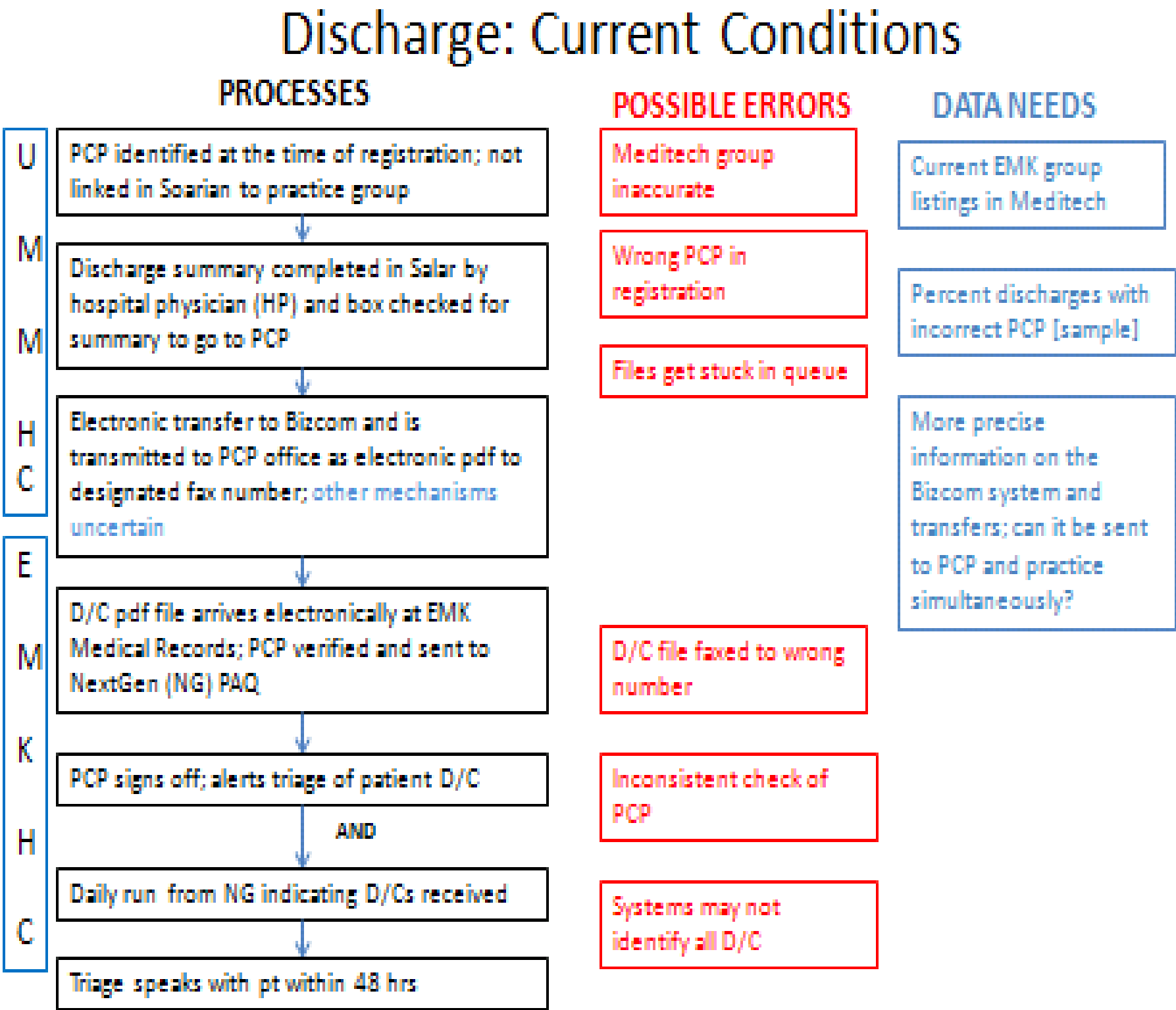
A3 – Enhanced PDSA

Team Members: UMassMemorial: Trish Seymour, Hospital Medicine, Zailee Estrada, Manager Patient Access; Shinae Kim, IT Soarian Clinical Applications, Daniel Lindstrom, MSII, Edward M Kennedy CHC: Jose Ramirez, VP, Worcester Operation; Tamara Pascoe, Medical Director, Worcester; Julie Eisele, Director of Nursing, Worcester

Problem Statement: There is inadequate and inconsistent care coordination between primary care practices and hospital providers during care transitions and especially at the time of hospital discharge. This has negative impact on patient safety, patient experience, and provider satisfaction.

