

# MECKLENBURG COUNTY HEALTH DEPARTMENT

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## CLINIC DIVISION PERFORMANCE IMPROVEMENT ASSESSMENT REPORT

JUNE 13, 2017



NAVIGANT

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# SECTION 1: INTRODUCTIONS

NAVIGANT

# NAVIGANT HEALTHCARE: WHO WE ARE

WHO WE ARE: **600+** CONSULTING PROFESSIONALS

**3,000** BUSINESS PROCESS MANAGEMENT PROFESSIONALS

**MULTIDISCIPLINARY**



Physician Enterprise Solutions    Strategy Solutions

Specialized Solutions    **Centralized Analytics**    Revenue Cycle Solutions

Performance Excellence Solutions    Government Healthcare Solutions

WHAT WE DO: • STRATEGY  
• OPERATIONAL IMPROVEMENT  
**DELIVERED TO:** • BUSINESS PROCESS MANAGEMENT



**#5** ON MODERN HEALTHCARE'S LARGEST HEALTHCARE MANAGEMENT CONSULTING FIRMS



FORBES – AMERICA'S BEST MANAGEMENT CONSULTING FIRMS: **HEALTHCARE 4 STARS**

# NAVIGANT HEALTHCARE IS ONE OF AMERICA'S LARGEST CONSULTANCIES

## Navigant Healthcare

- Employs more than 3,000 healthcare professionals, with 500+ as full-time consultants
- Provides guidance on trends and innovation in the industry
- Implements solutions to improve financial, operational and quality performance
- Brings new capabilities in state-of-the-art performance excellence

### Strategic Advisory

Navigant provides healthcare executives with objective, practical, results-oriented assistance to set strategic directions that enable long-term growth through the ever-changing industry.

### Operations Management and Implementation

Navigant has extensive experience, and a successful track record, helping healthcare organizations implement solutions to improve financial, operational and quality performance.

### Outsourcing and Technology Solutions

Navigant provides outsourcing and technology solutions to improve efficiency and help clients make more informed decisions based on better information management.

Health Systems    Physician Groups    Payers  
State and Government Health Agencies    Life Sciences

## Our clients benefit from our scale and breadth of expertise

- We can seamlessly deploy multiple experts to address emergent planning issues
- We know our clients' markets
- We share insights from across the country



# OUR TEAM BRINGS PRACTICE MANAGEMENT EXPERTISE & INDUSTRY PERSPECTIVE

**Robert Kirk,**  
**CASHA, FACMPE**  
*Director*

Physicians  
Ambulatory Enterprise  
Solutions,  
Charlotte, NC

Robert is a Director with Navigant's Healthcare and Physicians Enterprise Solutions practice. Mr. Kirk has more than 30 years of experience in healthcare executive leadership and management, clinic operations, finance, performance improvement, strategic planning, and revenue cycle with a particular emphasis in working with large multispecialty medical groups consisting of 650+ physicians in multiple locations that are owned and operated by large integrated healthcare enterprises. Robert has significant experience in strategic planning, governance and leadership, performance improvement, and working collaboratively with employed and independent physician organizations. He is Board Certified and a Fellow in the American College of Medical Practice Executives.

**Brent Shive,**  
**MBA, FACHE**  
*Director*

Sales and Solutions,  
Charlotte, NC

Brent is a Director in the Sales and Solutions practice at Navigant. He is a Healthcare Executive with more than 30 years of extensive experience in strategic account management of collaborative relationships with hospitals and health systems of all sizes. Brent helps healthcare providers improve financial, operational and quality performance and is accustomed to high value outcomes in clinical, financial and operational performance by focusing on effective, collaborative account planning and implementation.

# OUR TEAM BRINGS PRACTICE MANAGEMENT EXPERTISE & INDUSTRY PERSPECTIVE

**Arvind Ramanathan,**  
**MBA/MHA**  
*Associate Director*  
Physicians Ambulatory  
Enterprise Solutions,  
Chicago, IL

Arvind is an Associate Director with Navigant's Healthcare and Physician Enterprise Solutions practice with extensive expertise in integrated healthcare system network practice management. Arvind is an experienced healthcare practitioner with over 13 years of operational/consulting experience. Arvind has worked in numerous leadership capacities in the provider side of the healthcare industry where he has gained in-depth knowledge of how the business side of medicine operates. Specifically, he has experience in the following areas: physician practice management, project management, revenue cycle management, financial modeling and analysis, business development, strategic planning and process improvement.

**Mary Zacharias,**  
**RN**  
*Managing Consultant*  
Physicians Ambulatory  
Enterprise Solutions,  
Minneapolis, MN

Mary offers 40 years of experience as a registered nurse, with a primary focus in nursing leadership and healthcare information technology. Recently she has focused her industry experience in clinical and ancillary department workflow analyses and Epic optimization. She has used these strong characteristics, as well as her comprehensive knowledge of ambulatory and inpatient clinical workflows to effectively perform in-depth clinical and ancillary workflow analyses with a focus on process improvement. Her areas of expertise include workflow analysis, clinical operations improvement, nursing leadership, project management and EMR implementation.

# OUR TEAM BRINGS PRACTICE MANAGEMENT EXPERTISE & INDUSTRY PERSPECTIVE

**Josue Rodas, MT,  
MBA**

*Director*

Clinical  
Transformation,  
Tampa, FL

Josue has more than 30 years of healthcare experience with emphasis in laboratory business development, and operations. He has established a track record assisting large institutions with their strategic laboratory needs, best practice-driven transformation, business development, and performance improvement efforts.

**Cherye Morgan  
MHA, FACHE**

*Director*

Clinical  
Transformation,  
Chicago, IL

Cherye has 27 years of executive level experience in provider and payer operations and management consulting, allowing her to expertly bridge the worlds of strategy, business and clinical operations. She has advised healthcare clients in strategic planning, business and clinical operations, Medicare and Medicaid compliance, quality and corporate compliance, care management, medical records, patient throughput, patient safety and wellness and consumer driven healthcare.

**Briel Edmeier,  
Senior Consultant**

Physicians Ambulatory  
Enterprise Solutions,  
Washington D.C.

Briel is a Senior Consultant with Navigant Consulting. She has experience in practice assessments in both the acute and physician setting, physician productivity, physician staffing, acute and physician revenue cycle, ICD-10 and project management. Briel specializes in data analytics and process improvements while providing implementation support.

# SECTION 2: ENGAGEMENT OVERVIEW

# OUR UNDERSTANDING OF YOUR NEEDS ...

## **Purpose**

Mecklenburg County (County) is requesting a proposal for consulting services to provide an assessment of the Clinical and Operational processes of the Health Department Clinic Division. The Assessment Report should consist of the following:

- List of recommendations for improving the current and future operating environment
- Proposed organizational structure that would be considered 'best practice'
- Broader strategic options to manage current and future clinical services

for the Southeast and Northwest clinics.

## **Scope Areas**

Review and assess current business and clinic processes in the following areas:

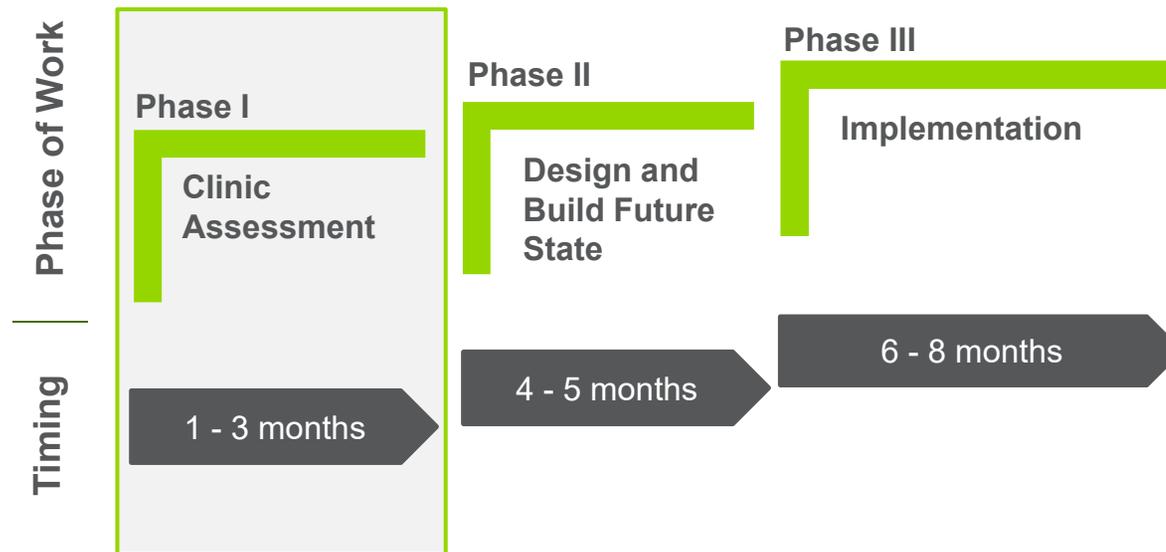
- Clinical Environment
- Laboratory Environment
- Staff Efficiency and Effectiveness, Management Span of Control
- Clinic Standards of Operation
- Patient Care Quality Measures and Monitoring

## MORE SPECIFICALLY WHAT WE EVALUATED ...

- Patient Experience included but not limited to patient throughput and satisfaction, education, testing, results reporting and follow-up.
- Communications, between and among, parties.
- Clinical Operations workflow, processes / procedures, testing, and results reporting incorporating “Leading Practice” standards.
- Laboratory workflow included ordering, results reporting, accountability, and patient notification.
- Provider and clinic staffing efficiency and effectiveness.
- Clinic policies and procedures, job aids, competency assessment, and identification of gaps in training specific to the use of EMR.
- Patient Care Quality Assurance measures / monitoring, and made recommendations, as appropriate, to improve the quality program / initiatives.
- Administrative and organizational structure to better manage clinic operations.
- Clinical operations in accordance to “Leading Practice” standards of operations; including buy versus build opportunities.

## WE ACCOMPLISH THIS BY ...

- A developed and focused approach that allowed us to consider all of the areas that have been and will be identified from the Clinic Assessment for Implementation.



- The work steps within Phase I:
  - Helped Navigant understand your organization.
  - Build a project structure that allows for collaboration to identify opportunities for improvement and implement solutions to enhance your organizations performance.

## OUR WORK CONSISTED OF ...

- Performed an assessment with data provided by MCHD and compared this information against national benchmark survey data.
- Benchmarked sources (2016 reports based on 2015 data):
  - Medical Group Management Association (MGMA) - Physician Compensation & Production, Cost and Revenue Surveys.
- Reviewed key performance indicators (KPI's) for revenue, physician productivity and staffing.
- Completed the following:
  - Conducted a clinic services assessment.
  - Interviewed key executives, management, operations and revenue cycle leaders and staff from MCHD.
  - Interviewed Physicians / Mid-level Providers.
  - Interviewed MCHD clinical and non-clinical personnel.
  - Observed operations at clinic locations.

## OUR METHODOLOGY AND APPROACH ...

- Our assessment included the following:
  - Interviewed leadership and key stakeholders from Mecklenburg County Department of Public Health.
  - Conducted onsite practice observations and practice staff interviews.
  - Collection and analysis of FY2016 and YTD FY2017 clinic encounter data, clinical FTE's, and staffing levels used to perform:
    - Provider productivity and staffing analysis of KPI's.
    - Identified and quantified opportunities for improvement.
- Our Assessment Report includes:
  - Presentation to Mecklenburg County Department of Public Health leadership.
  - Presentation to County leadership.
    - Key message regarding our findings and observations.
    - Recommendations by key initiatives.
    - Pathway towards implementation.

# KEY STAKEHOLDERS WE INTERVIEWED

Location / Department	Position	Total
Executives		4
Clinic/Dept. Management		8
Call Center	Registrar	3
ITS	ITS	3
Laboratory	Laboratory Staff	2
Medical Records	Medical Records	3
Northwest	Non-clinical Staff	3
	Other Clinical Staff	2
	Provider	4
	Registrar	2
	RN	3
Southeast	Non-clinical Staff	1
	Other Clinical Staff	1
	Provider	2
	Registrar	1
	RN	5
<b>Grand Total</b>		<b>47</b>

SECTION 3:  
EXECUTIVE SUMMARY

## WHAT MCHD CLINICS DO WELL ...

- Even with the recent issues regarding the clinic performance, the general consensus is that the Clinics are recognized in the community as providing excellent healthcare.
- Viewed as a valuable partner for the community of Mecklenburg County and its patient population.
- Innovative in delivering health care services within the community.
- High quality physicians and clinical providers.
- Leadership and management have been with the organization for a long time.
- Perceived to be the employer of choice for clinic personnel.
- Health Department has a quality nursing program with qualified nurses who serve the people of Mecklenburg County with care and compassion.
- Health Department is composed of a demographically diverse team with the majority of employees committed to providing high quality care to patients.
- Majority of employees are committed to “seeing the issues through to a improved organization”.
- The organization met its Quality Program standards during the last accreditation survey and was accredited for a full 4 years.
- We believe that MCHD could provide even more value by improving organizational performance.

## WHAT MCHD CLINICS DO WELL ...

- There is evidence that policies and procedures exist and are communicated to staff through appropriate channels that address the critical compliance requirements such as the following:
  - Compliance and Quality Department, Compliance Program, Privacy and Security, Code of Conduct.
  - Proof of policy dissemination, specifically for a code of conduct to employees and non-employees.
  - Hotline operating P&P's related to Investigation, Response and Prevention.
  - HR policies and procedures related to discipline enforcement.
  - Monitoring and Auditing for Compliance related work P&P's.

# WEAKNESSES THAT SHOULD BE ADDRESSED ...

## EMR / Cerner

- The current EMR that was purchased when the Health Department transitioned in 2013 is inadequate for the following reasons:
  - Current version of Cerner PowerChart and Specialty Practice Management is an inferior product compared to the version used by Carolinas Health System (CHS).
  - Key stakeholders (e.g. NP's, RN's, Clinical Assistants) were not involved in the product selection.
  - Clinic leadership is not adequately participating in the management and evolution of the present applications.
    - No defined, on-going EMR optimization plan exists historically or presently.
  - Lack of ownership to drive accountability: Adherence to the “use” policies and procedures.
  - Clinical requirements for documenting in the EMR for each of the clinical programs were not clearly understood or properly vetted, before implementation, which has resulted in an ineffective EMR.
  - Clinical staff are documenting in multiple systems (e.g., Avatar, NCIR, NC EDSS, etc.) and / or are using a combination of paper and PowerChart which is very time-consuming, inefficient and ineffective.

# WEAKNESSES THAT SHOULD BE ADDRESSED ...

## EMR / Cerner

- Due to design flaws paper documentation forms are filled out and scanned into the patient's EMR.
- MCHD is dependent on Cerner for building additional functionality, which in the past, has been met with resistance by Cerner and also constrained by bureaucracy at the County level.
- It is the opinion of IT personnel that an upgraded version of Cerner will cost 3 million+ dollars and will require additional IT resources for build and future maintenance.
- PowerChart does not interface well with other necessary Public Health documentation software programs (e.g. Avatar which is used by the BCCCP program; NC EDSS, disease surveillance program used by the TB clinic; NCIR, immunization registry program used by the Immunization clinic).

# WEAKNESSES THAT SHOULD BE ADDRESSED ...

## Clinical Care Model and Delivery

- Disjointed organizational structure resulting in an unorganized medical practice culture.
- Clinic organizational structure not performing or organized appropriately to promote an efficient and effective operations. Clinics / programs are siloed resulting in redundant procedures, processes, and resources.
- Current clinic operations not performing at “Leading Practice” standards.
- Opportunities exist to improve patient experience / satisfaction.
- Patient access problems exists for patients.
- Provider volume is below 50% of independent benchmark expectations.
- Clinicians need to operate at the “top of their license”.
- Practice operations have been minimally standardized and centralized across MCHD. Customer Care Center (CCC) is the only centralized function that exists and it does not meet operational expectations or meets the operational needs of the clinics.
- Lack of a long term (e.g. 5-year) organizational strategic plan. The 2 year strategic plan that presently exists, meets state requirements but doesn’t go beyond those requirements to plan for the future of the clinic departments.

