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Process Change at an All-Volunteer Run Clinic with PCMH Level 1 Recognition

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Implementing Process Changes in an All-Volunteer Run Clinic with PCMH Stage 1 Recognition

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Clinical Leadership Theme

This project directly involves the Clinical Nurse Leader (CNL) essential *Informatics and Healthcare Technologies*, and the CNL role function will be to act as a Team Manager. (AACN, 2013). The global aim of this process improvement is to improve the clinic workflow to increase patient and provider satisfaction in a Patient-Centered Medical Home (PCMH).

Statement of the Problem

The need for this project was discovered during the process of applying for PCMH recognition (of which the clinic has now earned level 1), and successful implementation of this project will meet PCMH guidelines. While applying for PCMH recognition, a clinic workflow document had to be drawn up to meet the requirements; it became clear during that workflow assessment that there was no standardized process in place for providers.

ABC Clinic is an entirely volunteer-run clinic with no paid clinical positions, and without a clear leader in place, processes were completed by providers however they felt was best. ABC Clinic has recently entered into an agreement with the University of San Francisco (USF) which has resulted in faculty and student volunteers being placed at the clinic, leading to a more formal structure in place along with an increase in volunteer retention. A clinic workflow and process were put into place by USF faculty and students during the PCMH project (see appendix A), but this workflow did not include billing, as at the time the clinic did not accept any insurance. Now that the clinic has started accepting Medi-Cal and billing patients, the workflow needs to be updated to reflect this change. Claim denials from Medi-Cal in the past couple months of billing have emphasized this need to the clinic, as well as the need for education for providers once the improved process has been put into place. The purpose of this project is to update and refine the

clinic workflow in order to better provide patient-centered care and increase both patient and provider satisfaction.

<div align="center">**Project Overview**</div>

This project will consist of utilizing Electronic Medical Record (EMR) technology in a clinic treating primarily underserved populations to increase revenue by improving the billing process for Medi-Cal and potentially other insurers. This will further involve workflow and process changes as well as education for the providers at the clinic. Billing is still new at the clinic, and so there is no workflow organized around correct coding for procedures. While PCMH stage 1 recognition was recently gained, the clinic has some areas of improvement needed to better meet the PCMH standards.

Informatics is a large part of this project, utilizing the skills of a Clinical Nurse Leader (CNL) to successfully implement a microsystem change. This project will further involve education and interdisciplinary collaboration for a successful implementation. The goal of this project is to organize and streamline the current clinic workflow to account for billing.

By the end of this project, goals include (1) that each provider in the clinic will understand and utilize the new workflow, (2) that this process improvement will result in increases in patient and provider satisfaction as determined by surveys, and (3) that the clinic will no longer have as many rejected reimbursement claims from Medi-Cal due to incorrectly entered CPT and ICD10 codes. The specific aim of this process improvement is to organize and streamline clinic workflow, as well as educate providers on this new workflow, including billing and reimbursements in a PCMH. This specific aim more accurately describes the overall global aim of this project as improving the clinic workflow is the overarching goal, but the specific steps that will be taken to reach this goal are more clearly noted.

Rationale

As previously stated, the need for this project was determined originally during the PCMH recognition process, and then was later reinforced by the clinic's issues with Medi-Cal reimbursements. To identify why these billing issues were occurring, a root cause analysis was completed using the "5 Whys" method (see appendix B). At the end of the 5 Whys analysis, the root cause was determined to be that the clinic had added a new process (billing) without also updating the clinic's workflow or educating the clinic's providers on this new process. Therefore, this project is focusing on closing that gap by ensuring that this process is improved as well as educating providers on the improved process.

This project will be using evidence to implement this microsystem change while ensuring continued smooth operation of the clinic. Evidence and research will also be used to formulate the process and workflow changes necessary for providers to begin using the billing system. Further evidence will be needed to aid in appropriate educational resources and training for providers to use the system. The clinic has piloted accepting Family PACT, an insurance service available in California to anyone who falls at or below 200% of the Federal Poverty Guidelines who need family planning services (California Department of Public Health, 2012). This pilot succeeded and is continuing as normal practice, showing that the volunteer providers and the workflow as a whole can accept process changes when implemented correctly. For more information on these clinic strengths, a SWOT analysis was performed and can be seen in appendix C.

