Improving a Clinic's Process to Increase Preventative Health Screenings

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This project aims to improve staff efficacy in providing qualitative care to the lesser fortunate population, which of whom are unable to have adequate access to healthcare. In this case, the clinical nurse leader (CNL) identifies the need for increasing preventative health screenings, especially since this practicum clinic aims to provide care to the underserved population. Therefore, strategies were used to plan and implement particular methods in order to bring awareness and change to the microsystem.

Clinical Leadership Theme

This project correlates with the CNL competency of Informatics and Healthcare Technologies. The CNL role will fulfill duties and function as an Information Manager. As the CNL, it is imperative to collect data information and generate evidence of patient care in the microsystem. The global aim is to improve the quality of patient care and increase the rate of preventative health screenings by analyzing data through the electronic health record (EHR) system, based on measurements from the Patient-Centered Medical Home (PCMH) Standards of 2014.

Statement of the Problem

The initial project was to solely focus on how the facility could meet PCMH standards and qualify for this status. After an in-depth study of PCMH guidelines, staff and the CNL student decided to focus on specific clinical measures that will directly improve staff performance and patient care. A short time ago, the clinic was recognized as a Federally Qualified Health Center (FQHC) and received a grant to help sustain the organization. Prior to this achievement, only volunteers managed the health clinic and because of this, there was unreliability in the sustainability of clinic processes and procedures. With the FQHC grant, the
facility was able to hire permanent staff, which has enabled them to undertake the revision of proper processes for the microsystem. However, with continuous changes and the inability to complete tasks, there is an issue with adequately revising and maintaining processes, staff compliance, and staff retention.

The project focused on the medical health conditions category from a PCMH element. From this topic, it was determined that the specific focal point for this project is to analyze the reason for low depression screening and cervical cancer screenings, and how staff compliance of this screening process can be resolved. According to the organization’s policy, these preventative health screenings must be performed on every patient of the clinic. The Centers for Disease Control and Prevention [CDC, (2013)] explains that receiving preventative services such as screenings are examples of how people can lead a healthy and productive life. Moreover, preventative care services performed at the appropriate stages of life help avoid the onset of diseases or can keep current diseases from becoming more debilitating, reducing medical costs (CDC). Because this is a small clinic with limited staff and resources, and due to the taxing demands of each of the staff members, they lack efficient performance in EHR consistency and the process of health screening expectations. Therefore, the purpose of this project is for the CNL student to aid in rectifying this problem.

**Project overview**

The health clinic’s primary focus is to foster care to marginalized communities—homeless, uninsured, LGBTQ, people of color—of San Francisco. The clinic continually strives to advance its health care system by seeking opportunities that will enhance the way patients receive care. While PCMH is an incentive-based program, it also emphasizes care through information technology and health information, ensuring patients are receiving proper care as
identified through the EHR. In like manner, EHR technology is utilized to generate baseline reports on health screenings, allowing the CNL student to review percentages and increase it by mitigating the current screening process. After gathering baseline data and sharing it with staff, the CNL will promote and influence a change of the microsystem by collaborating with the healthcare team. This project involves the analysis of the current pattern and flow, and to incorporate new ideas by successfully educating and potentially retraining interdisciplinary members over a three-week study period.

The goal of this project is to ensure staff follows a consistent screening process each time a patient is seen in the health clinic. Education awareness of the problem and visual cueing—a Reference List (See Appendix A), Visual Signage, and an EHR Flowchart List—will be used to prompt and remind staff that health screenings should be performed. The purpose of this implementation is to empower staff to incorporate a pattern that will collectively encourage them to strive for screening process consistency. Moreover, the goal is to not only increase screening numbers but to also promote advocacy for patient health at the same time. In doing so, this collaborative process will aid towards meeting PCMH benchmarks, which will potentially grant the facility recognition and per-patient reimbursements. Furthermore, it can potentially prevent chronic and detrimental health issues, which can eventually become a financial burden to both the patient and health clinic. It is critical to highlight that although cost is important, the health of an individual is even more valuable and if clinic ways are reevaluated then it can strengthen the care that is provided to the patients. In relation to the global aim of improving our EHR data to meet PCMH 2014 requirements, the specific aim is to improve coordinated care so that the identified preventative screening discrepancies can be eliminated, producing qualitative care based on a PMCH level.
Rationale

The need for this project evolved by exploring baseline data and identifying correlating gaps of the health care clinic. After generating reports on depression and cervical cancer screening, along with using the Primary Care Practice Profile to assess the” 5P’s” (See Appendix B) and performing a root cause analysis (See Appendix C), it helped identify various problems and facilitated with the decision to move forward with this project. In addition, a stakeholder analysis (See Appendix D) was conducted and a SWOT of the microsystem was analyzed (See Appendix E).