# WEAKNESSES THAT SHOULD BE ADDRESSED ...

## Clinical Care Model and Delivery

- Clinical and quality performance standards and metrics minimally exist or are not used to gauge clinical performance.
- The lack of an organized and robust infrastructure has limited MCHD success resulting in patient dissatisfaction, staff and provider dissatisfaction.
- Medical interpreters are obtaining patient medical histories without the presence of a RN or provider.
  - Interpreters are asking the questions on the medical history form and writing down the answers.
  - The interpreter will then provide a summary of the answers to the clinician. This is out of scope for what they are trained to do.
- Practice operations have been minimally standardized and centralized across MCHD. CCC is the only centralized function that exists and it does not meet operational expectations or meets the operational needs of the clinics.

# WEAKNESSES THAT SHOULD BE ADDRESSED ...

## Clinical Care Model and Delivery

- Majority of staff do not secure computer workstations whether in an exam room or their offices leaving patient personal health information unprotected.
  - Observed staff shutting off computer monitor, rather than securing or locking the workstation.
  - Observed patient charts opened in PowerChart in offices with no one in attendance.
  - This could potentially violate HIPAA standards.
- Multiple types of documents are scanned into the EMR. In the current setting, it is challenging to retrieve patient medical information as document titles vary when scanned and everything goes into one folder.
- Policies and procedures are managed inconsistently throughout the clinics.
- Accessing policy and procedure documents can be difficult for staff.
- Responsibilities / tasks of provider's and RN's as it relates to a patient visit are not clearly defined or understood.
  - Patients must wait for providers to complete their documentation before the RN can discharge the patient.
  - Perception is some Nurse Practitioners are spending too much time educating patients which is the responsibility of RNs.

# WEAKNESSES THAT SHOULD BE ADDRESSED ...

## Clinical Care Model and Delivery

### **RN Observations / Interview Themes**

- Perception is that RNs do not feel as though they are an asset to the team.
  - Leads to increased turnover and a lack of commitment.
- Perception is that some RNs feel as though leadership is not vested in their future – no path to assist them in furthering their careers.
  - CEUs are not readily available.
  - Not enough training provided to ensure that they understand clinic P&Ps.
- Some RN Supervisors stated that they do not have the time necessary to ensure that P&Ps are up to date and relevant.
- RNs do basic tasks that can be assigned to non-clinical personnel.

### **Clinic Infrastructure**

- Staff throughout the clinics feel they do not have the necessary tools to do their work and to make the clinic efficient.

# WEAKNESSES THAT SHOULD BE ADDRESSED ...

## Clinical Care Model and Delivery

### Clinical Navigator Role

- Current responsibilities include:
  - Triaging all walk-in patients (up to 25 patients per day).
  - Seeing some patients on nurse profile (up to 16 patients per day)
  - Rooming scheduled patients, discharging patients.
  - Expected to keep the clinic “running smoothly” and on-time.
- Based on our experience and knowledge the volume of work this person is responsible for is excessive.

### Procedures

- RN’s are obtaining informed consent from patients prior to procedures.
- Pre-procedure verification process (correct procedure, correct patient, correct site) is not conducted prior to the start of a procedure potentially increasing the risk .
- Unscheduled procedures are at times added to a patient visit, resulting in disruptions to the provider schedule and backs up the clinic.

# WEAKNESSES THAT SHOULD BE ADDRESSED ...

## Clinic Customer Care Centralized Program

- CCC operations in its current state is ineffective providing limited usability for the clinic operations.
- CCC staff stated that the call abandonment rate is approximately 20% of all calls.
  - At times, the appointment line is busy and patients will have to call back.
  - Some patients physically come into the clinic to schedule an appointment.
  - This could affect patient flow negatively and cause unnecessary bottlenecks.
- Some clinical / non-clinical staff not aware of:
  - Who is responsible for collecting and entering demographic information (CCC staff, Registration staff or both).
  - What information CCC should be collecting prior to arriving at clinic registration.
    - Perception is that CCC staff not asking / entering insurance information and are simply scheduling patient appointments.
- CCC and Registration staff sometimes input incorrect demographic and insurance information into SPM. This has caused the following:
  - Patient visit delayed due to the time needed to correct this information.
- CCC does not have an “enhanced” clinical triage process.

# WEAKNESSES THAT SHOULD BE ADDRESSED ...

## Clinic Customer Care Centralized Program

### **Patient Reminder Process**

- Per the actual process, patients receive automated appointment reminder calls.
- However, staff gave conflicting statements that patients were being called to remind them of their upcoming appointments.

### **Patient Requesting STD Appointment**

- If patient states they have symptoms and there is no appointment available, personnel will urge patient to go directly into the clinic to be triaged by a RN.
- Personnel communicates to patients, if they go directly to the clinic and if symptoms are not present, they may not get an appointment.
- When patient arrives at the clinic, RN will triage patients to see if symptoms are present. RN will decide if patient needs to be seen “stat” or assist with the subsequent scheduling of an appointment.
- Personnel will direct several patient per day to walk-into the clinic to be triaged.
- This has become a significant patient dissatisfier due to:
  - Patients not being accommodated after the triaging process
  - The negative downstream effect it has to already scheduled patients.

# WEAKNESSES THAT SHOULD BE ADDRESSED ...

## Clinic Customer Care Centralized Program

### Insurance Verification Process

- Could take an extended period of time as personnel are directly calling the insurance company to verify insurance eligibility.
- Insurance information is written down and transposed into the system for all patients.
- Only patients with valid commercial insurance is ultimately entered into SPM.
- Medicaid eligibility not run on all patients prior to patient being seen in clinic.

# LABORATORY ASSESSMENT QUALIFICATION ...

Leading Practice	Current Practice	Rating
Appropriate lab patient registration, order entry processes for blood draws	Patients reporting for lab draws are registered, orders documented in patient encounter forms; orders are interpreted and handled by laboratory personnel	
Lab orders electronically transferred to the laboratory for processing	Pathnet-Cerner enabled order entry is in place	
Centralized receiving and specimen processing is performed by support personnel	Single entry point for laboratory accessioning and receiving is in place	
Laboratory equipment / methods / work flow are appropriate for level of testing	The laboratory test menu is limited (primarily STD-related testing) - methods for time sensitive testing (RPR, gram stain, wet preps) are appropriate. Methods for non-time sensitive testing are scientifically appropriate but not needed in clinic-based laboratory (e.g. molecular)	
Laboratory Management/Supervision is appropriate for level of service	The laboratory currently operates without a permanent and seasoned Manager and has been under Interim technical management for several months	
Laboratory Medical Directorship and CLIA accreditation are appropriate and in compliance for current service level	Laboratory medical directorship is rendered by an outside (seasoned) Pathologist and the laboratory is duly accredited CLIA and achieved satisfactory performance in most recent survey	

Navigant utilized an overall risk ranking system as outlined below:

-  **High Risk - Significant Concern**
-  **Moderate Risk - Areas of Concern Identified**
-  **Minimal Risk - Few Issues Identified**

# LABORATORY ASSESSMENT QUALIFICATION ...

Leading Practice	Current Practice	Rating
Point of care (waived) testing is appropriate for the size / scope of services performed and overseen by the laboratory	Clinics hold their own CLIA waived license, under separate medical directorship for hemoglobin and urine pregnancy testing; operational variation exists in handling the actual testing (needs standardization)	
Staff is cross-trained in multiple areas to maximize flexibility	Lab personnel are cross-trained to function in all areas of the laboratory; staff routinely rotate between clinics	
Staff skill mix and Span of Control (SoC) are appropriate based on laboratory test mix, volume, and overall lab complexity	The laboratory skill mix includes an even split between MLTs and MTs; a Senior Med Tech handles day to day technical operations; the Clinic Medical Director handles personnel / administrative matters. The department lacks a permanent Manager; one MLT position is vacant	
Test results are transmitted electronically back to ordering provider	Tests performed in-house and referred to LabCorp (commercial lab) are reported electronically upon completion; outstanding report logs are in place as well as remote printer (from LabCorp) to provide electronic and paper copies of reports	
	Tests referred the NC state laboratory are reported in paper reports, which then require manual transposition (by the lab); then scanning (of the report) by medical records personnel	
There's evidence of an active Quality Assurance Program	Current quality control monitors meet regulatory requirements; this includes test quality controls, temperature charts, preventive maintenance records, and corrected report records. Evidence of active SLA monitors for tests sent to NC state lab and LabCorp was not found	

# LABORATORY ASSESSMENT – KEY OBSERVATIONS

## Observations / Interview Themes

1. The laboratory current state-of-affairs is not sustainable in the long term due to the increasing requirements to operate a High complexity (CLIA) laboratory that lacks a permanent Lab manager and performs (in-house) molecular assays and traditional GC / other plated cultures. Operational challenges are further compounded with the manual transposition requirements of tests referred to NC State Lab, which require paper ordering & reporting due to the lack of an interface, while experiencing service issues.
- The clinic needs to consider a two-phase approach that appropriately aligns laboratory and clinic services (based on client clinical needs), and establishes an appropriate strategy for future lab services and operations:

## Recommendations

1. **First**, change the laboratory CLIA accreditation level from “High” to “Moderate” complexity and realign the lab scope of services to retain only retain time sensitive in-house testing (gram stain, wet prep, RPR, HIV screen, and waived tests). Concurrently outsource all non-time sensitive testing including molecular assays, cultures, other, as well as tests currently referred to the NC State Lab. **Second**, consider a new strategy to manage the laboratory in the long-term (now as a Moderate Complexity lab operation):

**Option 1 (ideal):** Establish a strategic Laboratory Management Affiliation with an experienced and reputable external lab provider to manage the remaining in-house lab operations. This provides a solid basis for the laboratory to remain atop of transformational changes required to deliver high quality laboratory services, including dedicated and experienced lab administrative and technical oversight.

- An option is to leverage the existing Agreement with LabCorp and extend it to provide on-site services (aligned with time sensitive tests), while referring non-time sensitive tests to their commercial lab facility, and providing lab medical directorship.

# LABORATORY ASSESSMENT – KEY OBSERVATIONS

Observations / Interview Themes	Recommendations
<p><i>CONTINUED...</i></p> <ol style="list-style-type: none"><li data-bbox="191 781 940 846">2. Evidence of active SLA monitors for tests currently referred out was not found.</li><li data-bbox="191 954 982 1024">3. There's operational variation between clinics handling POCT – urine pregnancy and hemoglobin.</li></ol>	<p><b>Option 2 (less ideal):</b> Retain in-house a limited in-house test menu required to support immediate patient needs. Leverage established reference testing services with LabCorp to refer all non-time sensitive tests and tests currently referred to the NC State lab. Place remaining (limited scope lab operation) oversight under the Clinic administrative oversight and Medical Directorship.</p> <ol style="list-style-type: none"><li data-bbox="1077 760 1906 943">2. Develop and implement a Service Level Standard (SLA) dashboard to monitor service expectations are met by reference laboratory providers [e.g. Turn Around Time (TAT), past due reports, lost and rejected specimen monitors].</li><li data-bbox="1077 987 1940 1057">3. Standardize POCT lab testing protocols between the clinic and the laboratory.</li></ol>

# LABORATORY ASSESSMENT – OPPORTUNITY PRIORITIZATION

Recommendations	Tentative Time Line	Key Implementation Requirements	Potential Risks
Re-align the In-house test menu - retain only time sensitive tests	3 – 6 months	<ul style="list-style-type: none"> <li>• Make Decision/Operational transition planning</li> <li>• CLIA accreditation change</li> <li>• Modification of lab policies/protocols</li> </ul>	1
Discontinue in-house molecular and plated culture testing; refer to commercial lab	2 – 4 months	<ul style="list-style-type: none"> <li>• Make Decision/Operational transition planning; pricing agreement with commercial lab</li> <li>• CLIA accreditation change</li> <li>• Modification of lab policies/protocols</li> </ul>	2
Limit referrals to NC State lab; leverage existing commercial lab capabilities	2 – 4 months	<ul style="list-style-type: none"> <li>• Make Decision/Operational transition planning</li> <li>• Reach pricing agreement with commercial lab</li> <li>• Update internal lab policies/protocols</li> </ul>	3
Implement SLA dashboard	1 – 3 months	<ul style="list-style-type: none"> <li>• Make decision/Agree on applicable SLAs</li> <li>• Develop dashboard and tools (forms)</li> <li>• Establish governing policy/update lab protocols</li> </ul>	4
Pursue a strategic laboratory Management Affiliation with external partner for remaining in-house laboratory operations	6 – 12 months	<ul style="list-style-type: none"> <li>• Make decision and develop action (work) plan</li> <li>• Complete required due diligence of tentative commercial lab partner(s) – note: data sharing will be required after NDA is established</li> <li>• Formalize Lab Management arrangement (based on due diligence findings)</li> <li>• Complete transition plan</li> </ul>	5

- 1 – Low risk: Test menu for time sensitive services remains intact; non-time sensitive services would be outsourced
- 2 – Low risk: Test referral arrangement, interface, and logistical arrangements already exist
- 3 – Low risk: An interface with LabCorp and a pricing agreement are already in place
- 4 – Low risk: SLAs – used to monitor timely completion of tests referred out – will complement the current Lab QA program
- 5 – Some risk exists that test volume/spend could be deemed too low to firm up external Lab Management Partner relationship

# LABORATORY – STRATEGIC AFFILIATION BENEFITS

## Key Benefits Include:

- Standardized and advanced testing methodologies for all lab assays
- Improvements in turn-around times
- Seamless test result order entry and reporting to health clinic EMRs
- Dedicated 24 / 7 hr customer service support
- Provides more stable, predictable lower cost structure
- Eliminates future capital investments in the laboratory, freeing up capital for other higher priority needs
- Reduces risk and liability associated with the performance of laboratory testing
- Enhanced abilities to leverage laboratory data for quality improvement initiatives

# WEAKNESSES THAT SHOULD BE ADDRESSED ...

## Clinic Management – Observations / Interview Themes

- Does not have the pulse of staff perceptions.
- Not listening to the employees concerns.
- Management attending meetings from building to building with little time to address issues.
- Management has done a poor job of addressing staff performance issues.
  - Rather than disciplining staff, they shift these poor performers to other areas within the Health Department.
- “Span of Control” is large for Management.
- Staff perception / comments and their comments regarding MCHD leadership:
  - Have been around for a long time.
  - Have not been proactive in instituting change.
  - Do not want to take extra burden or the extra step to improve clinic operations.
  - Certain managers have stayed in their position so they can be fully vested in their pension.
  - Unresponsive to managers comments regarding their heavy work loads.
- Management does not meet as a collective group to share ideas and discuss issues.
  - Thus, silos have developed.
  - Nursing management staff meet very infrequently.

# WEAKNESSES THAT SHOULD BE ADDRESSED ...

## Clinic Management – Observations / Interview Themes

- Leadership needs to:
  - Establish a focus and a mission for nursing.
  - Personnel need to understand “why they are doing what they are doing” and “how their actions impacts everyone upstream and downstream within the clinics”.
- Management has, at times, behaved inappropriately with Executive Leadership.
- Both Executive Leadership and Management have not served as a good role models for their subordinates.
- Executive Leadership and Management does not acknowledge bad behavior and do not hold personnel accountable for their actions.
- Executive Leadership and Management do not exert their influence and power to drive changes.
- Senior leadership is not visible in clinics.

# WEAKNESSES THAT SHOULD BE ADDRESSED ...

## Clinic Management – Observations / Interview Themes

### **Executive Leadership**

- Health Director wants to be involved in a more strategic nature instead of being “hands-on” to improve clinic operations.
- Health Director needs to support management in instances where they have to hold staff accountable for their roles and responsibilities.

### **Medical Directors**

- Roles of the Medical Director and Assistant Medical Director are somewhat ambiguous.
- Medical Directors have not exerted their influence to bring about change.
- Medical Directors need to be more present and assertive in accomplishing goals / objectives. (e.g. meetings agendas are accomplished).

### **Director of Nursing**

- Director of Nursing (DON) has been a significant barrier regarding changes presented by the Quality team.
- No connection between DON and Clinical Operations.
- Perception of staff is that DON instills a level of fear within the clinical staff.

# WEAKNESSES THAT SHOULD BE ADDRESSED ...

## Clinic Management – Observations / Interview Themes

### **RN Supervisor Role**

- RN Supervisors are not visible in the clinic due to the numerous meetings they are attending.
  - Not available in the clinic during busy / peak times.
  - Unable to execute clinic duties.
  - Staff's perception is that they attend too many meetings.
- Providers have stated that the RN Supervisor role has not been properly used within the clinic setting.
- RN Clinic Supervisors are not exhibiting critical thinking skills to better direct traffic within the clinic.
  - Lack of forethought regarding how busy the clinic is.
  - For example, when the STD clinics are not busy, RN Clinic Supervisor does not flex staff from this area to assist the Family Planning clinic when it is really busy.