Fortunately, the financial and business case that supports this project is not exorbitant in cost. A stakeholder analysis was performed prior to assessing the finances of the project (see appendix D). The project's cost itself is very little, as the CNL student will be analyzing and

reorganizing the current workflow and further setting up various "cheat sheets" for the providers

to use in ensuring they both understand their new responsibilities and can accurately chart for

reimbursements (the sheets will include common CPT/ICD10 codes to enter into the EMR).

Printing the cheat sheets is a very minor cost, though there may be some extra provider time

spent on this new workflow throughout the day rather than on patient care as the providers start

to incorporate these new requirements and ideas into practice.

However, since the providers are all volunteers and none of them are paid, there is no

direct monetary cost for wasted provider time to the clinic. Meanwhile, the benefits and the value

the project will offer are extreme. Collins et al. (2013) discuss how a clinic with PCMH

recognition will receive more reimbursements than a clinic without due to insurer bonuses and

increases, and this evidence of added compensation on top of the normal rates should inspire

providers to embrace the new process and bolster my business case overall. With this new

process in place, including provider training and the "cheat sheets", the clinic will actually start

earning money in the form of reimbursements rather than having to rely solely on donations. The

clinic having a positive cash flow will not happen overnight and there may be a few months of

rocky/low reimbursements as everyone gets used to the new process, but over time the clinic

should become self-sufficient and self-sustaining.

Methodology

The actions being taken to implement this project include organizing a checklist of CPT

and ICD10 codes that correspond with each other for easy data entry for the providers, as well as

implementing an improved process workflow for how to bill (and who will bill), and finally

offering an educational meeting to teach the providers the improved process and the billing

details. Data will be collected on both the efficacy of the educational component and the number

of patients with insurance successfully billed both prior to and after the process implementation. This data should allow for verification of whether or not the process and the education were effective.

This project involves more than one component, but if only a process improvement was implemented without also offering education to the providers, it is unlikely that the change will "stick". According to Bindman et al. (2013), improving billing processes in a PCMH (particularly billing involving CMS) requires both education for physicians and buy-in for changes from the providers. The main goal is the process improvement, however – the increased reimbursements and the provider education are just side goals that will help along the way and are necessary for this change.

According to Capella (2015)'s slides on Kotter's eight-step model of change, this change model has been implemented within this CNL project. This model of change had two main differences from the original plan for this project. First, it emphasized the importance of a sense of urgency to the project, and secondly it also added the idea that "short-term wins" should be included along the way. (Capella, 2015). While there was a minor sense of urgency to the project in that the clinic is looking forward to receiving reimbursements, there was no true sense of urgency as the clinic has been relying solely on donations for so long that the staff and volunteers were used to the status quo. There was a situation where the volunteer providers were waiting for a process to be put in place before starting to bill, but were in no rush for that process to happen.

The importance of urgency is certainly paramount to this project, and incorporating Kotter's model of change has emphasized that. The providers and other volunteers understand that this process needs to be implemented soon. With this process, and with increased

reimbursement, comes the opportunity for more paid positions and the chance for the volunteers

to be paid for the work currently done for free. The possibility of employment resonated with the

volunteers, and added a sense of urgency to the project. This incorporates the CNL competency

of demonstrating the ability to coach team members in performing nursing processes, the nurses

and nurse practitioners will be encouraged to implement the improved billing process into their

daily practice at the clinic. (AACN, 2013). This is a process that is within the scope of practice

of nurses, though in bigger clinics would be done by MAs. Nurses do need to be aware of how to

appropriately chart and use informatics in their day to day nursing processes in order for their

site to receive reimbursements. This can then also involve the CNL competency of using

information technologies to document patient care. (AACN, 2013).

Literature Review

The PICO strategy used was:

P: Providers and patients

I: Implementing a billing process

C: Free clinic

O: Increasing reimbursements

This led to no finds that truly related to the clinic, though it did lead to many interesting

articles about free clinics. Once the term "workflow" was added to the I, and "PCMH" to the P to

describe the clinic, results appeared that offered good information as to how to set up a process

in a PCMH clinic, rather than just results that discussed whether or not free clinics help patient

outcomes (interesting, but not useful). This PICO strategy was very interesting, as some of the articles discovered through this were articles not found in earlier searches.