In order to obtain baseline data and assess the starting point, depression screening and cervical cancer screening percentages were generated through the EHR. This data represents a total percentage from last year and the results were as follows, 51% of patients have been screened for depression and 14% of patients have been screened for cervical cancer (See Appendix F). Since these numbers are rather low, it was important to assess the causation of this matter. When initially making an assessment, it was critical to speak with the healthcare team and ask about barriers to EHR usage and health screenings (See Appendix G for Interview Survey). Each day, the clinic team consists of three temporary medical assistants (MA), one newly hired nurse practitioner, one physician, and an operations manager who acts as an interim director of nursing. Typically, it is the MAs responsibility to follow a certain process for a scheduled patient visit (See Appendix H for Process Map). For instance, before the patient consults with the physician, the MAs are accountable for checking and reviewing the EHR “dashboard” (which is a snapshot overview) of the patient’s chart to assess what items need to be completed. However, due to the current situation of a high staff turnover rate along with new and
temporary MAs, there is improper training, a deficit in EHR dashboard usage, and inconsistent documentation practices.

While the usage of the dashboard is representative of a to-do list, the MAs use a flowchart list (described as a checklist) as an alternative for a patient overview. While this is a snapshot and guide for obtaining patient health history, it is not used for an established patient rather it is only used for a new patient admissions assessment. As part of the new patient assessment, a required action item in the EHR flowchart list is to screen for depression. However, cervical cancer screening is not required, nor is it on the flowchart list, causing this data to not be captured effectively. Occasionally, an MA may ask if the patient has had cervical cancer screening in order to determine if one is needed. If cervical cancer screening is performed by the clinic, the current procedural terminology (CPT) billing codes must be entered into the patient’s chart, proving documentation of in-office procedure screening. However, prior to becoming an FQHC, staff was never concerned about entering CPT codes because billing was not a stipulated in the organization's rules. Unfortunately, even though billing is now necessary per an FQHC, some staff still has these same habitual tendencies of not entering CPT codes accordingly, affecting reimbursements as well.

**Cost Analysis**

After a critical review of strategies on saving money, there is zero cost for the implementation of this project. Staff allowed the CNL student to have allotted time during the weekly meetings in order to share project information, educate staff, and receive feedback. Therefore, it did not take away extra money or time from the health clinic team nor delay patient care. While these cueing tools, preventative screening signage’s and reference lists, will be printed from the facilities copy machine, it was ideal to utilize dispensable resources for it will
not account for added costs to the unit. If the health clinic does not incorporate consistent patterns to run an effective microsystem, there is potential for loss of clinic funds and additional costs, such as: further EHR retraining, EHR maintenance, inability to sustain FQHC status, PCMH reimbursements, and billing reimbursements. However, if the facility works efficiently, they will obtain funds through the following potential benefits: PCMH per-patient reimbursements, billing reimbursements and FQHC grant (See Appendix I for Cost Analysis).

Methodology

The objective and purpose of this project are to increase preventative health screenings and staff compliance by explaining the reasons for preventative screening, educating the team on EHR user effectiveness through cues, and expressing how the success of this project relies on the entire team. If achieved, the health clinic staff has potential to demonstrate a higher quality of work per a PCMH level.

For this project and based on literature research, cueing will be used to assist members in remembering to screen patients for depression or cervical cancer. In the EHR, the flowchart list will be updated to require cervical cancer screenings so that it will not go unnoticed during an admissions assessment. Furthermore, the flowchart list must be reviewed during every patient visit, rather than only for new patient admissions. Moreover, if screening needs to be performed, healthcare workers need to ensure they are entering CPT codes for data documentation and billing purposes; this way the facility can receive payment reimbursements. If a screening procedure took place outside of the facility, patients will be asked to bring in their records so that the clinic can account for that data by inputting it into the EHR. The reference lists are printed and given to the MAs as a source if they are unsure of when to screen patients and what screening information is needed during a patient visit. Screening signage will be posted in the
patient exam rooms as a prompt for patients to ask about preventative screening services and for staff to be reminded of it as well.