# WEAKNESSES THAT SHOULD BE ADDRESSED ...

## Quality and Compliance

- Based upon interviews with leadership and staff, the current definition of quality and compliance appear to be one of doing no harm and not the expanded view from the IOM.
- Current efforts focus on meeting the basic needs of state regulators required through the accreditation process (QA) and meeting efficiency standards that seek to increase access to clinic visits.
- An improvement in quality is not well tied to the strategic plan and integrated into the operational processes throughout Mecklenburg County Clinic to drive a strategy focused on improving public health or ensuring operational successful.
- The current view of quality is to focus on what is broken vs. continual improvement, therefore operational processes are not continually improved and are not capable of being consistently effective or capable of predictable outcomes.
- The majority of monitoring of clinical outcomes is currently focused on efficiency tied to access (number of patient visits in the family planning clinic) and less about improving clinical care, being accurate or effective in meeting needs.
- Interviews pointed to a cultural mindset that quality and compliance is delegated to resources in the quality department and not seen as everyone's responsibility.
- There is minimal focus on designing, managing, or improving key work processes.

# WEAKNESSES THAT SHOULD BE ADDRESSED ...

## Quality and Compliance

- Current data collected is limited in its use to measure, analyze, and then improve organizational performance therefore it is difficult to build an effective and supportive workforce or engage them in achieving a high-performance work environment.
- The organization is operating in a reactive mode characterized by activities to respond to rather than by a focus on process improvement and the reactions are largely driven by problems. Therefore results that are important to the organization's ongoing success are missing, not used or are randomly reported.
- There is a need to move towards a more proactive process for continually improving quality which must begin with the board and executive leadership driving this process.
- It is not evident that the organization has a complete and formal compliance program that addresses:
  - The organization's business activities and consequent risks.
  - Provides ongoing education to those persons who could have material impact on those risks.
  - Includes auditing and reporting functions designed to measure the organization's actual compliance and the effectiveness of the program to identify problems as quickly and efficiently as possible.

# WEAKNESSES THAT SHOULD BE ADDRESSED ...

## Quality and Compliance

- Not evident that there is a written plan for auditing and monitoring that includes subject, method and frequency of audits based upon key functional areas and potential associated risks.
- There is not evidence of an active compliance committee comprised of appropriate representatives from each relevant functional business unit and / or department as well as senior management. This minimizes the ongoing communication to employees regarding compliance related policies and procedures on internal audits, coding, billing and clinical departments.
- The compliance officer is too low level of a resource to carry out the required responsibilities of expected authority such as direct access to the governing board, all senior management and legal counsel.
- It is not evident that the compliance officer provides routine reports to senior leadership and the board about the compliance program.
- It is not evident that the organization has completed a comprehensive risk assessment to identify relevant compliance risk areas other than what is required under the state accreditation process.

# WEAKNESSES THAT SHOULD BE ADDRESSED ...

## Quality and Compliance

### Quality Improvement Team Interview Themes

- Overwhelmed with work.
- Quality department does not feel respected as they lack clinical staff on the team.
- Key clinician stakeholders are not consistently involved and have prevented quality project initiatives from moving forward.
- Quality initiatives are not taken seriously and the importance is not placed on them.
- Current focus is on the Quality Assurance or monitoring piece.
- Quality staff should not be responsible for building or managing any operational functions or competencies.
- Quality staff perceptions are that the clinical staff do not seek leading practices as a norm.
- Receives pushback from clinicians and leadership regarding the planning and implementation of certain quality initiatives.
- Clinic policies and procedures are inconsistent, duplicative and confusing. Many policies are not reviewed on periodic basis by operational and clinical owners.
- Quality initiatives should be the responsibility of all employees and built into the business and clinical operational processes. The Quality department's is to facilitate not lead these efforts.
  - Does maintain Quality related policies and monitors the individual quality program.

# WEAKNESSES THAT SHOULD BE ADDRESSED ...

## Quality and Compliance

### **Clinical Staff Perception of QI Team**

- Operating outside their scope of practice.
  - For example, if an individual is not a RN, they cannot develop nursing P&Ps.
- QI team does not understand clinical workflow as the clinical staff.
- “Why are they making decisions for clinicians and directing clinical workflow?”
- Family Planning Redesign initiative:
  - Perception was that clinicians did not have a voice to give input on an ongoing basis to the development of this initiative. Upon reviewing the QI meeting minutes, nursing leaders were involved in this process.
  - Did not like the Quality staff when they were on site watching and timing their work.
  - Quality team did not talk to clinic staff about clinic workflow – only told them they were doing it all wrong.

# WEAKNESSES THAT SHOULD BE ADDRESSED ...

## Organizational Assessment

- Registration, Check-In and Check-Out operational areas need to be revamped based on a redesigned CCC function.
- Registration process has two layers:
  - Most patients check-in at main registration desk and then have to check-in a second time at registration desk of respective clinics.
  - Registration at main desk could take up to 30 minutes.
  - Registration at secondary clinic desk could take up to 15 minutes.
  - Cycle time to fully register patient could take up to 50 minutes.
- Clinic personnel stated that Registration staff sometimes do not check the identities of patients at check-in. This has led to demographic errors inputted not being caught and the unnecessary creation of duplicate patient charts.
  - Potential increase of PHI exposure.
- Personnel stated that the redundancy of collecting patient information on paper is performed to adhere to strict state guidelines.
  - Patients are required to fill out multiple forms based on their program/visit. All forms are placed in an “out guide” by registration staff.
  - This serves as the patients “paper chart” for their visit.

# WEAKNESSES THAT SHOULD BE ADDRESSED ...

## Organizational Assessment

- Staff perception is some P&Ps lack sufficient substance.
- Perception is the enforcement of policies are applied inconsistently across departments.
- No clear direction from HR what the process is for repeated violations of this policy.
- Inconsistent application of policies has been brought to the attention of MCHD management. They have the perception that they are unable to apply the policies developed by HR within their clinic setting. This has been disputed by HR who states that the Health Department can apply developed policies.
- Performance Reviews
  - Perception is that managers are not provided with clear guidance as to how performance reviews should be administered.
- Some PDQs have not been updated from the Carolinas Health System transition to Mecklenburg County.
  - For example, organizational charts within the PDQs have not been updated to represent current operations.
- Newly hired RNs lack specific knowledge related to Public Health.

# WEAKNESSES THAT SHOULD BE ADDRESSED ...

## Organizational Assessment

- Staff are not held accountable for their inappropriate behavior or actions by leadership.
  - This inaction provides staff with a negative feedback loop that “bad behavior” is tolerated and there are no consequences for their actions.
- Some managers do not exhibit/model appropriate behaviors for their staff.
  - Staff, also, model these inappropriate behaviors, leading to a bad culture and a inhospitable work environment for staff.

# WEAKNESSES THAT SHOULD BE ADDRESSED ...

## Recommendations Based on MGMA 2016 Benchmark Standards:

- Initiate actions to increase provider productivity.
- Identify barriers to schedules, access, and provider assignment to clinics and execute necessary changes.

Provider	FTE	Start/Term Adjusted FTE	Annualized Total Encounters <sup>(9)</sup>	MGMA Median Encounter Standard <sup>(7)(8)</sup>	Encounter Opportunity <sup>(4)</sup> (Median)	Financial Opportunity <sup>(5)</sup> (Median)	MGMA 75th %tile Encounter Standard <sup>(7)(8)</sup>	Encounter Opportunity <sup>(4)</sup> (75th %tile)	Financial Opportunity <sup>(5)</sup> (75th %tile)	FTE Adjusted Productivity %tile	Above/ Under Benchmark
<b>Summary</b>	<b>6.96</b>	<b>6.31</b>	<b>14,926</b>	<b>16,507</b>	<b>2,429</b>	<b>\$ 48,585</b>	<b>21,960</b>	<b>7,034</b>	<b>\$ 140,690</b>	<b>40</b>	<b>Below</b>

<sup>1</sup>Per Rick Ricker Lisvel FTE still to be determined

<sup>2</sup>Termed personnel

<sup>3</sup>Not employed during first half of FY2017

<sup>4</sup>Calculated by taking Median/75th %tile Encounter Standard - Annualized Total Encounter

<sup>5</sup>Calculated by taking Encounter Opportunity (Median & 75th %tile) x \$20 (Avg Charge/Encounter)

<sup>6</sup>Adjusted for clinic days (3-days/w week) and administrative days (2-days/w week)

<sup>7</sup>MGMA Family Medicine without OB related visit statistics for MDs and NPs/PAs.

<sup>8</sup>MGMA 2016 benchmark using 2015 survey data

<sup>9</sup>Clinic encounters annualized using data from July 1, 2016 to December 31, 2016

# WEAKNESSES THAT SHOULD BE ADDRESSED ...

Recommendations based on NC Department of HHS Public Health Staffing Standards:

- Initiate actions to increase provider productivity.
- Identify barriers to schedules, access, and provider assignment to clinics and execute necessary changes.

Provider	FTE	Start/ Term Adjusted FTE	Annualized Total Encounters <sup>(9)</sup>	Adjusted Public Health Staffing Encounter Standard <sup>(7)(8)</sup>	Encounter Opportunity <sup>(4)</sup>	Financial Opportunity <sup>(5)</sup> (Median)	FTE Adjusted Productivity of Standard %tile	Above/ Under Benchmark
<b>Summary</b>	<b>6.96</b>	<b>6.31</b>	<b>14,926</b>	<b>30,280</b>	<b>15,354</b>	<b>\$ 307,089</b>	<b>49%</b>	<b>Below</b>

<sup>1</sup>Per Rick Ricker Lisvel FTE still to be determined

<sup>2</sup>Termed personnel

<sup>3</sup>Not employed during first half of FY2017

<sup>4</sup>Calculated by taking Adjusted Public Health Staffing Encounter Standard - Annualized Total Encounter

<sup>5</sup>Calculated by taking Encounter Opportunity x \$20 (Avg Charge/Encounter)

<sup>6</sup>Adjusted for clinic days (3-days/w eek) and administrative days (2-days/w eek)

<sup>7</sup>Assumed standards were Median visit related statistics for MDs and NPs/PAs.

<sup>8</sup>Data pulled from NC Dept. of HHS (<http://publichealth.nc.gov/lhd/>).

<sup>9</sup>Clinic encounters annualized using data from July 1, 2016 to December 31, 2016

# OPPORTUNITIES THAT SHOULD BE CAPITALIZED UPON ...

## Community Outreach

- Recast MCHD position within the community by:
  - Addressing operational issues and patient access.
- Providers must dedicate time, provide practical solutions and resolutions within the clinic.
- Tactical Implications
  - Facilitate governance and management, vision, and mission.
  - Facilitate communications among multiple constituents, both internally and externally.
  - Establish performance expectations and address issues.
  - Lead quality development and value based performance initiatives/clinical transformation.
  - Lead patient satisfaction initiatives.
  - In partnership with management, lead operational efficiencies and practice optimization improvements.

# OPPORTUNITIES THAT SHOULD BE CAPITALIZED UPON ...

## EMR / Cerner

- Create a Health Information Technology (HIT) Steering Committee, led by clinicians, with decision-making power. The committee will be responsible for the following:
  - Develop a health information technology strategic vision.
  - Oversight of clinical documentation requirements assessment.
  - Oversight of Cerner PowerChart and SPM in-depth assessment of current functionality.
  - Develop an EMR optimization plan.
  - Develop a Meaningful Use (MU) strategy – must be in place by the end of 2017 to attest for MU in April 2018.
  - Develop a patient portal strategy– must be in place by the end of 2017 (one of the MU criteria).
  - Develop a strategy to connect to NC HealthConnex (State-wide Health Information Exchange) – must be in place by February 2018 to receive Medicaid reimbursement.

# OPPORTUNITIES THAT SHOULD BE CAPITALIZED UPON ...

## EMR / Cerner

- Conduct an in-depth assessment of the critical clinical documentation requirements that must be captured to deliver quality patient care and meet all state and federal reporting requirements:
  - Create a Documentation Forms working group whose purpose will be to obtain a clear understanding of all documentation requirements for each clinical program/SPM, as well as state and federal reporting requirements.
  - Gather all forms currently in use in each of the clinical programs and SPM – log all forms into a database by clinical program.
  - Assess all forms for commonality and differences.
  - Establish final documentation requirements necessary to deliver quality patient care and meet all state and federal reporting requirements for each clinical program.
- Once documentation and reporting requirements have been established, conduct an in-depth assessment of current PowerChart and SPM functionality to determine if system optimization will meet your needs.
- If current PowerChart and SPM functionality will not meet your needs, consider replacing PowerChart and SPM with one of the following:

# OPPORTUNITIES THAT SHOULD BE CAPITALIZED UPON ...

## EMR / Cerner

- Upgraded version of Cerner.
- Epic EMR provided by Novant's Community Connect program.
- EMR specific to Public Health.
- Review all applications in use by MCHD and explore options for interfacing with PowerChart and SPM to minimize duplication of data entry.
- Optimize network performance to minimize slow connection and freezes of Cerner environment.
- Develop on-going PowerChart and SPM refresher training for current employees and providers.
- Revise Nurse Informaticist job description.
  - This position should be the bridge between health information technology and clinical workflow.
  - This position should report to nursing.

# OPPORTUNITIES THAT SHOULD BE CAPITALIZED UPON ...

## Clinical Care Model and Delivery

- Develop a formalized telephone triage program with the following components:
  - Dedicated staff with specialized training.
  - Decision support tools.
  - Access strategies.
  - Attention to call flow.
  - Documentation templates.
  - Policies and procedures.
- Expand the role of the Clinical Assistants under the license of the physician.
  - Develop guidelines and annual competency testing for Clinical Assistants.
  - Revise the Clinical Assistant job description to reflect additional responsibilities per their training.
- The practice of using medical interpreters for obtaining medical histories without a clinician present should be prohibited. After informing Executive Leadership, this issue was resolved. (See “Appropriate Use of Medical Interpreters”).

# OPPORTUNITIES THAT SHOULD BE CAPITALIZED UPON ...

## Clinical Care Model and Delivery

- Need improved phone capabilities to enhance interpreter visits and maximize staff time:
  - At a minimum, purchase additional portable phones.
  - Stationary phones in each exam room is ideal.
  - Post signage in each exam room with phone line numbers and codes.
  - Consider use of Skype or similar method. Visit becomes more personal for the patient.

# OPPORTUNITIES THAT SHOULD BE CAPITALIZED UPON ...

## Clinical Care Model and Delivery

- Work with Medical Records to develop specific naming conventions and taxonomy.
- Consider POC scanning strategy.
- Develop policies and procedures outlining how documents should be scanned.
- Implement the World Health Organization's (WHO) "My Five Moments for Hand Hygiene" program for the outpatient setting. (See WHO Guidelines for Hand Hygiene in the Outpatient Setting").
  - Increase signage in patient care areas reminding everyone to use proper hand washing techniques.
  - Implement annual mandatory training on proper hand washing techniques.
- Review lab interface with PowerChart to see if this workflow can be improved.
- All referrals to outside providers should be put in as an order in PowerChart – this will enhance data tracking capabilities.

# OPPORTUNITIES THAT SHOULD BE CAPITALIZED UPON ...

## Clinical Care Model and Delivery

- Develop clear guidelines and expectations on the following **RN responsibilities** during the patient visit and hold RN's **accountable** for completion.
  - Height, weight and vital signs (could also be delegated to the Clinical Assistant)
  - Chief complaint
  - Allergies
  - Tobacco use
  - Medication review (prescription and OTC)
  - Verify and add preferred pharmacy
  - Review and input medical and surgical history, family and social history
  - Nursing note
  - Communicate verbally with provider that patient is ready to be seen
  - Reinforce and educate patient on provider's discharge instructions and plan of care
  - Provide written documentation of discharge instructions to patient prior to leaving the clinic

# OPPORTUNITIES THAT SHOULD BE CAPITALIZED UPON ...

## Clinical Care Model and Delivery

- Develop clear guidelines and expectations on the following **Provider responsibilities** during the patient visit and hold provider's **accountable** for completion.
  - Review of information entered by RN
  - Interview and examine the patient
  - Document visit diagnosis
  - Update the Problem List
  - Place orders and prescriptions
  - Document patient discharge instructions and plan of care, before leaving exam room,
    - share instructions and plan of care verbally with the patient
  - Communicate verbally with clinical staff that patient is ready for discharge
    - Communicate to nurse if follow-up appointment is needed
  - Document level of service billing code and enter charges
  - Document progress note

# OPPORTUNITIES THAT SHOULD BE CAPITALIZED UPON ...

## Clinical Care Model and Delivery

- To retain good staff, the RN Supervisor needs to:
  - Invest in their direct reports by training them appropriately and ensuring that they understand clinic P&P's.
- Assign basic, non-clinical tasks to Clinical Assistant's.
- Complete a thorough assessment of all hardware throughout the clinics – computers, monitors, multi-function printers and Zebra printers.
  - Query staff to develop a good understanding of the current barriers and challenges they are experiencing.