Some of the articles found in the literature review are useful evidence based guides on how to implement a lasting microsystem change in a PCMH. Some examples of this include Arar et al.'s (2011) qualitative study which analyzed how small community clinics who are working towards PCMH recognition implemented quality improvement projects. The study directly discusses the difficulties of improving processes and clinic documentation in the clinical microsystem, including the need to document carefully for insurance purposes. Barriers to change were noted, including staff readiness, buy-in, and team communication. Bleser et al.'s (2014) study was similar in that it addresses the need for comprehensive changes during the implementation of a PCMH practice model. It explains how to successfully motivate and convince the providers and staff of a clinic to function like a PCMH. These motivational strategies are summarized and described in a practical, ready-to-implement manner. O'Malley et al.'s (2015) study reviewed how current PCMH practices increase their collaborations and teamwork particularly when faced with changes. The article recommends including staff in the new process design and using evidence to show staff that improvements benefit both the practice and the patient.

For a more direct discussion of one of the goals of the project, Collins et al. (2013) wrote an article that discusses the various ways that health plans have and will start to reimburse PCMH recognized clinics and the current and past incentive programs used. It further explains how when health plans use these incentives, overall costs decrease. This article will be useful to show the providers at the clinic exactly why this microsystem change will benefit the clinic. Similarly, Conrad et al.'s (2014) article is a lengthy review of how healthcare reform, including

the change to value-based payment systems including PCMH recognition gaining increased

reimbursements, can affect the quality of care and policies in practices. While this article does

not directly offer information on payment systems, the background information within it gives

anyone interested in PCMH and payment systems the language and understanding necessary to

implement payment changes after a PCMH process, and will be useful for providers at the clinic

to fully embrace the PCMH model.

Finally, for a very relevant article to this project, Ong-Flaherty's (2015) article, written

by a USF faculty member, addresses the changes at the clinic in question while further

explaining the role of a CNL in an outpatient setting. The article reviews CNL concepts and

succinctly describes the difficulties present at the clinic both prior to and during the PCMH

application process. This article is a very useful resource for how a practicing CNL analyzes the

clinic and determines needs assessments.

Timeline

This project began in late June 2015 and will conclude by the end of August 2015. The

education portion of the project will be held in early August 2015, and after that education the

goals of the project should be met by the end of that same month.

Expected Results

The expected results of this project will be an increase in patient and provider satisfaction

due to an improved workflow, as well as an increase in reimbursements for the clinic due to the

improved provider understanding of billing and the workflow in a PCMH. This project should

result in useful information for other PCMHs interested in implementing process changes after

earning PCMH recognition. While doing the literature review, it became obvious that while there

are multiple studies and papers available on process changes during the process of getting PCMH

recognition, there are very few on process changes after earning PCMH recognition. This gap

could be addressed after the completion of this project with a paper on the outcomes of this

project.

Nursing Relevance

Hopefully this study will contribute a greater understanding to CNLs of how to

implement a process change in a clinic that has recently undergone many process changes.

Further, it should help educate nurses at the clinic on what being a PCMH means, and how this

recognition affects the way the clinic operates and incorporates change. If the paper discussed in

the previous section is published, this project could even help other nurses outside of the clinic

who are in newly recognized PCMH practices to understand how being a PCMH can affect

practice operations and change.

Summary Report

The aim of this project was to complete a process change, educate the providers on this

change, and fix the previously billed months. All of these aims were met throughout the course

of this project. While the original plan called for a specific educational event to be held to

educate providers, time constraints meant that the education was instead held during a regularly

scheduled monthly provider meeting, which still accomplished the goal of the project. Pocket

billing checklists were created and posted at the clinic as well as given to the providers, but a

more organized and formal version of these checklists are currently being created and will be

implemented in the next month to replace the original rough version. Data is still being gathered

for the evaluation of the success of the billing process, but preliminary data has shown that the

improved process has increased reimbursement amounts at least threefold, and providers are

consistently entering in ICD9 information in all patient encounters.