Scope In: Inpatient admissions of EMKHC patients at Memorial Campus by the FM Hospitalist Service
Scope Out: Emergency Department visits

- Background/ Current Conditions:**
- PCP listing in Soarian is missing or wrong in a portion of patients
 - EMK does not currently have a real time report of inpatients
 - Soarian/Bizcom notification of admission to EMK appears to be inconsistent
 - Notification of admission goes to office medical records department – no notice sent to PCP
 - PCPs find accessing inpatient notes cumbersome
 - Some PCPs don’t know where to find inpatient documentation in NextGen
 - See side bar- Discharge: Current Conditions
 - Direct email communication from FM Hospitalists to EMK providers has not been functional.



- Root Causes:**
- Automated processes to notify PCP of admission are inconsistent
 - There is inconsistent recording of accurate primary care provider in hospital registration system
 - EMK providers are not identified as a group
 - Within the Health Center, the PCP is not necessarily informed of the admission (into goes to medical records)
 - Discharge documentation may not be sent to correct location
 - Discharge documentation delivery may be delayed if not signed promptly by hospitalist
 - EMK providers do not use UMassmemorial email addresses

Goals: To develop a standard system of care coordination and communication between EMK and FM Hospitalists at admission and discharge of inpatients
Estimated Project Completion: June 30, 2014

- Countermeasures (Plan):**
- Get a list of EMK providers with email addresses.
 - Tammy has already done this and it was forwarded to Hospitalist administrative assistant, Tracy, to enter into our master PCP list.
 - Get a sample report with EMK admissions over the last several months so we can check on accuracy of PCP data - completed and forwarded to EMK
 - Shinae to look into whether documents can be sent to the office via fax and the PCP via email.
 - Shinae/EMK to request a report from Soarian Financials which provides a list of current EMK inpatients at Memorial. Time and effort can be saved by modeling this on existing reports for other offices.
 - Be prepared at the next meeting to drill down on identifying the PCP at admission.

- Implementation (Do):**
- Another meeting is needed in order to fully define the current state
 - Items to be implemented will be identified at that meeting

Results/Conclusion (Study): Collect data and begin analysis. What behaviors did you observe? What happened? What were the challenges? What did you learn? Did you meet your measurement goal listed in the countermeasures (show results)?

Follow-up Actions (Act): Are we ready to make a system change (if so: who, what, when, where)? Do we need to make revisions and test again in next PDSA?