**Change Theory**

There are several steps that need to be taken in order to successfully implement strategies, and Kurt Lewin’s Change Theory will guide this project through three stages. Manchester et al (2014) explain Lewin’s Theory and how to facilitate change through it, which is a reference to the necessary steps used for this project. The process of identifying and evaluating what can be improved is a quality that not only shapes practices but also changes the characters of staff behaviors to align with the organization’s environment (Manchester et al.). In the first stage, unfreeze stage, it is important to assess whether the change is necessary. The question is, are there forces for or against change in the clinic? In a search for the answer, pros and cons of this project were measured and gaps between the current state and desired state were shared with the healthcare team. While in a meeting, the healthcare staff was unaware of the low percentage of screenings and was interesting about the project. Having the team on board for change is key because they are the driving force behind how successful this project could be. Acknowledging current performance and the need for implementing new changes, will create better outcomes for patient care and the organization (Manchester et al).

For the next step, the change stage is a process that enables staff to explore the implementation of change. Allowing team members to provide feedback on the matter motivates them to state ideas for the project. It is important to note that this stage of theory takes time and allowing the team a few weeks to feel comfortable with this change project has given them the opportunity to engage in communication and be more involved in addressing barriers or milestones. Moreover, attitudes and behaviors are formed to favor the new changes during this
IMPROVING A CLINIC’S PROCESS

process (Manchester et al.). Lastly, in hopes to establish stability and consistency of the change project, this step of the project is referred to the last stage, the refreezing stage. Data reports will be regenerated and compared to baseline screening percentages. If the project goes as planned, increased screening results are expected. The desired goal for depression screenings is 70% and 25% for cervical cancer screenings.

**Literature Review**

A search through the library database was performed using the PICO strategy. Specific words such as staff performance, visual signage, and EHR were used. To find relevant articles, synonyms of these words were incorporated into the search to help identify applicable sources. The articles from Esper and Walker (2015), Kohli and Tan (2016), and Kowitlawakul et al (2014) of this literature review support the use of reminders to help increase staff performance and how the use of EHR is a source of uniformity and creates consistencies with patient care.

Esper and Walker (2015) address the significance of the EHRs ability to capture documentation based on various measures. The authors analyzed a study on EHR patient encounters and share how generating EHR-derived reports is a quality measure. After review, there was a wide variation in performance of EHR documentation and accurate EHR documentation from staff. These results reflect a negative performance because the data is based on clinic workflow. However, the EHR is a tool that can be utilized to improve performance through a quality improvement process. The authors explain the relationship between staff education and improving documentation based on the chosen measures (i.e. health screenings), and how the implementation of cues can improve the process of patient outcomes. Therefore, as the CNL analyzes EHR data for the benefits of this project and as baseline measures are identified, implementing methods such as visual cues may improve health screening outcomes.
Kohli and Tan (2016) describe how the EHR is a platform to facilitate the integration of patient health history, safe planning, and proper treatment. By using data analytics and Information Systems research, the authors identified potential areas for transforming the delivery of healthcare. For example, when staff uses the EHR efficiently, it offers great value in understanding patient history through comprehensive assessment factors of the patient’s health. Patient records enable timely treatment and the EHR is a prompt to providers that when data is entered, they will be able to diagnose appropriately. However, incomplete information on patients may lead to health complications, which is why EHR data needs to inputted and screenings took place so that there can be clinical interventions that improve patient outcomes.

Kowitlawakul et al. (2014) conducted a qualitative analysis to explore the experience of faculty members using EHRs. To bridge the gap between staff and poor performance with EHR, the authors implemented health information technology sessions to train staff on EHR education. Since the EHR is significant in the healthcare system, the authors suggest that health care staff develop interventions to help with EHR competency. Therefore, as the CNL student educates staff about the benefits of using the EHR appropriately for health screenings along with exploring barriers, a solution such as cueing from the flowchart list is a helpful intervention to ensuring staff uses EHR efficiently.