# OPPORTUNITIES THAT SHOULD BE CAPITALIZED UPON ...

## Clinic Contact Centralized Program (CCC)

- CCC operations, in its current state, it is providing limited usability for the clinic operations.
- Documentation of patient calls into the manual log is a redundant process wasting employee time and reducing efficiency.
  - Since all calls are recorded, management can reference the specific patient call, as needed, to verify the accuracy of information collected.
  - Recommend process be discontinued.
- Explore the possibility of instituting an interface that allows notes documented within SPM to crossover to PowerChart to reduce the number of clicks and the navigation from window to window as the personnel are on a call with the patient.
  - Once the “ad hoc” process begins, the notes should crossover to PowerChart.

# OPPORTUNITIES THAT SHOULD BE CAPITALIZED UPON ...

## Clinic Contact Centralized Program (CCC)

- Evaluate functionality of Cisco phone system. Assess the following:
  - Why appointment line is busy?
  - Are there enough phone lines?
  - Is staffing adequate to answer the incoming call volume?
  - Evaluate existing phone tree options.
    - Determine the number of clinic related patient calls versus calls placed by public to reach other areas of the Public Health Department.
  - Eliminate the ability to leave patient messages to ensure all patient phone calls are answered in a queue.
- Create a communications mechanism to change patient behavior of presenting to the clinic to schedule an appointment.

# OPPORTUNITIES THAT SHOULD BE CAPITALIZED UPON ...

## Clinic Contact Centralized Program (CCC)

- Determine the number of clinic related patient calls versus calls placed by public to reach other areas of the Public Health Department.
  - Eliminate the ability to leave patient messages to ensure all patient phone calls are answered in a queue.
- Enhance the access to a RN to allow for the triaging of patients to determine if symptoms actually are present.
  - If symptoms are deemed to be present, RN could assist patients with scheduling a walk-in appointment for that day or next day.
  - If symptoms are deemed not to be present, RN could assist patient with the scheduling of an appointment as soon as possible.
  - Triage process, performed by RNs, will use physician approved clinical protocols.
- CCC should make every effort possible to verify insurance prior to the patient presenting. If possible, CCC should leverage a electronic verification tool.
- Management should create a “tickler” mechanism to highlight patients who have not had their insurance verified for a scheduled appointment.

# OPPORTUNITIES THAT SHOULD BE CAPITALIZED UPON ...

## Clinic Contact Centralized Program (CCC)

- Unclear if patient information is inputted at the time of a patient appointment request.
  - If patient information (demographic and insurance information) is not entered during the time of patient call, this process needs to be instituted as soon as possible.
- Through monthly “Lunch and Learns”, educate clinical/non-clinical staff on the functionalities of both the CCC and Registration areas to highlight the impact of their individual roles on clinic workflow.
- On a periodic basis, audit CCC and Registration staff to determine the accuracy of patient information that is collected prior to and during a patient visit.
- Explore the possibility of having CCC and Registration staff rotate and cross train between both departments. This will allow staff to see how one department affects another.
- Based on patient volume(s), determine appropriate staffing to effectively, timely and efficiently manage current and future CCC patient volumes.
- Consider alternative electronic scheduling methods.

# OPPORTUNITIES THAT SHOULD BE CAPITALIZED UPON ...

## Clinic Contact Centralized Program (CCC)

- Conduct a deeper in-depth assessment to determine true functionality and effectiveness of current CCC to determine if this model will meet MCHD needs.
  - Make decision to revise/enhance current structure, new build or buy is required.
  - Develop action/work plan based on decision.
  - Complete required due diligence of transition:
    - Impact on patient care, finances and patient satisfaction.
    - Financial impact on MCHD clinics.
  - Formalize communication and implement decision/transitions.
- CCC should make every effort possible to verify insurance prior to the patient presenting. If possible, CCC should leverage a electronic verification tool.
- Management should create a “tickler” mechanism to highlight patients who have not had their insurance verified for a scheduled appointment.
- Unclear if patient information is inputted at the time of a patient appointment request.
  - If patient information (demographic and insurance information) is not entered during the time of patient call, this process needs to be instituted as soon as possible.

# OPPORTUNITIES THAT SHOULD BE CAPITALIZED UPON ...

## Care Delivery Structure

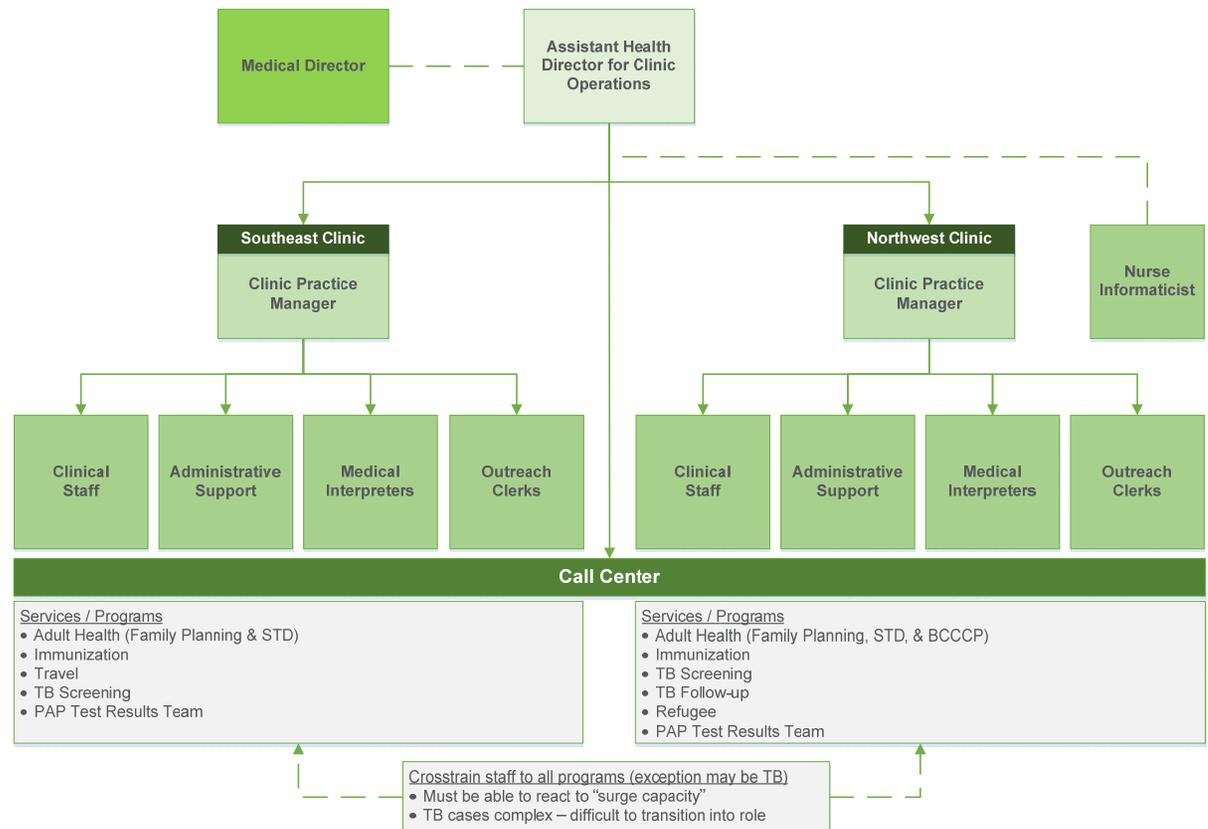
- Reorganize **Care Delivery Structure** from the current Program delivery model (e.g. STD, TB) to a Clinic Location delivery model.
- Enhances service delivery, patient access and satisfaction.
- Improves management accountability.
- Allows for cross training of personnel, enhanced job performance and satisfaction.

Southeast Clinic (Services / Programs)	Northwest Clinic (Services / Programs)
Adult Health (Family Planning & STD)	Adult Health (Family Planning, STD & BCCCP)
Immunization	Immunization
Travel	N/A
TB Screening	TB Screening
N/A	TB Follow-up
N/A	Refugee
PAP Test Results Team	PAP Test Results Team

# OPPORTUNITIES THAT SHOULD BE CAPITALIZED UPON ...

## Proposed Management Structure

- Restructure Management team:
  - Medical Director
  - Assistant Health Director for Clinic Operations
  - Other Practice Managers/Supervisors
- Proposed Structure:
  - Clinical
  - Administrative
  - Interpreters
  - Outreach
- Adjust Span of Control for Management.



Note: Medical Director position same as Dept. position.

# OPPORTUNITIES THAT SHOULD BE CAPITALIZED UPON ...

## Support Staff

- Existing patient encounters for FY2017 indicates that MCHD is overstaffed by 2.5 FTE. However, if provider productivity is increased to MGMA Median benchmark standard, MCHD will better leverage its existing FTE count appropriately.
- Recommendations: 1) Initiate actions to increase provider productivity; 2) Identify barriers to schedules, access, and provider assignment to clinics and execute necessary changes.

Support Staff FTEs Analyzed			
Front Office Support FTEs	18.4		
Clinical Support FTEs	11.2		
Ancillary Support FTEs	9.3		
Business Operations Support FTEs	9.6		
<b>Total Staff Analyzed</b>	<b>48.6</b>		
Support Staff FTE Opportunity			
	Conservative <sup>(2)</sup>	Midpoint <sup>(3)</sup>	Aggressive <sup>(1)</sup>
Front Office Support FTEs	0.8	1.1	1.5
Clinical Support FTEs	-	-	-
Ancillary Support FTEs	0.5	0.8	1.0
Business Operations Support FTEs	-	-	-
<b>Total FTE Opportunity</b>	<b>1.3</b>	<b>1.9</b>	<b>2.5</b>
Financial Opportunity including 25% benefits			
	Conservative <sup>(2)</sup>	Midpoint <sup>(3)</sup>	Aggressive <sup>(1)</sup>
Front Office Financial Opportunity	\$ 37,463	\$ 56,195	\$ 74,927
Clinical Support Financial Opportunity	\$ -	\$ -	\$ -
Ancillary Support Financial Opportunity	\$ 43,219	\$ 64,828	\$ 86,438
Business Operations Support Financial Opportunity	\$ -	\$ -	\$ -
<b>Total Potential Opportunity</b>	<b>\$ 80,682</b>	<b>\$ 121,023</b>	<b>\$ 161,364</b>

<sup>1</sup>Aggressive = MGMA Median Benchmark

<sup>2</sup>Conservative = 50% of MGMA Median Benchmark

<sup>3</sup>Midpoint = 75% of MGMA Median Benchmark

<sup>4</sup>MGMA Multispecialty Clinic w/ Primary Care Staffing Benchmark Used in Analysis

<sup>5</sup>MGMA 2016 Benchmark using 2015 survey data

# OPPORTUNITIES THAT SHOULD BE CAPITALIZED UPON ... RECOMMENDATIONS FOR THE BOARD OF HEALTH LEADERSHIP: 3 PRIMARY ROLES

## Quality and Compliance

1. **Establish policies** that define focus and differentiate responsibilities among the board and management ensuring more efficient board functioning and effective management.
2. **Make significant/strategic decisions**
  - a. Regarding the organization's vision, mission, and strategies.
  - b. Delegation of non-governance types of decisions to others.
3. **Provide oversight vs. management of the organization's activity**
  - a. Demonstrate commitment to Quality and Compliance.
  - b. Establish committees or processes to monitor quality and compliance.
  - c. Support the public health clinic in meeting regulatory standards.
  - d. Ensure that the County Manager and the Health Director carry out these responsibilities.

# OPPORTUNITIES THAT SHOULD BE CAPITALIZED UPON ...

## KEY TO THESE RESPONSIBILITIES: THE BOARD UNDERSTANDS ITS ROLE FOR QUALITY AND COMPLIANCE

### Quality and Compliance

- Demonstrates a top-level, corporate commitment to high quality and organizational compliance.
- Requires that objective measures are used to evaluate the quality of care and services provided.
- Ensures that quality and compliance are integrated in the strategic business plan.
- Ensures that quality and compliance are continually monitored and improved.
- Ensures that the County Manager and the Health Director carries out these responsibilities.

# OPPORTUNITIES THAT SHOULD BE CAPITALIZED UPON ... LEADERSHIP RECOMMENDATIONS FOR BOARD, COUNTY MANAGER, HEALTH DIRECTOR AND EXECUTIVES

## Quality and Compliance

### Create Vision and Build Will

- Create a clear and compelling vision for the organization's future tied to organizational strategic goals.
  - Identify a few mission critical improvement projects tied to these goals.
- Engage the leadership at all levels in adopting system-wide aims for reducing patient harm and delivering the right clinical care to improve team culture and build organizational alignment while ensuring that the board provides support for difficult changes that are necessary.
- Create an urgency around the need for and acceptance of change. Move from reactive norms and practices to a proactive mindset for continual improvement.

# OPPORTUNITIES THAT SHOULD BE CAPITALIZED UPON ... RECOMMENDATIONS FOR HEALTH DIRECTOR AND EXECUTIVES

## Quality and Compliance

### Develop Capability and Deliver Results

- Develop/maintain the organizational structure, people, policy, budget, and resources that support the organizational capability for embracing change/innovation.
  - Develop basic improvement knowledge for all levels of employees.
  - Engage front line staff in the identification of opportunities for improving quality and compliance and provide support for changes in policy and process.
  - Establish the focus for setting and managing priorities.
  - Establish breakthrough performance goals vs, minimal targets.
  - Develop a portfolio of high-priority projects to support the breakthrough performance goals.
  - Deploy resources to projects that are appropriate for the aim.
  - Provide leadership sponsorship and support for each project.
  - Assure the development of key measures that align with the Institute of Medicine (IOM) dimensions of quality based upon the need of those to be served.
  - Establish an oversight and learning system to increase the chance of producing the intended results.
  - Reward the intended and positive leadership/employee behavior as well as team efforts.

# OPPORTUNITIES THAT SHOULD BE CAPITALIZED UPON ...

## Culture

- Develop a communications process that disseminates information effectively from both a top-down and horizontal perspective. Appropriate communications should be disseminated among all stakeholders through the following meetings:
  - Management meetings (bi-monthly)
  - Program meetings by clinic (monthly)
  - Provider/clinical staff meetings (quarterly)
  - Executive Leadership town hall meetings (semi-annually)
  - Electronic communications that are structured and tailored from Executive Leadership/Management. (PRN)
  - Program huddles (daily)
- Develop an organizational culture that:
  - Increases camaraderie/cohesiveness between employees and management.
  - Empowers personnel to be innovative to continually improve practice operations and share leading practices.
  - Leadership and Management should exhibit positive behaviors and promote a culture of teamwork, diversity and inclusion, collaboration, and respect.

# OPPORTUNITIES THAT SHOULD BE CAPITALIZED UPON ...

## Culture

- Create a culture/atmosphere where personnel feel valued and important.
  - Institute recognition programs.
- Encourage all personnel to follow the proper chain of command in regards to any issues/concerns that they might have.
- Direct reports should voice these issues/ concerns to their immediate Manager. If personnel feel that issues/concerns have not been resolved, it is at this point that they should reach out to other resources for assistance.
- Executive leadership must create an environment that:
  - Fosters trust.
  - Openness without retribution
  - Encourages input and involvement (in accordance with clinic goals/objectives).
  - Fosters a partnership between clinics, county departments and community.
- Documentation of patient calls into the manual log is a redundant process wasting employee time and reducing efficiency.

# OPPORTUNITIES THAT SHOULD BE CAPITALIZED UPON ...

## Scheduling

- Separate Family Planning and STD clinics:
  - Build profiles by provider and not by program
  - Assign all STD patients to one provider and all Family Planning patients to a different provider.
  - Have providers rotate through each clinic daily or weekly.
- Schedule all new patients to Family Planning and those who have not been to the clinic for greater than one year with a provider.
  - Work with CCC to develop this algorithm.
- Open visit slots later than 5 p.m. on Wednesday.
- Schedule patient visits needing interpreter services by phone (language other than Spanish) for 30 or 60 minutes appointment slots.
- Manage patient grace period by implementing a variety of patient reminder systems.
- RN Supervisor should check clinic schedule 72 hours in advance to allow for smoothing of patient appointments to avoid bottlenecks in clinic workflow.