One of the projected challenges to the project, its sustainability, turned out to be an easily

surmountable challenge. After the process improvement was implemented and the providers

were educated, the new process quickly became "the way it has always been done", and new

volunteers were trained on the process as if that was the case. That universal embracing of the

change led to its successful adoption and implementation, and there are no current foreseeable

barriers to this process in the future. Overall, this process change has been a successful and

much-needed change in ABC Clinic, and its implementation has led directly to increased

reimbursements and a soon-to-be positive cash flow for the clinic. Plans are already underway

for how to improve the clinic's quality and patient-centered care further with the benefits
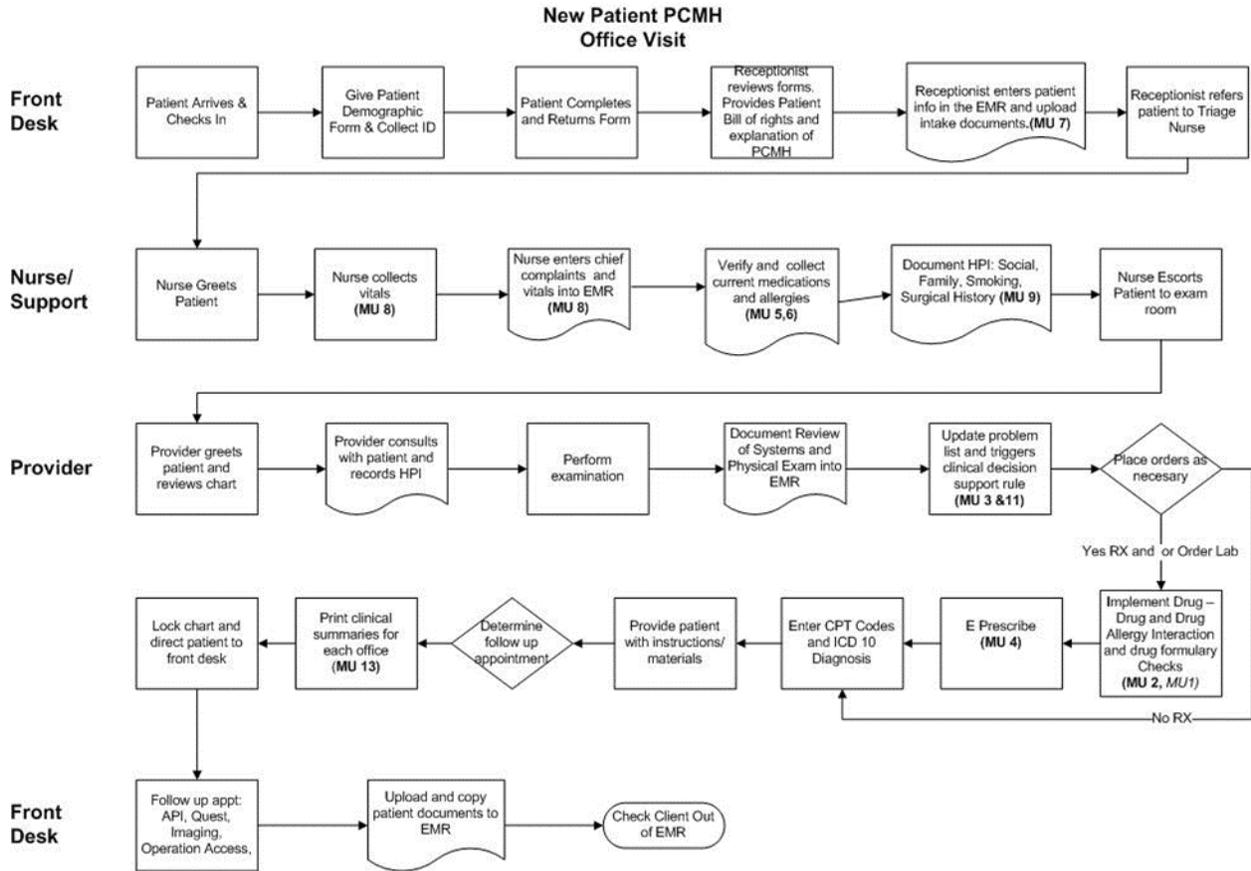
realized from this project.