As education on the EHR may directly improve patient data, the literature from Wiles, Roberts, and Schmidt (2015) and Audet et al. (2015) describes how the use of cues may directly improve staff compliance and performance. Wiles, Roberts, and Schmidt explain that compliance can be improved when implementing guidelines in the healthcare system. Using interventions such as education, feedback, and visual reminders can increase staff awareness and compliance. Audet et al performed a study on clinical encounters between HIV patients and healthcare
workers (HCW). Researchers discovered how HCWs were not educating HIV patients with prevention messages when an analysis of the EHR showed poor documentation. The authors used an evidence-based approach to retraining HCWs, which included: training materials, educational sessions, posters, flipcharts with messages and images in each of the counseling and clinical rooms as indicators to perform prevention messages to patients. This study took place over 11 months and as a result, pre-intervention of health prevention education from HCWs was at 1.9% versus post-intervention at 13.6%. Therefore, by implementing a reference list and signs regarding preventative health screenings, there is potential for increasing staff performance, thus increase health screenings percentages.

With the implementation of EHR education and visual aids to prompt staff for screening reminders, there is potential for staff to create consistent patterns in patient care. If the clinic is to run effectively, the literature shows that a PCMH model is a great way to exemplify care. Gabl (2015) explains that if healthcare wants to model PCMH, MAs and other healthcare professionals need to shift the clinic setting to team-based care through interventional strategies, such as by gathering all essential patient information. This reflects paying attention to the quality of patient care and care coordination since all HCWs are in the forefront. Moreover, the physicians, nurses, and especially the MAs all must participate in the plan of care through the use of the EHR. It is the team's responsibility to plan, work, and communicate together in order to achieve consistent quality care. Therefore, because this clinic’s staff heavily relies on each other, it is essential the team exemplifies care through meeting policies and carrying out processes effectively, especially since the responsibility of each patient falls on all of the members in making sure health screenings are being performed in the clinic.

**Timeline**
The project commenced in early February 2017 and will conclude by the end of April 2017. This project is listed in steps as a guide to persistently remain on a plan. During this project, a microsystem assessment will have been performed, the current circumstance will have been identified, and baseline data gathered. After the implementation of cues, data will be regenerated and reports will be shared with the entire healthcare team by the end of the project. See Appendix J for a detailed description of the project timeline.

**Expected Results**

The outcome imagined is for staff to comply with changes to the microsystem and acknowledge the comprehensive value of this project. With the understanding for the reasons of incorporating cues as an aid to support achievement, staff may be prepared and encouraged to put more effort into performing at a higher qualitative PCMH level. With this in mind, the outcome expected within a three-week study, is for depression screenings to increase to 65% and cervical cancer screening to increase to 30%. If so, staff will be motivated to work harder and prove we can possibly meet the overall standards of PCMH with ease. Nonetheless, since this may be considered a pilot project due to the various strenuous factors of the microsystem, the gaps identified may not be so easy to fix.

A theory of this project is that it may put staff in a predicament of deciding whether there are more important tasks that need to be tended too. Considering that staff constantly have a heavy workload due to understaffing and high turnover rate conditions, in addition to the lack of supervision and lack of knowledge in many microsystem processes, this project may infer that adding more changes to an imperfect process may not bring expected results. In the light of this, strong efforts were put into this project, which is a considerable learning experience not only for the CNL student but for everyone involved in this project as well.
Nursing Relevance

The purpose of the clinic is to provide care for those who do not regularly or easily have access to healthcare. It is the clinic's responsibilities to give qualitative care for its patients since its mission is to ensure the underserved population is given the same health care qualities and opportunities as those who are easily able to access it. The CNL is able to recognize gaps through performing a comprehensive assessment and implement quality improvement strategies from evidence-based practices. Performing a study in order to improve a microsystem process contributes to the qualities of the nursing profession. It is important for the CNL to exemplify leadership abilities through effective encouragement, communication, and teamwork to facilitate change. Being able to recognize barriers and strategize a plan on how to move forward is a way to ensure that staff is working to the best of their abilities because we may be patients only hope to a healthier life. Hopefully, the clinic staff is able to gain an understanding of the CNLs purpose to promote a higher quality of patient care. Moreover, for the clinic staff to understand the importance of patient advocacy and the relevance of why preventive screenings are key to ensuring patients continue to live a well.