# OPPORTUNITIES THAT SHOULD BE CAPITALIZED UPON ...

## Registration / Check-In / Check-Out

- Perform a deeper dive assessment of the numerous registration area(s) to consolidate key registration related processes, procedures and functions.
  - Maximize the standardization of processes, procedures and functions.
  - Consider moving appropriate functions to CCC environment. Example functions to consolidate:
    - Registration
    - Scheduling of patient visits, procedures, lab, pharmacy, etc.
    - Preregistration and post visit activities where possible.
- Evaluate the feasibility of using patient kiosk devices in registration areas (main or at each clinic).
- Establish mechanism to identify CCC/Registration staff who incorrectly enter demographic information on a monthly basis.
- Institute re-education and training programs to ensure work standards are put into place such as “Lunch and Learn” seminar to learn the proper processes to register/check-in/check-out patients.
- Conduct monthly lunch & learn sessions with required attendance.

# OPPORTUNITIES THAT SHOULD BE CAPITALIZED UPON ...

## Registration / Check-In / Check-Out

- Employee should acknowledge training with acknowledgement enter into personnel files.
- Hold registration staff accountable with disciplinary action if three instances of errors occur.
- Use all available electronic means available for registration/check-in and check-out.
- Re-evaluate the use of redundant forms to collect patient related information.
- Holding staff accountable for mistakes and increasing training and education on registration processes will reduce transposition errors and help improve clinic workflow.
  - Ensure adherence to applicable P&Ps – **No exceptions.**
  - Strictly adhere to HR process and disciplinary steps/actions – **No exceptions.**
- Eligibility should be verified at every visit prior to patient being seen in clinic.
  - If patient exceeds authorized number of visits allotted for insurance carrier, registrar needs to obtain additional authorizations.
  - CCC Manager and the respective Registration Manager for each clinic should confer on a monthly basis to identify instances where insurance is not verified.
  - CCC Manager should establish a mechanism to determine CCC personnel who have not verified patient insurance.

# OPPORTUNITIES THAT SHOULD BE CAPITALIZED UPON ...

## Registration / Check-In / Check-Out

- Ensure adherence to applicable P&Ps – **No exceptions**.
- Change patient grace period policy.
  - Manage patient grace period by implementing a variety of patient reminder systems.
  - Communicate to patients and staff new standard and enforce at Point of Service (POS).
- Via “Lunch and Learn” meetings, clarify to staff how CCC handles patient “no shows”.
- RN Supervisor should check clinic schedule 72 hours in advance to allow for smoothing of patient appointments to avoid in bottlenecks in clinic workflow.
- Front desk lead/supervisor should proactively manage front desk and check out personnel to respond to changes in patient flow through clinics.
  - High volume check in occurs in early am and start of afternoon clinic sessions. Adjust personnel assigned at check-in to peak times.
  - High volume check-out occurs in late morning and afternoon sessions. Shift check-in personnel from check in to check-out.

# OPPORTUNITIES THAT SHOULD BE CAPITALIZED UPON ...

## Registration / Check-In / Check-Out

- Cross-train all primary and secondary registration staff on the check-out process including the collection of patient payments and scheduling of subsequent appointments.
- CCC should ask/note that interpretation services will be needed to accommodate non-Spanish non-English speaking patients (Burmese and Somali).
- Establish a “lunch and learn” on a quarterly basis to allow different areas of the clinic to address common errors detected as well as educate staff on critical processes that affect clinic workflows.
- Establish a communications mechanism to encourage patients to use appointment line to schedule office visits.
- Open visit slots later than 5 p.m.
- Schedule patient visits needing interpreter services by phone (language other than Spanish) for 30 or 60 minutes appointment slots.

# OPPORTUNITIES THAT SHOULD BE CAPITALIZED UPON ...

## Human Resources

- Mecklenburg County's Human Resources (HR) related Policies and Procedures (P&P) are broad.
- Staff perception is some P&Ps lack sufficient substance.
- Perception is the enforcement of policies are applied inconsistently across departments.
- No clear direction from HR what the process is for repeated violations of this policy.
- Inconsistent application of policies has been brought to the attention of MCHD management. They have the perception that they are unable to apply the policies developed by HR within their clinic setting. This has been disputed by HR who states that the Health Department can apply developed policies.
- County doesn't recognize Charge RN (Clinical Navigator) role from a salary perspective.
- High turnover of staff inhibits clinic continuity.
- Lack of communication/coordination between HR and the Public Health departments in regards to the transfer of employees who have performance issues.
- Performance Reviews
  - Perception is that managers are not provided with clear guidance as to how performance reviews should be administered.

# OPPORTUNITIES THAT SHOULD BE CAPITALIZED UPON ...

## Human Resources

- Some PDQs have not been updated from the Carolinas Health System transition to Mecklenburg County.
  - For example, organizational charts within the PDQs have not been updated to represent current operations.
- Newly hired RNs lack specific knowledge related to Public Health.
- Staff are not held accountable for their inappropriate behavior or actions by leadership.
  - This inaction provides staff with a negative feedback loop that “bad behavior” is tolerated and there are no consequences for their actions.
- Some managers do not exhibit/model appropriate behaviors for their staff.
  - Staff, also, model these inappropriate behaviors, leading to a bad culture and a inhospitable work environment for staff.

# OPPORTUNITIES THAT SHOULD BE CAPITALIZED UPON ...

## Human Resources

- It is the responsibility of MCHD Management to define how the P&Ps will be managed and applied to staff.
- Management needs to clearly define the P&Ps that the staff are expected to adhere to ensure compliance. Communicate P&Ps relevant to the operations of clinics.
- Conduct retraining and educational sessions for management.
- Conduct retraining and educational sessions for staff members who are not complying with policies and procedures.
- Working with HR, clearly define the process in place for disciplining management/ employees who do not adhere to policies procedures.
- MCHD executive leadership must address this issue between County HR and clinic operations.
- Adherence to policies and procedures are paramount to the successful operation of the clinics on a daily basis. Failure to enforce such policies has and will significantly impact clinic operations, employee morale and satisfaction, and effectiveness of the clinics overall.

# OPPORTUNITIES THAT SHOULD BE CAPITALIZED UPON ...

## Human Resources

- All employees, regardless of their time designation (FT, PT, Flex, PRN), must be properly oriented, exposed to all training programs, policies and procedures, and clinic culture to ensure proper assimilation and ongoing successful performance.
- Mandatory training in these areas are paramount to the successful operation of the clinics on a daily basis.
- Failure to administer will significantly impact clinic operations, employee morale and satisfaction, and effectiveness of the clinics overall.
- Update PDQ's to reflect Mecklenburg County specific information and requirements.
- Develop clear guidance and conduct educational training regarding performance reviews preparation to conducting the actual performance review.
- Leadership has to be committed to changing inappropriate behavior of their staff with the assistance of HR.
- Leadership should be critiqued anonymously by their peers to see how their actions contribute to the behaviors of their staff/subordinates.
- Executive leadership (Health Director/Medical Director) must hold other members of the executive and management team accountable for their performance, behavior and impact on culture.

# OPPORTUNITY PRIORITIES

Priority	Opportunity
1	Enhance <b>EMR</b> performance to maximize clinic performance, maximize patient management, eliminate multiple documentation approaches, and minimize risks.
2	Restructure current <b>Clinical Care Model and Delivery</b> resulting in improved patient satisfaction and patient access, implement alternative methods to deliver care, and improved financial performance of the clinics.
3	Resign <b>Customer Contact Center / Call Center</b> to maximize centralization and standardization of patient registration, prior authorizations and precertification, scheduling of patient appointment types and procedures and enhance Clinical Nurse Triage.
4	Pursue a strategic <b>Laboratory Management Affiliation</b> with an external partner for remaining in-house laboratory operations.
5	Redesign <b>Clinic Management</b> structure.
6	Enhance <b>Quality Programs</b> to permeate clinic organization and exceed state requirements.

# OPPORTUNITY ASSESSMENT RISK

Based upon Navigant's extensive knowledge and experience working with clinic organizations, we utilized an overall risk ranking system as outlined below:

-  High Risk - Significant Concern
-  Moderate Risk - Areas of Concern Identified
-  Minimal Risk - Few Issues Identified

Criteria	Minimal	Moderate	High
EMR			
Clinical Care Model and Delivery			
Clinic Contact Centralized Program (CCC)			
Practice Standardization			
Lab Ops / Management Affiliation			
Care Delivery Structure			
Management Structure			
Quality and Compliance			
Providers / Staffing			

# IMPLEMENTATION INITIATIVES

Category	Low	Medium	High
EMR	 	 	 
Clinical Care Model and Delivery	 	 	 
Clinic Contact Centralized Program (CCC)	 	 	 
Practice Standardization	 	 	 
Lab Ops / Management Affiliation	 	 	 
Care Delivery Structure	 	 	 
Management Structure	 	 	 
Quality and Compliance	 	 	 
Providers / Staffing	 	 	 

Based upon Navigant’s extensive knowledge and experience working with clinic organizations, we utilized an overall implementation estimation as outlined below:

 Potential Economic Value

 Difficulty of Implementation

# PROPOSED IMPLEMENTATION PLAN

	Phase I Assessment	Phase II Design and Build	Phase III Implementation
Goal	Define Opportunities	Develop Solutions	Deliver Results
Project Activities	<ul style="list-style-type: none"> <li>• Create project charter</li> <li>• Identify and engage MCHD stakeholders for assessment, schedule interviews</li> <li>• Conduct best practice review</li> <li>• Submit data request</li> <li>• Conduct current state situational assessment</li> <li>• Conduct qualitative review (interviews and process observations)</li> <li>• Conduct quantitative review (benchmarking, data analysis, span of control &amp; validation).</li> <li>• Identify magnitude of improvement opportunities (gap between current state and target benchmark for each functional area)</li> <li>• Define implementation Workstreams</li> </ul>	<ul style="list-style-type: none"> <li>• Conduct further due diligence to support design</li> <li>• Design, build, and test people, process and technology solutions and identify realization schedule for solutions/recommendations</li> <li>• Define scope and scale of pilot</li> <li>• Determine scaling timeline/ramp-up across organization</li> <li>• Create detailed implementation plans for each of the approved solutions/recommendations</li> <li>• Develop staff training plan and materials</li> </ul>	<ul style="list-style-type: none"> <li>• Conduct pilot per design</li> <li>• Conduct full rollout of solutions/ implementation of approved recommendations</li> <li>• Monitor actual quality, operational and financial performance against realization schedule</li> <li>• Develop plans to achieve targets when targets are not being met</li> <li>• Monitor and reassess risk and impact</li> <li>• Transfer knowledge and capability to MCHD</li> </ul>
Deliverables	<ul style="list-style-type: none"> <li>• Project charter</li> <li>• Current state situational summary</li> <li>• Gap analysis between current state and target benchmark</li> <li>• Identification of process improvement opportunities</li> <li>• Prioritized initiatives and implementation Workstreams</li> <li>• Desired performance expectations/ targets – financial, quality and operational</li> </ul>	<ul style="list-style-type: none"> <li>• Solutions and/or design specifications including workflows, process maps, governance structure, etc.</li> <li>• Benefit realization methodology and plan</li> <li>• Detailed implementation work plan</li> <li>• Training plan and materials</li> </ul>	<ul style="list-style-type: none"> <li>• Updated implementation work plan</li> <li>• Risks and Issues log</li> <li>• Project dashboard and status report</li> <li>• Value realization</li> <li>• Transition plan</li> <li>• Lessons learned</li> <li>• Monthly measurement updates</li> <li>• IMPLEMENT!</li> </ul>
	<b>Completed Phase I Assessment</b>	Work with County Leadership team to identify the best resources for Phase II & III.	

# SECTION 4: CLINICAL ASSESSMENT

NAVIGANT

# GENERAL OBSERVATIONS - ALL CLINICS

## Observations / Interview Themes

- Phone calls from patients needing to speak with a nurse (e.g. having symptoms) are documented on a paper phone log.
  - Messages are taken by anyone who answers the phone and then relayed to the RN.
  - RN will call patient back when she has time.
  - Advice is provided to patient but not documented in PowerChart.
  - Some calls going to a “Nurse Advice Line” which no one answered and patients were forced to leave messages.

## Recommendations

- Develop a formalized telephone triage program with the following components:
  - Dedicated staff with specialized training.
  - Decision support tools.
  - Access strategies.
  - Attention to call flow.
  - Documentation templates.
  - Policies and procedures.

# GENERAL OBSERVATIONS - ALL CLINICS

## Observations / Interview Themes

- Most Clinical Assistants in the clinics have completed extensive training for their positions and based on that training their responsibilities could be expanded.
- In some clinics, medical interpreters are obtaining patient medical histories without the presence of a RN or provider.
  - Interpreters are asking the questions on the medical history form and writing down the answers.
  - The interpreter will then provide a summary of the answers to the clinician. This is out of scope for what they are trained to do.

## Recommendations

- Expand the role of the Clinical Assistants under the license of the physician.
  - Develop guidelines and annual competency testing for Clinical Assistants.
  - Revise the Clinical Assistant job description to reflect additional responsibilities per their training.
- The practice of using medical interpreters for obtaining medical histories without a clinician present should be prohibited. After informing Executive Leadership, this issue was resolved. (See “Appropriate Use of Medical Interpreters”).

# GENERAL OBSERVATIONS - ALL CLINICS

## Observations / Interview Themes

- Staff must use portable phones when calling the interpreter phone line (occurs most often for language other than Spanish).
  - There are only two portable phones available at the SE clinic.
  - At times, staff must wait for a phone, adding time to an already lengthy visit.

## Recommendations

- Need improved phone capabilities to enhance interpreter visits and maximize staff time:
  - At a minimum, purchase additional portable phones.
  - Stationary phones in each exam room is ideal.
  - Post signage in each exam room with phone line numbers and codes.
  - Consider use of Skype or similar method
    - Visit becomes more personal for the patient.

# GENERAL OBSERVATIONS - ALL CLINICS

## Observations / Interview Themes

- Majority of staff do not secure computer workstations whether in an exam room or their offices leaving patient personal health information unprotected.
  - Observed staff shutting off computer monitor, rather than securing or locking the workstation.
  - Observed patient charts opened in PowerChart in offices with no one in attendance.
  - This could potentially violate HIPAA standards.

## Recommendations

- Policies and procedures protecting patient personal information should be **strictly enforced.**
  - Review all policies related to privacy and security to ensure they are current.
  - Review whether computers are set to lock after a certain amount of time.

# GENERAL OBSERVATIONS - ALL CLINICS

## Observations / Interview Themes

- Multiple types of documents are scanned into the EMR. In the current setting, it is challenging to retrieve patient medical information as document titles vary when scanned and everything goes into one folder.
- Policies and procedures are managed inconsistently throughout the clinics. Accessing policy and procedure documents can be difficult for staff.

## Recommendations

- Develop a document scanning strategy:
  - Determine if document scanning can be done at the following levels: patient, encounter or order.
  - Work with Medical Records to develop specific naming conventions and taxonomy.
  - Consider POC scanning strategy.
  - Develop policies and procedures outlining how documents should be scanned.
- Consider investing in a healthcare-specific policy management software program.
  - Simplifies and automates policy access, review and approval throughout the organization.

# GENERAL OBSERVATIONS - ALL CLINICS

## Observations / Interview Themes

- Leading practice hand-washing techniques are not utilized properly throughout the clinics.
- Test results are delivered to provider's PowerChart Inbox in "groups".
  - This approach makes it difficult and time-consuming to react / respond to individual test results.
  - It is the provider's understanding that this is a "Cerner" thing and nothing can be done about it.
- Referrals to outside providers are not put in PowerChart as an order.

## Recommendations

- Implement the World Health Organization's (WHO) "My Five Moments for Hand Hygiene" program for the outpatient setting. (See WHO Guidelines for Hand Hygiene in the Outpatient Setting").
  - Increase signage in patient care areas reminding everyone to use proper hand washing techniques.
  - Implement annual mandatory training on proper hand washing techniques.
- Review lab interface with PowerChart to see if this workflow can be improved.
- All referrals to outside providers should be put in as an order in PowerChart – this will enhance data tracking capabilities

# GENERAL OBSERVATIONS - ALL CLINICS

## Observations / Interview Themes

- Responsibilities / tasks of provider's and RN's as it relates to a patient visit are not clearly defined or understood.
  - Patients must wait for providers to complete their documentation before the RN can discharge the patient.
  - Perception is some Nurse Practitioners are spending too much time educating patients which is the responsibility of RNs.