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Appendix A

Clinic Workflow organized during PCMH process

New Patient PCMH Office Visit

Front Desk
- Patient Arrives & Checks In
- Give Patient Demographic Form & Collect ID
- Patient Completes and Returns Form
- Receptionist reviews forms. Provides Patient Bill of rights and explanation of PCMH
- Receptionist enters patient info in the EMR and upload intake documents.(MU 7)
- Receptionist refers patient to Triage Nurse

Nurse/ Support
- Nurse Greets Patient
- Nurse collects vitals (MU 8)
- Nurse enters chief complaints and vitals into EMR (MU 8)
- Verify and collect current medications and allergies (MU 5,6)
- Document HPI: Social, Family, Smoking, Surgical History (MU 9)
- Nurse Escorts Patient to exam room

Provider
- Provider greets patient and reviews chart
- Provider consults with patient and records HPI
- Perform examination
- Document Review of Systems and Physical Exam into EMR
- Update problem list and triggers clinical decision support rule (MU 3 &11)
- Place orders as necesary

Yes RX and or Order Lab

- Implement Drug – Drug and Drug Allergy Interaction and drug formulary Checks (MU 2, MU1)
- E Prescribe (MU 4)
- Enter CPT Codes and ICD 10 Diagnosis
- Provide patient with instructions/ materials
- Determine follow up appointment
- Print clinical summaries for each office (MU 13)
- Lock chart and direct patient to front desk

No RX

Front Desk
- Follow up appt: API, Quest, Imaging, Operation Access,
- Upload and copy patient documents to EMR
- Check Client Out of EMR

Bold – MU 15 Core Objectives
Italicized – MU Required Five Menu Objectives

Appendix B

5 Why's root cause analysis

Problem Statement: Billing is not occurring correctly in the clinic because the providers are not

entering necessary information in the charts.

Why are providers not entering the necessary information in the charts?

Because they did not previously have to, and have received no training on what information is

necessary.

Why have the providers received no training?

Because the billing change was implemented by hiring an outside specialist without consulting

with the providers.

Why were the providers not consulted?

Because the manager had thought that charting billing information was already a normal part of

the providers' workflow.

Why was it not part of the providers' workflow?

Because it hadn't previously been necessary, and so the workflow did not include a specific step

within the process to ensure that providers completed both the ICD9 and CPT codes when

charting.

Root Cause: The workflow does not include a specific step within the process for entering this

information.

Appendix C

SWOT analysis

Strengths	Weaknesses
Flexibility Good training program Providers excited about billing aspect of process change Clinic volunteers & staff open to process change	Non-profit status means money is tight Providers have no previous billing experience in the clinic's EMR Clinic EMR is universally disliked by providers as it is "hard to work with"
Opportunities	**Threats**
Insurance reimbursements will lead to more money for the clinic This increase in clinic money could lead to paid positions being offered to current volunteers Once Medi-Cal billing and process are in place, other insurers should follow suit	It will be difficult to find a time that all the volunteer providers can attend for the process and billing education Medi-Cal may continue to reject claims, even with process improvements in place Non-profit board may not approve further expenses, if any come up

Appendix D

Stakeholder analysis

Stakeholders	Importance	Influence and Power	Interests/Positive Impacts	Concerns/Negative Impacts
Management	To ensure that the clinic is no longer a drain on resources	Have complete control over continued clinic operations	To have enough positive cash flow to cover clinic costs To have enough positive cash flow to hire providers instead of relying on volunteers	Not implementing billing fast enough to cover costs for this year
Providers	To ensure that the clinic can make money	Responsible for charting the correct information for billing to occur	Can contribute by charting correctly Can possibly receive a paid position if billing is successful	Changing the established process may be difficult, particularly with volunteers Dislike the current EMR system
RNs	To ensure a cash flow for patient care	Responsible for ensuring that the correct information was charted	Can contribute by adding in CPTs if providers forget Can possibly receive a paid position if billing is successful	Have only limited time, some of which is being spent training new volunteer RNs May not know what CPTs or ICD9s to use
MAs	To ensure smooth clinic operations	Responsible for demographics entry, including insurance information	Can contribute by entering in all insurance information correctly Can point out if a provider neglects to chart info	Correcting a provider may be difficult for this power dynamic Are new at the clinic and still settling into the current process
Patients	To ensure high quality care	Responsible for bringing info	Can contribute by having insurance cards	Has never had to bring insurance info before