Summary Report

Performing health screenings on patients is a potential way to prevent or even identify health issues that may have otherwise not been apparent. In recognition of the importance on this matter, the health clinic has a policy for ensuring each patient is screened accordingly. In efforts to gather baseline information on how well staff has been doing with their part in providing patient care, data was collected from the EHR. As 100% of patients should have a documented record of all health screenings that have been performed, in the past year a total of only 51% of patients were screened for depression, while 14% were screening for cervical cancer. Therefore,
particular methods were incorporated to help in providing awareness to staff for screening patients.

In addition to educating staff on the purpose for providing preventative health screenings, visual cues (See Appendix K) were created to help and remind clinic staff about the screening process and purpose. The CNL student created a small laminated reference card to be attached onto staff badges, making it easily accessible. Moreover, a cervical cancer awareness sign was also created and displayed in each of the three health clinic exam rooms, the hallway, and the staff’s station. This sign was not only a cue for staff but also for patients, as it informed them to ask their provider about this particular health screening.

Over a three-week study period, these methods were implemented in an effort to increase depression and cervical cancer screenings. After this time period elapsed, reports were regenerated from the EHR to see how many patients were screened. Data showed that within three weeks, 54% of patients were screened for depression, while 22% of patients were screened for cervical cancer (See Appendix F for data comparison). As a result, there was a slight increase in screenings from the baseline measure (which was a total percentage from one year). While this implementation project could only conclude preliminary data, as there was only a small time gap to perform the study and capture statistics, there is hope that if data were regenerated post-implementation after a one-year period, the goal of 65% for depression screenings and 30% of cervical cancer screenings could potentially be met.

In order to reach this projection, my plan for sustainability is to provide the clinic with extra visual cues that can be distributed amongst new staff members. Moreover, in the evaluation process of the project staff discussed how the implementation has helped with the process because of the understanding they gained, along with the tools of having reminders easily
viewable and accessible. Staff has ensured that they plan to continue to use it as part of their process, which has helped with screening consistency. Overall, the health clinic has been grateful for this implementation as they recognize how this not only helps patient and their quality of care, but also reminds staff on how they play an important part in successfully fulfilling the goal of a change project.

**Conclusion**

The purpose of this project was to identify a potential problem affecting patient care and creating a plan to implement a solution. Providing awareness to staff and allowing them to participate in the project has helped with the success of an increase in health screenings percentages. As a CNL, this role has an influential force that is able to educate and not only change the microsystem environment, but the patient community as well.
References


https://www.cdc.gov/healthcommunication/toolstemplates/entertainmented/tips/preventivehealth.html


Kohli, R., & Tan, S. S. (2016). Electronic health records: how can is Researchers contribute to transforming healthcare?. *MIS Quarterly, 40*(3), 553-574.


Appendix A

MA Reference List
Disclaimer: This detailed list is proprietary to the agency and therefore has been refined for the purposes of this paper. This reference list is an example, showing the step-by-step process of pt. data collection.

<table>
<thead>
<tr>
<th>Process</th>
<th>New Provider Visit/ Detailed instructions</th>
<th>Established Provider Visit/ Detailed instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demographics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orientation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chief Complaint</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Screenings</td>
<td></td>
<td></td>
</tr>
<tr>
<td>History</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medications</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vital signs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Procedure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Documentation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discharge</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix B

5 P’s Assessment

### Primary Care Practice Profile

**A. Purpose:**
*Why does your practice exist?*

**Site Name:**

**Site Contact:**

**Date:**

**Practice Manager:**

**MD Load:**

**Nurse Load:**

**B. Know Your Patients:**
*Take a close look into your practice, create a "high-level" picture of the PATIENT POPULATION that you serve. Who are they? What resources do they use? How do the patients view the care they receive?*

<table>
<thead>
<tr>
<th>Est Age Distribution of Patients</th>
<th>%</th>
<th>List Your Top 10 Diagnoses/Conditions</th>
<th>Top Referrals (e.g. GI Cardiology)</th>
<th>Patient Satisfaction Scores</th>
<th>% Excellent</th>
</tr>
</thead>
<tbody>
<tr>
<td>80 + years</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% Female</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Est # (unique) jobs In Practice</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disease Specific Health Outcomes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes HgA1c</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hypertension B/P</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LDL &lt;100</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients who are frequent users of your practice and their reasons for seeking frequent interactions and visits</td>
<td></td>
<td></td>
<td></td>
<td>Pt Population Census: Do these numbers change by season? (Y/N)</td>
<td>#</td>
</tr>
<tr>
<td>Other Clinical microsystems you interact with regularly as you provide care for patients (e.g. OR, WMA)</td>
<td></td>
<td></td>
<td></td>
<td>Patients seen in a day</td>
<td></td>
</tr>
<tr>
<td>Mental health disorders</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Informatics</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Complete "Through the Eyes of Your Patient", pg 9*