## Recommendations

- Develop clear guidelines and expectations on the following **RN responsibilities** during the patient visit and hold RN's **accountable** for completion.
  - Height, weight and vital signs (could also be delegated to the Clinical Assistant)
  - Chief complaint, Allergies, Tobacco use
  - Medication review (prescription and OTC)
  - Verify and add preferred pharmacy
  - Review and input medical and surgical history, family and social history
  - Nursing note
  - Communicate verbally with provider that patient is ready to be seen
  - Reinforce and educate patient on provider's discharge instructions and plan of care
  - Provide written documentation of discharge instructions to patient prior to leaving the clinic

# GENERAL OBSERVATIONS - ALL CLINICS

## Observations / Interview Themes

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## Recommendations

- Develop clear guidelines and expectations on the following **provider responsibilities** during the patient visit and hold provider's **accountable** for completion.
  - Review of information entered by RN
  - Interview and examine the patient
  - Document visit diagnosis
  - Update the Problem List
  - Place orders and prescriptions
  - Document patient discharge instructions and plan of care, **before leaving exam room**, – share instructions and plan of care verbally with the patient
  - Communicate verbally with clinical staff that patient is ready for discharge
    - Communicate to nurse if follow-up appointment is needed
  - Document level of service billing code enter charges
  - Document progress note

# GENERAL OBSERVATIONS - ALL CLINICS

## Observations / Interview Themes

### RN Observations / Interview Themes

- Perception is that RN's do not feel as though they are an asset to the team.
  - Leads to increased turnover and a lack of commitment.
- Perception is that some RNs feel as though leadership is not vested in their future – no path to assist them in furthering their careers.
  - CEUs are not readily available.
  - Not enough training provided to ensure that they understand clinic P&Ps.

## Recommendations

- To retain good staff, the RN Supervisor needs to:
  - Invest in their direct reports by training them appropriately and ensuring that they understand clinic P&P's.

# GENERAL OBSERVATIONS - ALL CLINICS

## Observations / Interview Themes

### RN Observations / Interview Themes (cont'd)

- Some RN Supervisors stated that they do not have the time necessary to ensure that P&Ps are up to date and relevant.
- RNs do basic tasks that can be assigned to non-clinical personnel such as:
  - Ordering of vaccines.
  - Copying patient education pamphlets.
  - Recheck of emergency box supplies.

## Recommendations

- Assign basic, non-clinical tasks to Clinical Assistant's.

# GENERAL OBSERVATIONS - ALL CLINICS

## Observations / Interview Themes

### Clinic Infrastructure

- Staff throughout the clinics feel they do not have the necessary tools to do their work and to make the clinic efficient.
  - For example, printers and copiers need to be enhanced. For printers, registration staff have to print up to 7 pages for each patient.

## Recommendations

- Complete a thorough assessment of all hardware throughout the clinics – computers, monitors, multi-function printers and Zebra printers.
  - Query staff to develop a good understanding of the current barriers and challenges they are experiencing.

# ADULT SERVICES OVERVIEW - FAMILY PLANNING AND STD

## Observations / Interview Themes

### Family Planning Redesign Initiative

- QI team is leading this initiative – several clinicians asked “why is Quality team leading effort to redesign clinical workflow? They are not clinical and do not understand clinical workflow”.
- The perception is that Quality team is dictating clinical workflow and practice for the providers and RN’s.
- Perception is Quality team did not speak with staff directly about their workflow – “spent most of their time watching, timing and telling them what they were doing wrong”.
- Most staff feel they “do not have a voice” in the redesign effort.

## Recommendations

- Restructure Family Planning Redesign initiative.
  - Initiative and meetings should be led by clinicians with support from Quality team.
  - Communicate with staff on a regular basis about the initiative.
    - Who’s on the team.
    - Changes being considered.
    - Decisions being made.
  - Provide a mechanism for all staff to share their suggestions, especially if they are not a part of the active committee e.g. suggestion box.

# ADULT SERVICES OVERVIEW - FAMILY PLANNING AND STD

## Observations / Interview Themes

- Staff frequently commented that the Quality Team are attempting to implement changes that “seems like something new every week”. This is a big contributor to employee dissatisfaction along with their lack of direct involvement.
- The perception amongst employees is that MCHD is attempting to model Family Planning and STD clinic after Gaston County.
- MCHD providers and nurses are receptive to implementing a team-based model of care.

## Recommendations

- Provide quality improvement training to ensure staff understand the QA/QI process and purpose.

# ADULT SERVICES OVERVIEW - FAMILY PLANNING AND STD

## Observations / Interview Themes

### STD Walk-In Patients

- On average, 9 to 25 walk-in patients seek services/day at the NW clinic and 10 at the SE clinic.
- Approximately 90% of walk-ins are STD patients with symptoms.
- Patients are triaged by the Clinical Navigator who determines when they can be scheduled.
  - Clinical navigator at SE clinic makes certain that STD patients with symptoms are seen within 24 hours.
  - Clinical navigator at NW clinic attempts to schedule patients within 24 hrs. but can take up to 72 hours before patients can be scheduled because providers schedules do not have open slots.

## Recommendations

- Have one provider scheduled as “provider of the day” at NW clinic – responsible for all walk-in patients.
- Expanded Role STD RN at SE clinic:
  - Responsible for all STD walk-in patients and
  - See STD patients who are currently scheduled on the nurse profile.
- Redesign the present CCC to perform non clinical and clinical nurse triage tasks.
  - Non clinical tasks performed would be: patient appointments (new and follow up), precertification / preauthorization, patient eligibility.

# ADULT SERVICES OVERVIEW - FAMILY PLANNING AND STD

## Observations / Interview Themes

- Adding this number of unscheduled patients to a full schedule is disruptive and backs up the clinic.
- Patients who are triaged are tracked on the “Adult Health Triage Log” sheet – logs are stored in a file “somewhere”.
- The STD Expanded Role RN has been unable to see her own schedule of patients since March.
  - The standing orders under which she works need to be updated – Medical Director and Asst. Medical Director have yet to make the needed changes.

## Recommendations

- Develop a formalized clinical triage program for walk-in patients:
  - Patient encounters should be created in the EMR with appropriate documentation per established guidelines.
  - Develop policies and procedures detailing the clinical triage process.
- Standing orders for STD RN need to be completed immediately.

# ADULT SERVICES OVERVIEW - FAMILY PLANNING AND STD

## Observations / Interview Themes

### Clinical Navigator Role

- Current responsibilities include:
  - Triageing all walk-in patients (up to 25 patients per day).
  - Seeing some patients on nurse profile (up to 16 patients per day)
  - Rooming scheduled patients, discharging patients.
  - Expected to keep the clinic “running smoothly” and on-time.
- Based on our experience and knowledge the volume of work this person is responsible for is excessive.

## Recommendations

- Evaluate number of dedicated FTEs to this role and determine appropriate number of FTEs required to support the clinic.
  - If appropriate, assign other clinic personnel to support these duties.

# ADULT SERVICES OVERVIEW - FAMILY PLANNING AND STD

## Observations / Interview Themes

### Procedures

- RN's are obtaining informed consent from patients prior to procedures.
- Pre-procedure verification process (correct procedure, correct patient, correct site) is not consistently conducted prior to the start of a procedure potentially increasing the medical risk.
- Unscheduled procedures are at times added to a patient visit, resulting in disruptions to the provider schedule and backs up in the clinic.

## Recommendations

- Transfer responsibility of obtaining informed consent before procedures to the providers
  - This is considered leading practice (see "Informed Consent – More Than Getting a Signature" by The Joint Commission).
  - Provider's should document in the EMR that informed consent took place.
- Implement a pre-procedure verification process (leading practice) and document in the patient's EMR (see "The Universal Protocol for Preventing, Wrong Site, Wrong Procedure and Wrong Person Surgery" by The Joint Commission).

# ADULT SERVICES OVERVIEW - FAMILY PLANNING AND STD

## Observations / Interview Themes

- Clinical Assistants do not set-up the sterile field efficiently prior to procedures.
  - Sterile instruments and dressings are put onto the sterile field in “pile”.
  - Providers must take time to arrange the instruments in a single line in the order they use them.
- Drapes for a procedure were not available in the exam / procedure room.
  - Clinical Assistant had to leave room to find the appropriate drape, adding time to the visit.

## Recommendations

- Re-train Clinical Assistants to set-up sterile procedure field efficiently and hold Clinical Assistants accountable to complete correctly.
- All exam rooms should be stocked exactly the same and Clinical Assistants should be responsible for keeping rooms stocked.
- Develop a checklist of what each exam room should be stocked with – Clinical Assistants should check on a daily basis.

# ADULT SERVICES OVERVIEW - FAMILY PLANNING AND STD

## Observations / Interview Themes

### General

- Providers are securing follow-up appointments for patients.
  - Ask patient what day and time will work best.
  - Steps out of the visit and go to registrar's desk checking on appointment availability.
  - Registrar finds an appointment, fills out blue appointment card and gives to the provider.
  - Provider returns to visit and gives appointment card to patient.

## Recommendations

- Transfer responsibility of securing follow-up appointments to the RN as part of the discharge process.

# ADULT SERVICES OVERVIEW - FAMILY PLANNING AND STD

## Observations / Interview Themes

- Prior to seeing a patient, providers will review the patient's history and prior visits.
  - This oftentimes involves reviewing medical information that has been scanned.
  - Observed provider spend an additional 20 minutes looking for patient medical information that had been scanned from a previous Refugee visit.
- Providers and nursing staff do not collaborate or discuss patient care.
  - There is very little open communication between them.
  - RN's work in one office and providers work in a different office.

## Recommendations

- Medical information pertinent to patient visits must be documented in data fields provided in the EMR.
  - This information should **not** be documented on paper forms and then scanned into the system (see Cerner Overview for additional information).
- Office space should be re-configured to accommodate a team of clinicians working collaboratively together to provide quality patient care.

# ADULT SERVICES OVERVIEW - FAMILY PLANNING AND STD

## Observations / Interview Themes

- There is a perception amongst the providers that RN's are not providing adequate education and discharge instructions to patients prior to departure from the clinic.
- Patients **do** receive adequate education and instructions from both the providers and the RN's.
- Because discharge instructions are not provided to the patient in a written format, there is little chance patients will remember the details once they are discharged.

## Recommendations

- Formalize the discharge process and provide a written copy of discharge instructions to each patient at the end of their visit.
  - Providers should discuss plan of care with each patient and populate "depart" instructions in PowerChart prior to leaving exam room at the end of their assessment.
  - When providers exit the exam room they should verbally communicate with their team that the patient is ready for discharge.
  - RN's should review and reinforce discharge / depart instructions with patient and print a copy of instructions from PowerChart to give to the patient at discharge.

# ADULT SERVICES OVERVIEW - FAMILY PLANNING AND STD

## Observations / Interview Themes

### New PAP process

- Very paper and manually intensive.
- Created numerous paper hand-offs to multiple individuals which increases the risk for errors.
- Requires PAP reports to be scanned into Cerner.

### Patient Appointment

- Length of visit (registration to discharge) range from 2 to 4 hours.
- Visits needing interpreter services will typically double the amount of time for the patient visit.
- Current protocol is to double, and in some cases, triple book patients due to high no show rate.

## Recommendations

- Review PAP process and look for ways to minimize use of paper. NOTE: review is currently in process.
- Review interface with PowerChart and lab system – this is currently in process.
  - Results should be going to provider's PowerChart Inbox for review.
    - Provider should then communicate plan of action to clinical staff via Inbox communication.

# ADULT SERVICES OVERVIEW - FAMILY PLANNING AND STD

## Observations / Interview Themes

- Clinics presently close 1 hour for lunch – no patient appointments or interfaces occurs.
- There is also an hour before the clinic closes used to complete documentation. Arbitrarily built in to serve as a buffer.
  - Observed documentation being completed by RN and providers by the end of each patient visit which is leading practice standard.

## Recommendations

# ADULT SERVICES OVERVIEW - BCCCP

## Observations / Interview Themes

- Approximately 10 - 15 BCCCP visits scheduled per week in clinic.
  - Observed several no shows in one week.
  - Majority of patient volume is through the mobile unit program.
- Funding for the program is provided at the state and federal level.
  - Due to state requirements and reporting needs, there is a voluminous amount of documentation that occurs for this program.
  - All documentation is completed on paper which is then manually entered into the state system (Avatar).
  - Some documentation occurs in PowerChart.

## Recommendations

- Evaluate the benefits of continuing to schedule visits in the clinic due to low volume and issues with no-shows.
  - Concentrate on furthering partnerships with other clinics to increase patient volume either through the mobile units or the clinic – already in process.

# ADULT SERVICES OVERVIEW - BCCCP

## Observations / Interview Themes

- In the beginning, there was an interface between Avatar and Cerner but it was discovered 2 - 3 years ago, that the information from Cerner was not flowing into Avatar accurately.
  - As a result, data entry into Avatar is now done manually.
- \*It should be noted that we were unable to follow a patient through a BCCCP visit due to the high no show rate.  
Observations / Interview Themes listed here are based on conversations with BCCCP staff.

## Recommendations

- Reevaluate the interface between Cerner and Avatar to minimize the need for duplicative data entry.

# IMMUNIZATION CLINIC OVERVIEW

## Observations / Interview Themes

- Immunizations are not documented in the patient's EMR.
  - NCIR is being used as a substitute for documentation of patient immunizations.
- Clinical staff print multiple forms from NCIR to document patient encounter and then scan documents into PowerChart.
- Patients are required to sign a "Refusal to Vaccinate" form at each visit stating they are declining to receive a vaccine.
  - Frequently, patients are not refusing a vaccine, they just may not need a particular vaccine at that visit.

## Recommendations

- All patient immunizations should be documented in the patient's EMR (see "Immunization Documentation – CDC Guidelines").
- Determine purpose of "Refusal to Vaccinate" form – have patient sign **only if truly declining** a recommended vaccine.

# IMMUNIZATION CLINIC OVERVIEW

## Observations / Interview Themes

- There are two levels of registration:
  - Initial check-in/registration at main desk (takes approximately 30 minutes).
  - Second registration in the clinic completed by the Outreach Clerk (takes approximately 15 minutes).
    - Patient fills out “information form”
    - Outreach Clerk inputs information, from patient, into NCIR and then accesses PowerChart to verify and update demographics.

## Recommendations

- Review necessity for two levels of registration.

# IMMUNIZATION CLINIC OVERVIEW

## Observations / Interview Themes

- Registration and clinical staff do not communicate delays to patients, which causes anger and frustration.
- Clinical staff find numerous demographic / registration errors. For example:
  - Zip code was not accurate and as a result, RN was not able to e-Prescribe a medication for the patient – there was an extra digit in the zip code.
  - This error resulted in an additional 30 to 45 minute wait for the patient.
- Clinic does accept walk-in patients who are triaged by a nurse.
  - Highest volume is prior to school starting in the fall.

## Recommendations

- Registration and clinical staff should proactively communicate to patients unanticipated delays in care or status of their wait times.
- Develop specific training for Front Desk, Registration and CCC personnel. Conduct training as follows:
  - Monthly Lunch and Learn
  - Specific training modules for each area identified above, job category and functions.
  - Mandate 90+ pass rate and compliance.

# IMMUNIZATION CLINIC OVERVIEW

## Observations / Interview Themes

- Patient calls come to the nurses station from the receptionist – these calls are inputted onto a paper phone log.
- Calls are not documented in PowerChart even though advice is given.

## Recommendations

- Formalize patient phone call process:
  - Patient encounters should be created in the EMR with appropriate documentation per established guidelines.

# REFUGEE CLINIC OVERVIEW

## Observations / Interview Themes

- Refugee clinic operates on Monday and Wednesday each week.
  - Patient visits fluctuate from 5 to 20 patients per week.
  - Patients are first seen on Monday and return for a second visit on Wednesday.
  - Visits are conducted through an interpreter.
  - Patients move through stages of a visit as a family.
    - Each patient receives a numbered badge as a means of identification.
    - All documentation forms used for visit have the same number.

## Recommendations

# REFUGEE CLINIC OVERVIEW

## Observations / Interview Themes

- Monday's visit consists of history-taking, physical exam by physician, TB skin testing and education.
- On Wednesday's, patients return for reading of TB skin test, blood draws for lab tests, immunizations and education.
- All visits are completed in a 4 hour window in the morning each Monday and Wednesday.
  - Monday and Wednesday afternoon is used by staff to input information into PowerChart.