Transformation of the Fitchburg Family Medicine Residency and Practice

Project Information		Process Purpose	Problems/Case for Change									
<div>Leadership</div> <div><u>Executive Steering Committee:</u> Michael Cofone (HealthAlliance CEO) <u>Project Sponsors:</u> Dan Lasser (Family Medicine Chair) <u>Process Owners:</u> Nicholas Apostoleris (Division Chief) <u>Lean Coaches/ facilitators:</u> Nicholas Comeau <u>Observers</u> Robert Baldor – Vice Chair DFMCH Deborah DeMarco - DIO</div>	<div>Participant/Process Representatives</div> <div><u>Team members and Depts :</u><ul style="list-style-type: none">• James Ledwith – Residency Director• Bill Corbett – Community Medical Group• Sharon Cormier – Community Medical Group• Ann Folk – VP Revenue Cycle (HealthAlliance)• Dave Duncan – VP Facilities (HealthAlliance)• Bob Dullea – IT (HealthAlliance)• Alan Chuman – Administrator (UMass FMCH) <u>•Key external collaborators:</u><ul style="list-style-type: none">• John Demalia – CEO (CHC)• Pierre Primeau – VP Facilities (CHC)• Jacqueline Buckley – COO (CHC)• Eileen Anthony – ACGME FM Exec Dir</div>	<div>Preserve a high quality family medicine residency, build an efficient practice to support the residency, and collaborate effectively with the local Federally Qualified Health Center.</div> <div>Project Goals</div> <div><u>Goals/Key Measures – Residency:</u><ul style="list-style-type: none">•Receive approvals to recruit residents by 2014 02 15• Rank only highly qualified applicants for residency positions• Match 4/4 <u>Goals/Key Measures - Practice</u><ul style="list-style-type: none">• Determine structure of practice by 2014 03 15• Retain or hire management by 2014 03 30• Provide budgets and estimates required for funding beginning on 2014 02 15• Recruit and retain providers to fulfill budget expectations• Provide oversight for practice management• Participate successfully in all relevant quality improvement programs and initiatives</div>	<div><ul style="list-style-type: none">• Fitchburg Family Medicine Residency Program was told by UMass that it would be closing on 2014 06 30 due to poor financial performance of the residency’s host FQHC.• HealthAlliance Hospital determined that it would take over and be responsible for the residency and associated practice due to the need to train and retain family physicians in North Central MA, which is a medically underserved area.</div> <div>Voice of the Patient</div> <div><ul style="list-style-type: none">• Closing the Residency and associated practice would likely result in a significant primary care shortage for the area due to the FQHC’s financial difficulties and inability to recruit an appropriately sized clinical workforce. Patients would be facing delays in accessing care in Fitchburg without a significant residency practice in place as of 2014 07 01.</div> <div>Project Time Frame</div> <div><table><tr><th>Milestone/Date</th></tr><tr><td>•Planning Meeting #1 – 2014 01 23</td></tr><tr><td>•Planning Meeting #2 – 2014 01 27</td></tr><tr><td>•Planning Meeting #3 – 2014 02 04</td></tr><tr><td>•Value Stream Mapping Sessions: to be determined</td></tr><tr><td>•Follow up meeting #1 – Weekly conference call with team members</td></tr><tr><td>•Follow up meeting #2 – Weekly meeting with Michael Cofone regarding practice and communication issues</td></tr><tr><td>•Follow up meeting #3 - As needed meetings and communication with D Lasser regarding education, practice, and communication issues</td></tr><tr><td>•Follow up meeting #4 – Weekly resident and faculty meetings to communicate progress and challenges</td></tr></table></div>	Milestone/Date	•Planning Meeting #1 – 2014 01 23	•Planning Meeting #2 – 2014 01 27	•Planning Meeting #3 – 2014 02 04	•Value Stream Mapping Sessions: to be determined	•Follow up meeting #1 – Weekly conference call with team members	•Follow up meeting #2 – Weekly meeting with Michael Cofone regarding practice and communication issues	•Follow up meeting #3 - As needed meetings and communication with D Lasser regarding education, practice, and communication issues	•Follow up meeting #4 – Weekly resident and faculty meetings to communicate progress and challenges
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<div>Process Scope: Start/Stop</div> <div><u>Start:</u> HealthAlliance Board votes on whether to fund and support the residency and practice <u>Stop:</u> Practice opens on 2014 07 01.</div>	<div>Process Scope: In/Out</div> <div><u>In Scope:</u> All functions and responsibilities of the residency and practice during the transition period from 2014 02 01 through 2014 06 30 <u>Key Aspects (Linked to Status A3 documents):</u> <u>Education; Practice;</u> <u>Communication; Collaboration</u> <u>Out of Scope:</u> Current functioning of clinic under the FQHC</div>											

A3 – Enhanced PDSA

Project Title: Implementation of Scribes at the Barre Family Health Center
A3

Lead: Susan Begley, Ambulatory Manager

Date: 4/4/2014

Plan • Do • Study • Act (PDSA)

Team Members: Stephen Earls, Susan Begley, Barbara Fisher, Christine Vallee, Karen Walker, Alan Chuman (sponsor), Nick Comeau (coach), Barry Saver, Linda Weinreb, Judy Savageau, Kate Sullivan (Judy and Kate – design, data collection, measurement and analysis)

Problem Statement: Providers spend excessive hours in the health center and after-hours (at home through VDI) on EMR-related activities. This additional time keeps physicians from their family resulting in higher levels of dissatisfaction than desirable. This dissatisfaction also threatens the department’s ability to retain faculty and negatively impacts on quality of care, clinical productivity and patient satisfaction.