**C. Know Your Professionals:**
*Use the following template to create a comprehensive picture of your practice. Who does what and when? Is the right person doing the right activity? Are roles being optimized? Are all roles that contribute to the patient experience listed? What hours are you open for business? How many and what is the duration of your appointment types? How many exam rooms do you currently have? What is the morale of your staff?*

<table>
<thead>
<tr>
<th>Current Staff</th>
<th>FTEs</th>
<th>Comment/Function</th>
<th>3rd Next Available</th>
<th>Cycle Time</th>
<th>Days of Operation</th>
<th>Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>MD Total</td>
<td></td>
<td></td>
<td>PE</td>
<td>Monday</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NPs/PA Total</td>
<td></td>
<td></td>
<td></td>
<td>Tuesday</td>
<td></td>
<td></td>
</tr>
<tr>
<td>RNs Total</td>
<td></td>
<td></td>
<td></td>
<td>Wednesday</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LPNs Total</td>
<td></td>
<td></td>
<td></td>
<td>Thursday</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LNA/AMs Total</td>
<td></td>
<td></td>
<td></td>
<td>Friday</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Secretaries Total</td>
<td></td>
<td></td>
<td></td>
<td>Saturday</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Others/Psychologist</td>
<td></td>
<td></td>
<td></td>
<td>Sunday</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Do you use Fostel Pool?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you use On Call?</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

*Each staff member should complete the Personal Skills Assessment and "The Activity Survey", pgs 13-15*

**D. Know Your Processes:**
*How do things get done in the microsystem? Who does what? What are the step-by-step processes? How long does the care process take? Where are the delays? What are the “between” microsystems hand-offs?*

1. Track cycle time for patients from the time they check in until they leave the office using the Patient Cycle Time Tool. List ranges of time per provider on this table, pg 18/17

2. Complete the Care and Supporting Process Assessment Tool, pg 18

**E. Know Your Patterns:**
*What patterns are present but not acknowledged in your microsystem? What is the leadership and social pattern? How often does the microsystem meet to discuss patient care? Are patients and families involved? What are your results and outcomes?*

*Complete "Metrics that Matter", pgs 23-24*

Adapted from the original version, Dartmouth-Hitchcock, Version 2, February 2005
Appendix C
Root Cause Analysis: Fishbone Diagram
## Appendix D

### Stakeholder Analysis

<table>
<thead>
<tr>
<th>Stakeholder Name</th>
<th>Impact</th>
<th>Influence</th>
<th>What is important to the stakeholder?</th>
<th>How could the stakeholder contribute to the project?</th>
<th>How could the stakeholder block the project?</th>
<th>Strategy for engaging the stakeholder</th>
</tr>
</thead>
<tbody>
<tr>
<td>Management</td>
<td>High</td>
<td>Low</td>
<td>Maintaining facility operations and working conditions.</td>
<td>Agree to allow members to implement changes.</td>
<td>Not approving of project changes for the practice.</td>
<td>Weekly discussions of PCMH implementation.</td>
</tr>
<tr>
<td>Provider/Nurse Practitioner</td>
<td>High</td>
<td>Medium/Low</td>
<td>Maximizing quality of care for patients.</td>
<td>Communicate with other stakeholders to express their support.</td>
<td>Opposed to project implementation changes to clinic.</td>
<td>Information and feedback meetings every week.</td>
</tr>
<tr>
<td>Medical Assistants/Front Desk</td>
<td>High</td>
<td>High/High</td>
<td>Ensuring a smooth workflow process to facilitate patient care.</td>
<td>Being consistent with screening / social detriment data input processes.</td>
<td>Not following standard processes and accurate documentation</td>
<td>Collaborating and conducting sessions to discuss implementation of project.</td>
</tr>
<tr>
<td>Patients</td>
<td>High</td>
<td>Low/High</td>
<td>Being screened for preventative health purposes.</td>
<td>Providing appropriate information for screening purposes / for social detriment</td>
<td>Not providing information.</td>
<td>Explaining the process and asking questions and feedback.</td>
</tr>
</tbody>
</table>