## Recommendations

# REFUGEE CLINIC OVERVIEW

## Observations / Interview Themes

- Starting in July, a new TB test (T-spot) will be available that will replace the need for the TB skin test.
  - This will eliminate the need for patients to return for a second day visit.
- Per clinic staff, very challenging for one physician to complete 20 physicals in a 4 hour window.
- Length of time to move patients through all phases is prolonged due to the need for interpreters.
- The Refugee clinic had approximately 800 visits last year.
  - 500 – 600 were children.
  - Remaining were adults.

## Recommendations

- Starting in July (when new TB test available), implement the following workflow in the Refugee clinic:
  - Schedule patients as you would for an ordinary clinic visit (e.g. Adult Services) – conduct visit as follows:
    - RN intake / assessment
    - Provider assessment – order labs
    - RN complete all visit components and provide patient with written discharge instructions.
  - Schedule family members consecutively.
  - Utilize entire day for all visits.
    - Do not schedule all visits in the a.m. and leave documentation for the afternoon.

# REFUGEE CLINIC OVERVIEW

## Observations / Interview Themes

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## Recommendations

- Have patients arrive at their scheduled time throughout the day – families may arrive as a group.
- Limit visits to 10 per day.
- Complete all the necessary work for each patient in one day.
- Document real-time in PowerChart as much as possible, especially for the adult visits.
  - Child visits will primarily be on paper but data fields that can be documented in PowerChart should be done in real-time.
- Utilize Expanded Role RN for child visits as much as possible.

# REFUGEE CLINIC OVERVIEW

## Observations / Interview Themes

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## Recommendations

- Will need to schedule less patients, initially, to give staff time to adapt to new workflow.
- Develop an implementation plan for the new workflow with the following components:
  - Change management plan
  - Communication plan
  - Training plan
  - Clearly defined responsibilities for each role

# REFUGEE CLINIC OVERVIEW

## Observations / Interview Themes

- Clinic starts at 9:00 a.m. on Wednesday – this phase of the visit includes blood draws for lab tests.
- Observed first group of patients (family of 4) escorted to lab by interpreter at 9:25 a.m. then told they needed to wait until 10:00 a.m. for the lab to open before blood could be drawn.
- Once blood was drawn family waited an additional 20 minutes before visit could be completed by RN.
- This workflow added an additional 55 minutes to the patient visit.

## Recommendations

- Review lab workflow and consider the following:
  - Require lab to open at 9:00 a.m. on Wednesday.
- If new clinic workflow is implemented, visits that are scheduled on Wednesday could start at 10:00 a.m. eliminating the need for the above workflow change.

# REFUGEE CLINIC OVERVIEW

## Observations / Interview Themes

- Using a numbered badge system for patient identification appears impersonal.

## Recommendations

- Evaluate alternative patient notification and tracking systems such as:
  - Replace numbers on badge with patient names.
    - To keep multiple forms properly identified have registrars print a sheet of labels with patient identification information – this is the process in other clinics throughout the department.

# REFUGEE CLINIC OVERVIEW

## Observations / Interview Themes

- There are **multiple** paper forms used for required documentation of the various stages – primarily driven by state and federal requirements.
  - Approximately 75% of their clinical documentation **for adults** is completed in PowerChart.
  - Approximately 25% of their clinical documentation **for children** is completed in PowerChart – the remainder is completed on paper forms and scanned into PowerChart.
  - The information from all of the forms must also be manually entered into the NC Electronic Disease Surveillance System.

## Recommendations

- Conduct in-depth of assessment of documentation needs (see Cerner Overview recommendations for details).
- Once documentation and reporting requirements have been established, conduct an in-depth assessment of current PowerChart functionality to determine if system optimization will meet your needs.
- If system optimization is possible, implement changes to documentation based on guidelines.
- Conduct appropriate training of Refugee clinic personnel to ensure compliance with documentation requirements and the use of Cerner.

# REFUGEE CLINIC OVERVIEW

## Observations / Interview Themes

- The Refugee clinic is audited every 3 months by the state.
  - Required documentation is submitted on paper, adding to the burden of documenting the same information over and over again – very time consuming.
  - Finding the required documentation is challenging and time-consuming given that staff need to search the scanned patient records in Cerner.

## Recommendations

- Explore possibility of an interface with the state's Disease Surveillance System to minimize duplication of documentation.

# REFUGEE CLINIC OVERVIEW

## Observations / Interview Themes

- RN from TB clinic is pulled to work the Refugee clinic on Monday's and Wednesday's
  - Primary responsibilities include administering immunizations and educating patients with positive TB skin tests on next course of treatment.
- During a recent state audit, it was noted by the state there was no RN representation on Quality team.
  - Auditor recommended adding Child Health RN to Quality team as a subject matter expert as Child Health is a component of the Refugee clinic.

## Recommendations

- Adult Services and Immunization staff should be cross-trained to support the Refugee clinic.

# TB CLINIC OVERVIEW

## Observations / Interview Themes

- Staffing is challenging given the complexity of patients and variable daily workflow.
  - Almost impossible for a temp nurse to fill in when a staff nurse is out – remaining staff must absorb the work.
- High turnover of RN staff because of stressful, challenging environment.
  - Become overwhelmed, frustrated and confused with all they need to learn.
- Clinic is primarily case management oriented which adds to complexity of workflows.
  - Cases are long-term.
  - Family dynamics are investigated.

## Recommendations

- Conduct a further analysis of patient throughput and volumes evaluating ebbs and flows of patients in the clinic.
  - Determine staffing ratios based on patient acuity and complexity.
- RN currently scheduled full-time in Refugee clinic, and is trained in TB, should be the back-up for the TB clinic during times of increased need or loss of staff.
- Cross-train clinical staff from Adult Services and Immunization to the Refugee clinic in the event that Refugee nurse needs to work in TB.
  - Workflows between Adult Services, Immunization and Refugee are very similar.

# TB CLINIC OVERVIEW

## Observations / Interview Themes

- Need to incorporate all state and CDC guidelines in the care plan for treating patients.
- One RN in the department is designated as the “principal trainer” for new staff.
  - In addition to training responsibilities, this role manages a full case load of her own patients.
  - Training is an on-going, daily process.
  - The principal trainer is the go-to RN for questions from new staff.
  - Training an RN, adequately, can take 12+ months.
  - Due to the high turnover of staff, this role is always training – the burden of training new staff and a full caseload of patients can be overwhelming.

## Recommendations

- Clinical leadership should work closely with new hires in the TB clinic to ensure they are acclimating accordingly.
- Reduce patient caseload of principal trainer while actively educating and mentoring new staff.

# TB CLINIC OVERVIEW

## Observations / Interview Themes

- The staff perception is they are forced to share RN staff with Refugee clinic as management has denied requests for additional staff.
- Perception is that clinic leadership and county management do not understand the time and effort that is exerted to ensure patients comply with taking their medications.
  - The perception by many staff is that leadership is only concerned with “numbers” and do not take into consideration the complexity of caring for TB patients.

## Recommendations

- Leadership needs to develop communications to address the perception of the staff.

# TB CLINIC OVERVIEW

## Observations / Interview Themes

- Staff anticipate the daily workload of scheduled patients will increase starting sometime this summer based on new state guidelines for treatment of active TB.
  - Direct Observational Therapy (DOT) patients will need to be seen daily for 6 months rather than the current time frame of 2 weeks.
  - This will put added pressure on an already strained staff.
  - Potentially increases patient dissatisfaction.

## Recommendations

- Determine proper staffing ratios based on patient acuity and complexity.
  - Began recruiting process for additional staff in anticipation of new treatment guidelines.
- Clinical Assistant who is currently working part-time should be increased to full-time as soon as possible.

# TB CLINIC OVERVIEW

## Observations / Interview Themes

- Staff check the NC EDDSS system twice daily for new referrals – referrals can come from other sources as well.
- New referrals require a significant amount of investigative work prior to starting therapy.
  - Review of medical records.
  - Patient, immediate family and other close contacts interviews.
    - Finding and tracking all contacts is time consuming.
  - Consultation with medical director on correct course of treatment.
- Class B referrals (patients from a different country) can be challenging due to increased scrutiny from state and frequent spot audits.

## Recommendations

- Cross-train RN's from Adult Services and Immunization to assist with investigative work of new referrals.
  - Develop detailed guidelines they can reference when asked to assist with this work.

# TB CLINIC OVERVIEW

## Observations / Interview Themes

- On occasion, the department must respond to requests for a TB contact investigation.
  - Requires pulling staff from the clinic setting for 2 days and going out into a community setting (e.g. homeless shelter, school or business) to gather patient histories and administer TB skin tests.
  - On a recent investigation, staff conducted more than 130 interviews and administered the same number of skin tests.

## Recommendations

- Utilize staff from the Communicable Disease department rather than pulling staff from the clinic setting to conduct these investigations.
  - Communicable Disease staff are trained for this type of investigation.

# TB CLINIC OVERVIEW

## Observations / Interview Themes

- 90% of clinical documentation is completed on paper and not into Cerner directly.
  - Paper charts are kept on a rack in supply room.
  - When patient completes therapy, paper chart is sent Medical Records to be scanned into PowerChart.
- RN Supervisor recently attended a conference in Wake County which featured a demonstration of their PH department's Epic EMR.
  - Observed the functionality they need for TB documentation.
  - Additional counties in NC use Epic.

## Recommendations

- Conduct in-depth of assessment of documentation needs (see Cerner Overview recommendations for details).
- Once documentation and reporting requirements have been established, conduct an in-depth assessment of current PowerChart functionality to determine if system optimization will meet your needs.
- If system optimization is possible, implement changes to documentation based on guidelines.
- Conduct appropriate training of TD clinic personnel to ensure compliance with documentation requirements and the use of Cerner.

# TRAVEL CLINIC OVERVIEW

## Observations / Interview Themes

- Travel Clinic, on average, has 6 appointment slots on Friday of every week. (4 in the a.m. and 2 in the p.m.)
- RN who manages the Travel Clinic also has 6 – 8 hours of preparation time each week on Tuesday or Wednesday.
  - Creates individualized travel booklet by patient based on their travel destination.
  - Verifies that patients have submitted all their required paperwork 7-days in advance of their scheduled visit.
  - Based on CDC guidelines makes recommendations for immunizations and medications patient will need – this information is sent to Dr. White for approval.

## Recommendations

- MCHD should evaluate the viability of the Travel Clinic due to low volume of patients and high cost of RN wages to support.
  - There are 3 Passport Health® offices located in Charlotte that offer the same services.
- Make decision and develop action/work plan.
- Complete required due diligence of transition:
  - Impact on patient care and patient satisfaction.
  - Financial impact on MCHD clinics
- Formalize communication plans and assist with patient transitions as appropriate.

# TRAVEL CLINIC OVERVIEW

## Observations / Interview Themes

- Uses NCIR to document immunizations given.
- Uses PowerChart to order medications per protocol.

## Recommendations

# CLINICAL ASSISTANT I

## Observations / Interview Themes

- Scope of job duties and responsibilities at MCHD vs. their clinical training to perform specific duties is different.
- Initially, Clinical Assistants were responsible for taking height, weight, and vital signs.
  - These tasks were delegated to the RN in an effort to minimize the number of clinician contacts with patients and to reduce the number of transfers between rooms.
- Will room patients, take height, weight and vital signs if RN is backed up and busy.
  - Clinical Assistant rooming patients would be considered a normal job duty in private practice setting.

## Recommendations

# CLINICAL ASSISTANT I

## Observations / Interview Themes

- Clinical Assistant can perform POC testing for pregnancy tests. Errors have been documented but addressed.
  - Additional training required if they are going to continue to perform this test
  - General disagreement between clinicians regarding the use of Clinical Assistants to do POC tests (pregnancy tests).
- Clinical Assistants have completed extensive training (12 to 18 month course) and are capable of providing a more robust level of clinical support at the clinics.
  - Specific training includes:
    - Blood draws
    - Take medical, family, social history
    - List of medications

## Recommendations

- Expanding the role of Clinical Assistants could be done under the license of the physician:
  - Develop guidelines and annual competency testing for Clinical Assistants.
  - Revise the Clinical Assistant job description to reflect additional responsibilities per their training.

# CLINICAL ASSISTANT I

## Observations / Interview Themes

- Insurance information
- Trained to enter Dx/CPT Codes
- Sterilization procedures
- Autoclaving instruments
- Not performing the following duties at MCHD:
  - Blood draws
  - Medical, family and social history and enter into EMR.
  - Enter CPT Code information from Encounter form (they can only fill out the top part of the form).
    - However, they were trained to enter information from the rest of this form.
    - Not allowed per MCHD. DON, who interviews Clinical Assistants, clearly states what information they could or could not enter into EMR.

## Recommendations

# CLINICAL ASSISTANT I

## Observations / Interview Themes

- In the TB Clinic, Clinical Assistants will copy the entire patient chart before sending to Medical Records.
  - This is done for all patients.
  - Once scanned, documents are shredded.
  - Clinic keeps the paper chart of the patient until the treatment is completed and then sent to Medical Records to be scanned into Cerner.
- In the TB Clinic, RN and Clinical Assistant will schedule established patient follow-up appointments. They will input times and dates for follow-up appointment in a schedule book (input MRN and contact number for patient) for periodic medication delivery appointments (every 4 weeks).

## Recommendations

# CLINICAL ASSISTANT I

## Observations / Interview Themes

- RN and Clinical Assistant will provide the patient with a reminder card outlining their next appointment and the bottle number of their medication.
- RN and Clinical Assistant will provide this schedule book to a Registrar to make the appointment for the patient.

## Recommendations

# MEDICAL INTERPRETERS

## Observations / Interview Themes

### General Observations / Interview Themes

- Current duties are beyond the scope of current MCHD job description and state guidelines.
  - One Medical Interpreter performs work similar to an Clinical Assistant.
  - At times has served as a witness for Providers during patient procedures.
  - Made appointments for follow-ups.
  - Perform other assigned tasks outside of the scope of their job description and training.
- In some clinics, MIs are obtaining patient medical histories without a clinician being present during the patient interviews.

## Recommendations

- The practice of using medical interpreters for obtaining medical histories without a clinician present should be prohibited. After informing Executive Leadership, this issue was resolved. (See “Appropriate Use of Medical Interpreters”).

# MEDICAL INTERPRETERS

## Observations / Interview Themes

### General Observations / Interview Themes

- Asked questions from the medical history form and writing down the answers provided by the patient.
- The Medical Interpreter will then provide a summary of the answers to the clinician.
- Medical Interpreters lack the appropriate training, experience and certification to perform this task.
- Have updated demographic information within Cerner.
- Multiple patients are simultaneously waiting for interpretation services.
- Some clinical staff do not leverage interpreter phone line and instead wait for a Medical Interpreter to be free.

## Recommendations

- Please reference recommendation on previous slide.

# MEDICAL INTERPRETERS

## Observations / Interview Themes

### General Observations / Interview Themes

- This unnecessarily adds to a patient's wait time.
- Medical Interpreter's can assist up to 11 patients/day.
- Some clinical staff mentioned that Medical Interpreters lacked the training on how to interact with patient during a visit.
- A clinical staff member mentioned that a Medical Interpreter had acted in a very inappropriate and judgmental manner towards a patient's potential decision regarding their pregnancy.

## Recommendations

- Please reference recommendation on previous slide.

# NURSE ADVICE LINE

## Observations / Interview Themes

- Services currently provided are unclear, obscure and ineffective.
  - Nurse who managed the Nurse Advice Line termed from MCHD approximately a year ago. Staff has not been replaced.
  - CCC gives the Nurse Advice Line telephone number to patients who have general or symptom related questions.
  - Staff perception - unclear whether these calls go to a special phone at each of the clinics or to the nurse's station at each of the clinics.
  - Nursing supervisor stated that the Clinical Navigator for Adult Services was responsible for this line.

## Recommendations

- Discontinue the use of the Nurse Advice Line and replace with a fully functioning clinical triage support.

# NURSE ADVICE LINE

## Observations / Interview Themes

- It appears that patients calling with symptoms or questions may also be routed to the nurse's station by the main line receptionist.
- Voice message left by patients on the Nurse Advice Line are not returned in a timely manner.
- No encounter is created nor is the patient record documented in EMR.
- Not clear as to ownership and accountability of the advice line.

## Recommendations

- Please reference recommendations on previous slide.

# OPPORTUNITIES THAT SHOULD BE CAPITALIZED UPON ...

## Care Delivery Structure

- Reorganize **Care Delivery Structure** from the current Program delivery model (e.g. STD, TB) to a Clinic Location delivery model.
- Enhances service delivery, patient access and satisfaction.
- Improves management accountability.
- Allows for cross training of personnel, enhanced job performance and satisfaction.