Scope: Five Barre FHC attendings (of 7) will be included. Nurse practitioners and residents will not be included in this trial period.

Background/ Current Conditions:

Daily dictation is often left until the end of the day by providers. The dictation adds 2 to 4 hours of time at the worksite or at home (by VDI) to complete the daily requirements to finish patient visits. Previous Department climate surveys, and the Morehead Surveys conducted for the Medical Group have found Department of Family Medicine and Community Health (DFMCH) faculty overall to be satisfied with their faculty roles, but very dissatisfied with their clinical practice environment. This survey data is echoed in discussions in faculty meetings and in anecdotal accounts of problems in practice. Unhappiness with the EHR is also very high; dissatisfaction with the EHR and IS support was the area of greatest dissatisfaction highlighted in the Morehead survey. The Department has therefore made “making our practices work better” a priority for the upcoming year.

Root Causes:

Why we think scribes will improve patient satisfaction and physician satisfaction?

- Allscripts has added many functions to be handled directly by physician. (Machine)
- Volume of patients who need to be seen is increasing. (Man)
- Allscripts does not have templates or structured note capabilities. (Machine)
- Medical Scribes was sent samples of WCC, wellness visit & other types of visits to be incorporated for notes templates. (Machine)
- Patient care takes most or all of the visit time. (Man)

Goals/Objective:

- Improve physician satisfaction and minimize additional stress from work overload (by what %; awaiting pre-study satisfaction data).
- Decrease (and eliminate) incomplete chart documentation entered in Allscripts (by 100%; decreasing current incompleteness from approximately 20% to 0%).
- Increase time spent with family and satisfaction of leaving office at a reasonable time (by how much; awaiting pre-study satisfaction data).
- Physicians spend at least one hour less for each patient clinical day (between work and home on work-related activities).
- Participating attending providers and acute care practitioners will increase volume by 1 visit per session (572 visits/yr=2 visits/day).

Number of Patients / Provider to be added on Scribes for BARRE				
	current	extra pt	future	additional pts
Monday	36	1	36	
Monday	30	1	31	
Monday	12	1	13	
Tuesday	42	1	43	
Tuesday	48	1	49	
Wednesday	42	1	43	
Wednesday	36	1	37	
Wednesday	12	1	13	
Thursday	24	1	25	
Thursday	24	1	25	
Friday	24	1	25	
Friday	42	1	43	
	372	12	384	48
12 additional patients per week based on 48 weeks=576 additional office visits				

Physician Satisfaction Survey

Please circle the corresponding response for each question below. Feel free to add any additional comments/thoughts in the space provided at the bottom.

1. Please rate the effort needed to provide documentation in the EMR today.

Very Difficult Somewhat Difficult Neither Difficult nor Easy Somewhat Easy Very Easy

2. How did it feel to have a scribe in the room during the patient history?

Very Uncomfortable Somewhat Uncomfortable Neither Uncomfortable nor Comfortable Somewhat Comfortable Very Comfortable No Scribe Today

3. How did it feel to have a scribe in the room during the patient physical examination?

Very Uncomfortable Somewhat Uncomfortable Neither Uncomfortable nor Comfortable Somewhat Comfortable Very Comfortable No Scribe Today

4. How would you rate your office hours today as compared to usual?

Excellent Very Good Good Fair Poor

5. If you had a scribe, how much did their presence help? If you didn't have a scribe, how much do you think their presence would have helped?