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Appendix E

SWOT Analysis

**STRENGTHS (+)**
- Offers services to marginalized and underserved population
- Open to change
- Ability to multitask
- Constantly searching opportunities to advance microsystem
- Able to adapt to environment
- Continually working and improving patient quality of care

**WEAKNESSES (-)**
- Increased staff turnover; understaffed
- Money is tight with Federally Qualified Health Center (FQHC) status
- Noncompliant to using EHR; inconsistencies among staff
- Poor communication
- No set process/procedures for health preventative screening
- Unstructured EHR; hard to manage and there are difficulties with documentation

**OPPORTUNITIES (+)**
- To recognized as a Patient-Centered Medical Home
- Receive per patient reimbursements
- Maintain FQHC status
- Aspire to meet goals
- Increase patient qualitative care
- More possibilities to improve healthcare through recognizing weaknesses
- Hire more health professionals

**THREATS (-)**
- No per patient reimbursement if we PCMH standards are not met
- Unable to meet benchmarks results in ineligible to receive grant
- Decreased patient satisfaction and decreased patient visits
- Small facility equals less resources
- Staff leave due to low pay, yet increased responsibility
Appendix F

Preventative Health Screenings

**Depression Screening**

**Baseline**
- Screened: 51%
- Not Screened: 49%

**Three-Week Period Study**
- Screened: 54%
- Not Screened: 46%

**Cervical Cancer Screening**

**Baseline**
- Screened: 14%
- Not Screened: 86%

**Three-Week Period Study**
- Screened: 22%
- Not Screened: 78%
Appendix G

Interview Survey

**Healthcare Staff**

1. What is the current process for when a patient enters the health clinic & awaits care?

2. How do you prepare for this patient in regards to what care he/she needs and what is missing from the chart?

3. Do you have time to check and see if a patient has been screened for depression or cervical cancer?

4. What are the barriers preventing you in remembering the need for screening/entering screening information into the EHR.

5. How can I help with the screening flow?
   a. Reference List
   b. Signs
   c. Update Flowchart Checklist
At this point, the pt. dashboard should be used as well, but it is rarely utilized.
Appendix I

Cost Analysis

<table>
<thead>
<tr>
<th>Resources</th>
<th>Potential Loss</th>
</tr>
</thead>
<tbody>
<tr>
<td>EHR healthcare training per hour (x8)</td>
<td>$250.00</td>
</tr>
<tr>
<td>EHR maintenance per year</td>
<td>$150,000.00</td>
</tr>
<tr>
<td>FQHC per year</td>
<td>$217,000.00</td>
</tr>
<tr>
<td>PCMH per patient reimbursement</td>
<td>$22.00</td>
</tr>
<tr>
<td>Billing reimbursement per clinic policy</td>
<td>$25.00 - $245.00</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Resources</th>
<th>Potential Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>FQHC per year</td>
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</tr>
</tbody>
</table>
Appendix J

Project Timeline

![Gantt Chart](image)
Appendix K

Visual Cues

<table>
<thead>
<tr>
<th>NEW PROVIDER VISIT</th>
<th>ESTABLISHED PATIENT VISIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>* Tobacco screen</td>
<td>* Tobacco screen</td>
</tr>
<tr>
<td>* Alcohol screen</td>
<td>* Alcohol screen</td>
</tr>
<tr>
<td>* Drug screen</td>
<td>* Drug screen</td>
</tr>
<tr>
<td>* DMGYN screen</td>
<td>* DMGYN screen</td>
</tr>
<tr>
<td>* Last Tobacco test</td>
<td>* Last Tobacco test</td>
</tr>
<tr>
<td>* Health history</td>
<td>* Health history</td>
</tr>
<tr>
<td>* STD screening</td>
<td>* STD screening</td>
</tr>
<tr>
<td>* Pregnancy</td>
<td>* Pregnancy</td>
</tr>
</tbody>
</table>

**SCREENINGS**

**SCREENINGS**

It’s PAP SMEAR Time!

Ask Your Provider About Cervical Cancer Screening