Access To Care –
Breaking Down The Barriers

CENTRAL VIRGINIA HEALTH SERVICES

CHC LEADERSHIP INSTITUTE LEARNING PROGRAM 2018-19

CAPSTONE TEACH BACK: JUNE 12, 2019

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THE VIRGINIA CHC LEADERSHIP INSTITUTE

1. Team

- Dr. Andrew Walker
- Sharon Chandler, NP
- Kim Jones, Practice Manager
- Anna Gauldin, MA

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2. Barriers to Care

How the study began:

- Transportation or lack of
- Patients being late
- Providers
- Schedules
- Lack of Centralized Policy
- Computers/Software
- Staffing
- No Show Rate
- Ability to Pay
- Hours of Operation
- Structural Issues, Maintenance
- No medical records available
- Patient Agenda
- Kiosk
- Weather
- Patient Volume
- Handicap Access
- Quality Measures
- Life Balances

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3. Assets

- Debbie Baber, COO
- Kathy Tillett, ECW Specialist
- ECW software
- Mediquire software
- Centralized Referrals
- Clinical staff and providers within each of our sites
- Front Desk
- Terry Laine
- Caitlyn Fetter
- Google

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4. Focus

- Pre-Visit Planning: screening mammography to be ordered, performed, resulted and in the patient chart before the patient's next appointment.

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5. Need

- Preventive care is needed.
- Reduce patient visit time dedicated to preventive measures, allowing the provider’s face to face time to focus on the patient’s primary reason for the appointment.
- Increase the time a provider must have to address the healthcare concerns of the patient.
- By improving access, it improves the patient's experience and builds a positive relationship between the provider and the patient.
- Increase the time the clinical staff has with the patient preparing the patient for the providers visit.
- Reduce burn-out and fatigue within the clinical staff and providers.

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6. Objectives

- Improve a patient's access to care.
- Maximize clinical time.
- Pilot a program for scheduling mammograms outside of the clinical visit setting to improve patient clinical time.
- The pilot study would be designed to be incorporated across the organization.
- Determine a workflow for ordering, scheduling and receive mammogram results before the patient’s next appointment.
- Potentially increase the number of patients that could be seen each day.
- Increase patient mammogram rate.

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7. Development and Action Plan

- Coordination of meetings.
- Review of corporate policy.
- Access to software to determine non-compliant patients, by site or provider.
- Evaluation of software available that meets our criteria/accuracy and ease of use.
- Who has access to the information.
- What services are available for the patient without insurance to utilize.
- Who will do the work.
- What do staff need to know to select patients and order mammograms.
- What criteria do patients have to meet.
- What is the process for ordering a mammogram.
- Who will train the staff.

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8. Testing and Refinement/Results

Despite narrowing our topic, we ran into more barriers to care...

- Problems with accuracy of lists:
  - Mediquire: prescheduled list of patients/Eclinical Works: patients assigned to one provider or one site – no filter.
- Creating the list – patients with upcoming appointments in the next 30 days (Mediquire).
- Who was able test our workflow - two sites: completed by the Practice Manager and MA.
  - Printed list determined to not be accurate
  - Time constraints
  - Staffing constraints
- Staff had to review the accuracy of the list, check for mammogram order, did the patient go, were results received, contact the patient.
- Problem in the system - need to know the parameters used by corporate to determine compliancy.
- Nurses do not feel qualified and would like training.
- Successfully scheduled a few patients.

9. Results to Date

- Processes are in place but the results are few at this time due to:
  - Data in both systems is unfiltered and cumbersome.
  - It was an over-load of information.
  - Lists didn't match.
- Found historical mammograms documented incorrectly.

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10. Lessons Learned

- Communication is tricky when everyone on the team works at a different site,each hold a different position and see the problem from different angles.
- Bad weather can mess up the best laid plans.
- Patients are not always as concerned as the office that mammograms should be done prior to the visit with the provider.
- If unable to get the mammogram prior to the visit, another process needs to be in place.
- Too much data can be as bad as not enough.
- Staffing impacts what we can do.

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11. Success Story

- In sharing our PDSA, one site was able to show that the mammogram rate on December 2018, was 51.61% and on May 2019, the rate had increased to 53.78%. Not a large increase but a success. The process for the increase was not a part of pre-visit planning but post-visit planning.
- Anytime you deliberately focus on a clinical measure, you will see an improvement.

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12. Next Steps

- Review the process in another six months to see if there are proven results.
- What are the changes that need to be made.
  - ECW – merging of alerts in CDSS
  - Care coordinator within each site to clean up patient data, pre-visit planning, set alerts for ordering mammograms.
- Involvement with Sr. Management to strategize a pre-visit plan.
- If we are happy with the processes and results, prepare a report to Senior Management requesting it to be implemented across the corporation.
- Will we need to change our workflow to make it more effective.

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