Very Much A Little Not At All

6. Other concerns or comments about using scribes in ambulatory patient visits at the Barre Family Health Center?

Countermeasures (Plan):

- Evaluate Scribe Companies: Elite Scribes, Scribe America, Valadoc (virtual + live), Physician Angels (Virtual).
- Put scribes in place who come from a vendor that we have identified. Identify scope of work. Interviewed 4 companies; found virtual scribes were not effectively being used by their references.
- Discuss scribe “idea” with attending providers. “Sell” scribe idea to administration of Department + Ambulatory.
- Plan methodology to study impact of scribe implementation. Providers will download app onto their phones to monitor time spent at health center as well as at home doing dictation.

Implementation (Do): Scribes hired through Elite Scribes. Project targeted start date: 4/21/2014. Trained on process: Who will be trained and when? Put in place (describe scope of work)—Medical Scribe Services-Exhibit A below. Medical group contribution-40% of cost estimate \$88,000.00=\$35,200.00. Requested 2 laptops for Medical Scribes. 4/4/14

Phase	Pretest Phase I	Pretest Phase II	Implementation Phase I	Implementation Phase II	Posttest
Dates	March 24 – March 31	April 7 – April 21	April 21 – May 19	May 19 – July 14	July 14 – July 28
Expected Time Frame	1 week	2 Weeks	1 Month	Months 2 & 3	2 Weeks
Measure(s)	Provider Work Life Survey	Hours Tracker Iphone/Android App	n/a	Provider Satisfaction with Scribes Patient Satisfaction/Comfort with Scribes	Provider Work Life Survey Hours Tracker Iphone/Android App
Goal	7 BFHC attendings will respond to the Physician Work Life Survey	5 BFHC attendings working with scribes will use the Hours Tracker app for tracking hours worked (both at BFHC & VDI) for a 2 week period	Initial 1 month period will be used to work out kinks in the system with the implementation process (no measures collected)	Minimum of 50 provider surveys will be collected representing all sessions when a scribe is present Minimum of 100 patient surveys will be collected representing all sessions when a scribe is present	7 BFHC attendings will respond to the Physician Work Life Survey 5 BFHC attendings working with scribes will use the Hours Tracker app for tracking hours worked (both at BFHC & VDI) for a 2 week period
NOTE: additional physicians to be involved, if needed?			Marcy Boucher (start date 9/1) Kristin Wickstrom, PA & Duncan Wellan, NP		

Results/Conclusion (Study):

- Pre and post measures of time spent at health center and on VDI using iPhone/Android Hours Tracker app; collect arrival and departure times for the two-week period before implementation of scribes and a two-week period shortly after the 3-month trial period. Physicians will be requested to download the data on a weekly basis into an Excel file and submit this to Kate Sullivan via email.
- Pre & post measures of physician satisfaction (See Physician Work Life Survey) – Pre-data to be collected by March 31, 2014. Post-data to be collected within two weeks of the end of the 3-month scribe trial period. The BFHC Ambulatory Manager will collect this data.
- First set of surveys distributed/collected (4/4/14); to be analyzed
- During implementation, patient satisfaction/comfort (See Patient Satisfaction Survey) to be collected during months 2 and 3 (of the 3-month trial) from a minimum of 100 patients representing each of the 5 attendings and all sessions when a scribe is present. The scribes will collect this data from patients.
- During implementation, provider satisfaction/comfort (See Physician Satisfaction Survey) to be collected during months 2 and 3 (of the 3-month trial period) from a minimum of 50 patient visits when a scribe is present – representing each of the 7 attendings. The scribes will collect this data from physicians.
- Pre & post measures of patient volume (data to be collected from the clinical system).

Follow-up Actions (Act):

3-6 month study; if successful expand to other providers, sites, + 3rd yr residents.

Action Items from Meeting: 4/4/14

- Remind physicians about Hours Tracker - turning on and off (SB)
- Submit Laptop request with IS and Capital (SB)
- Physician pre-work/life surveys are done; data will be entered and analyzed (KS and JS)
- Need to obtain report from Allscripts by specific date and 2 weeks after the date to document chart documentation completion (Karen Walker)
- Kate Sullivan will get access to Allscripts as read only to help with data measurement (KW)
- Medical Scribes was sent information to help with note templates (Earls)

Next Meeting: 4/18/2014; 8:00 am phone conference with Team Members

Call in number: 508-334-7000 participation code 655042#