Southeast Clinic (Services / Programs)	Northwest Clinic (Services / Programs)
Adult Health (Family Planning & STD)	Adult Health (Family Planning, STD & BCCCP)
Immunization	Immunization
Travel	N/A
TB Screening	TB Screening
N/A	TB Follow-up
N/A	Refugee
PAP Test Results Team	PAP Test Results Team

# SECTION 5: ORGANIZATIONAL ASSESSMENT

# CULTURE OVERVIEW

## Observations / Interview Themes

### General Observations / Interview Themes

- Communications has been a significant issue and lacking between:
  - Management, providers, clinical staff, and support staff.
  - Clinics/Programs
- Nurse Leadership does not hold structured and routine staff meetings (e.g. monthly).
- Historically, there has been a lack of trust and conflict between some providers (MDs and NPs) and clinical staff (RNs and Clinical Assistants).
  - Some providers do not like to work with certain clinical staff or other support personnel.
  - Providers complain that RNs not doing their job effectively.

## Recommendations

- Develop a communications process that disseminates information effectively from both a top-down and horizontal perspective. Appropriate communications should be disseminated among all stakeholders through:
  - Meetings
    - Management meetings (bi-monthly)
    - Program meetings by clinic (monthly)
    - Provider/clinical staff meetings (quarterly)
    - Executive Leadership town hall meetings (semi-annually).
  - Electronic communications that are structured and tailored from Executive Leadership/Management. (PRN)
  - Program huddles (daily)

# CULTURE OVERVIEW

## Observations / Interview Themes

### General Observations / Interview Themes

- Numerous RNs and Clinical Assistants mentioned that there is a “Them vs. Us” mentality that Nurse Practitioners exhibit.
  - For example, RNs wanted shared space with Providers to increase collaboration and communications.
  - Providers pushed back on this request further substantiating the “Them vs. Us” perception.

## Recommendations

- Develop an organizational culture that:
  - Increases camaraderie/cohesiveness between employees and management.
  - Empowers personnel to be innovative to continually improve practice operations and share leading practices.
- Leadership and Management should exhibit positive behaviors and promote a culture of teamwork, diversity and inclusion, collaboration, and respect.
- Create a culture/atmosphere where personnel feel valued and important.
  - Institute recognition programs.

# CULTURE OVERVIEW

## Observations / Interview Themes

### General Observations / Interview Themes

- Interview Themes from a RN and Clinical Assistant regarding Northwest Clinic:
  - Lack of employee cohesion and camaraderie within the clinic.
  - Culture and atmosphere is unpleasant resulting in difficult work environment.
- Provider perception regarding clinical staff (RNs and Clinical Assistants) are that personnel lack:
  - Sense of urgency to complete tasks.
  - Work ethic to perform the minimal requirements of their job.
  - Sense of pride in their work.
- Many personnel demonstrate pride in their jobs.

## Recommendations

- Please reference recommendations on previous slide.

# CULTURE OVERVIEW

## Observations / Interview Themes

### General Observations / Interview Themes

- “That’s not my job” is a pervasive attitude throughout the health department, even at the leadership level.
- Jumping chain of command is pervasive.
- Staff at times have even reached out to the County Manager and Assistant County Manager regarding issues and concerns.
- Some Nurse Practitioners have not followed the proper chain of command to voice concerns/issues.
  - Have gone directly to the Director of Nursing to voice complaints instead of address issues with the RN Supervisor of the clinic.

## Recommendations

- Encourage all personnel to follow the proper chain of command in regards to any issues/concerns that they might have.
- Direct reports should voice these issues/concerns to their immediate Manager. If personnel feel that issues/concerns have not been resolved, it is at this point that they should reach out to other resources for assistance.
- Executive leadership must create an environment that:
  - Fosters trust.
  - Openness without retribution
  - Encourages input and involvement (in accordance with clinic goals/objectives).
  - Fosters a partnership between clinics, county departments and community.

# CULTURE OVERVIEW

## Observations / Interview Themes

### General Observations / Interview Themes

- Manager perceptions:
  - Many Managers have been at MCHD for a long period of time and although their experience is good, the inability to change with the times has stagnated creative thinking.
  - Low morale has been a pervasive issues. However, it has decreased even further after the “incident”.

## Recommendations

- Please reference recommendations on previous slide.

# CLINIC CONTACT CENTRALIZED PROGRAM (CCC)

## Observations / Interview Themes

### Appointment Line

- Patient calls to schedule an appointment.
  - Reason for appointment ascertained as well as date/time requested by patient.
  - Patient information (visit, insurance and payment) gleaned through the call is documented in multiple locations:
    - Manual log
      - Personnel log all calls (up to 1,500 calls/month) capturing reason for patient phone call.
      - Team Lead not aware why patient information is entered into log.
    - SPM: inputted in schedule module.
    - PowerChart: inputted into “extended” and “alert” chart sections.

## Recommendations

- Documentation of patient calls into the manual log is a redundant process wasting employee time and reducing efficiency.
  - Since all calls are recorded, management can reference the specific patient call, as needed, to verify the accuracy of information collected.
  - Recommend process be discontinued.
- Explore the possibility of instituting an interface that allows notes documented within SPM to crossover to PowerChart to reduce the number of clicks and the navigation from window to window as the personnel are on a call with the patient.
  - Once the “ad hoc” process begins, the notes should crossover to PowerChart.

# CLINIC CONTACT CENTRALIZED PROGRAM (CCC)

## Observations / Interview Themes

### Appointment Line

- If patient does not get through to personnel, they can leave a message to request a call back from personnel to get appointment scheduled.
- At times, the appointment line is busy and patients will have to call back.
- Some patients physically come into the clinic to schedule an appointment.
  - This could affect patient flow negatively and cause unnecessary bottlenecks.
- In addition to appointment related calls, personnel receive calls to reach other areas of the Health Department.
- CCC personnel stated that the call abandonment rate is approximately 20% of all calls.

## Recommendations

- Evaluate functionality of Cisco phone system. Assess the following:
  - Why appointment line is busy?
  - Are there enough phone lines?
  - Is staffing adequate to answer the incoming call volume?
  - Evaluate existing phone tree options.
    - Determine the number of clinic related patient calls versus calls placed by public to reach other areas of the Public Health Department.
  - Eliminate the ability to leave patient messages to ensure all patient phone calls are answered in a queue.
- Create a communications mechanism to change patient behavior of presenting to the clinic to schedule an appointment.

# CLINIC CONTACT CENTRALIZED PROGRAM (CCC)

## Observations / Interview Themes

### Patient requesting STD appointment

- If patient states they have symptoms and there is no appointment available, personnel will urge patient to go directly into the clinic to be triaged by a RN.
- Personnel communicates to patients, if they go directly to the clinic and if symptoms are not present, they may not get an appointment.
- When patient arrives at the clinic, RN will triage patients to see if symptoms are present. RN will decide if patient needs to be seen “stat” or assist with the subsequent scheduling of an appointment.
- Personnel will direct several patient per day to walk-into the clinic to be triaged.
- This has become a significant patient dissatisfier due to:
  - Patients not being accommodated after the triaging process
  - The negative downstream effect it has to already scheduled patients.

## Recommendations

- Enhance the access to a RN to allow for the triaging of patients to determine if symptoms actually are present.
  - If symptoms are **deemed to be present**, RN could assist patients with scheduling a walk-in appointment for that day or next day.
  - If symptoms are **deemed not to be present**, RN could assist patient with the scheduling of an appointment as soon as possible.
  - Triage process, performed by RNs, will use physician approved clinical protocols.

# CLINIC CONTACT CENTRALIZED PROGRAM (CCC)

## Observations / Interview Themes

### Insurance Verification Process

- Could take an extended period of time as personnel are directly calling the insurance company to verify insurance eligibility.
- Insurance information is written down and transposed into the system for all patients.
- Only patients with valid commercial insurance is ultimately entered into SPM.
- Medicaid eligibility not run on all patients prior to patient being seen in clinic.

### Patient Reminder Process

- Per the actual process, patients receive automated appointment reminder calls.
- However, staff gave conflicting statements that patients were being called to remind them of their upcoming appointments.

## Recommendations

- CCC should make every effort possible to verify insurance prior to the patient presenting. If possible, CCC should leverage a electronic verification tool.
- Management should create a “tickler” mechanism to highlight patients who have not had their insurance verified for a scheduled appointment.
- Unclear if patient information is inputted at the time of a patient appointment request.
  - If patient information (demographic and insurance information) is not entered during the time of patient call, this process needs to be instituted as soon as possible.

# CLINIC CONTACT CENTRALIZED PROGRAM (CCC)

## Observations / Interview Themes

### General Observations / Interview Themes

- Some clinical/non-clinical staff not aware of:
  - Who is responsible for collecting and entering demographic information (CCC staff, Registration staff or both).
  - What information CCC should be collecting prior to arriving at clinic registration.
    - Perception is that CCC staff not asking/entering insurance information and are simply scheduling patient appointments.
- CCC and Registration staff sometimes input incorrect demographic and insurance information into SPM. This has caused the following:

## Recommendations

- Through monthly “Lunch and Learns”, educate clinical/non-clinical staff on the functionalities of both the CCC and Registration areas to highlight the impact of their individual roles on clinic workflow.
- On a periodic basis, audit CCC and Registration staff to determine the accuracy of patient information that is collected prior to and during a patient visit.
- Explore the possibility of having CCC and Registration staff rotate and cross train between both departments. This will allow staff to see how one department affects another.

# CLINIC CONTACT CENTRALIZED PROGRAM (CCC)

## Observations / Interview Themes

### General Observations / Interview Themes

- Patient visit delayed due to the time needed to correct this information.
- Causes additional wait times for patients already waiting for their scheduled appointment.
- For example, zip code that was entered incorrectly prolonged a patients visit unnecessarily as RN was unable to send prescription via the ePrescribe system.
- CCC does not have an “enhanced” clinical triage process.

## Recommendations

- Based on patient volume(s), determine appropriate staffing to effectively, timely and efficiently manage current and future CCC patient volumes.
- Consider alternative electronic scheduling methods.
- Conduct a deeper in-depth assessment to determine true functionality and effectiveness of current CCC to determine if this model will meet MCHD needs.
  - Make decision to revise/enhance current structure, new build or buy is required.
  - Develop action/work plan based on decision.
  - Complete required due diligence of transition:

# CLINIC CONTACT CENTRALIZED PROGRAM (CCC)

## Observations / Interview Themes

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## Recommendations

- Impact on patient care, finances and patient satisfaction.
- Financial impact on MCHD clinics.
- Formalize communication.
- Implement decision/transitions.

# SCHEDULING OVERVIEW

## Observations / Interview Themes

- Current profiles are managed by program and not by provider.
- Providers see a combination of STD and Family Planning patients throughout the day.
- Family Planning visits are more time-intensive than STD patients.

## Recommendations

- Separate Family Planning and STD clinics:
  - Build profiles by provider and not by program.
  - Assign all STD patients to one provider and all Family Planning patients to a different provider.
  - Have providers rotate through each clinic daily or weekly.

# SCHEDULING OVERVIEW

## Observations / Interview Themes

- Patient visits scheduled with a RN who are new or have not been to the Family Planning clinic for greater than a year must be initially “established” by a provider in order to be seen by a RN.
- Establishing a patient involves provider seeing the patient, obtaining a quick history, placing orders, and documenting a visit note.
- This is disruptive to each providers already scheduled patients.
- In addition, providers do not receive credit for accommodating patients and the work necessary to “establish” them.

## Recommendations

- Schedule all new patients to Family Planning and those who have not been to the clinic for greater than one year with a provider.
- Work with CCC to develop this algorithm.

# SCHEDULING OVERVIEW

## Observations / Interview Themes

- Extended clinic hours on Wednesdays does not increase access for patients who are seeking/needing appointments after their work schedule. Last scheduled slot is 5 p.m.
- Patients who need phone related Medical Interpretation services during their clinic visit typically see their appointment duration significantly extended.
  - Current patient time slots are 15 or 30 minutes.
- Over booking has been a pervasive problem and scheduled to compensate for the high patient “no show” volumes the clinic had been experiencing.

## Recommendations

- Open visit slots later than 5 p.m.
- Schedule patient visits needing interpreter services by phone (language other than Spanish) for 30 or 60 minutes appointment slots.
- Manage patient grace period by implementing a variety of patient reminder systems.
- RN Supervisor should check clinic schedule 72 hours in advance to allow for smoothing of patient appointments to avoid bottlenecks in clinic workflow.
- Implementation of appropriate tactics and techniques should be deployed to address the high volume of patient “no shows”.

# REGISTRATION / CHECK-IN / CHECK-OUT

## Observations / Interview Themes

### Registration / Check-in

- Registration process has two layers:
  - Most patients check-in at main registration desk and then have to check-in a second time at registration desk of respective clinics (e.g., Adult Health and Immunization clinics).
  - Registration at main desk could take up to 30 minutes.
  - Registration at secondary clinic desk could take up to 15 minutes.
  - Cycle time to fully register patient could take up to 50 minutes.
- TB / Refugee Registration personnel perform all registration, check-in, check-out and scheduling related tasks.

## Recommendations

- Perform a deeper dive assessment of the numerous registration area(s) to consolidate key registration related processes, procedures and functions.
  - Maximize the standardization of processes, procedures and functions.
  - Consider moving appropriate functions to CCC environment. Example functions to consolidate:
    - Registration
    - Scheduling of patient visits, procedures, lab, pharmacy, etc.
    - Preregistration and post visit activities where possible.
- Evaluate the feasibility of using patient kiosk devices in registration areas (main or at each clinic).

# REGISTRATION / CHECK-IN / CHECK-OUT

## Observations / Interview Themes

### Registration / Check-in (cont'd)

- Have seen a negative trend of Registration/CCC staff entering/collecting incorrect demographic information from patient.
- Clinic patient registration is responsible for correcting information incorrectly inputted by CCC staff.
- Clinic personnel stated that Registration staff sometimes do not check the identities of patients at check-in. This has lead to demographic errors inputted not being caught and the unnecessary creation of duplicate patient charts.
  - Potential increase of PHI exposure.

## Recommendations

- Establish mechanism to identify CCC/Registration staff who incorrectly enter demographic information on a monthly basis.
  - Institute re-education and training programs to ensure work standards are put into place such as “Lunch and Learn” seminar to learn the proper processes to register/check-in patients.
    - Conduct monthly lunch & learn sessions with required attendance.
    - Employee should acknowledge training with acknowledgement enter into personnel files.
  - Hold registration staff accountable with disciplinary action if three instances of errors occur.

# REGISTRATION / CHECK-IN / CHECK-OUT

## Observations / Interview Themes

### Registration / Check-in (cont'd)

- Personnel stated that the redundancy of collecting patient information on paper is performed to adhere to strict state guidelines pertaining to the collection of accurate patient information.
  - Patients are required to fill out multiple forms based on their program/visit. All forms are placed in an “out guide” by registration staff.
  - This serves as the patients “paper chart” for their visit.

## Recommendations

- Use all available electronic means available for registration/check-in and check-out.
- Re-evaluate the use of redundant forms to collect patient related information.
- Holding staff accountable for mistakes and increasing training and education on registration processes will reduce transposition errors and help improve clinic workflow.
  - Ensure adherence to applicable P&Ps.
  - Strictly adhere to HR process and disciplinary steps/actions.

# REGISTRATION / CHECK-IN / CHECK-OUT

## Observations / Interview Themes

### Registration / Check-in (cont'd)

- Medicaid eligibility not verified for all patients.
- Patient is seen in clinic even if they have maxed out their benefits.
- Patient seen without authorization or visits exceed number of visits.
- CCC does not verify insurance for all patients.
- As a result, responsibility falls to the registration personnel to perform this task.
- Registration personnel have to call insurance company by phone to verify eligibility and thus prolongs the patient visit and could affect subsequent patients waiting for their appointment.
  - Each instance of this task not performed, negatively impacts clinic workflow.

## Recommendations

- Eligibility should be verified at every visit prior to patient being seen in clinic.
  - If patient exceeds authorized number of visits allotted for insurance carrier, registrar needs to obtain additional authorizations.
- CCC Manager and the respective Registration Manager for each clinic should confer on a monthly basis to identify instances where insurance is not verified.
  - CCC Manager should establish a mechanism to determine CCC personnel who have not verified patient insurance.

# REGISTRATION / CHECK-IN / CHECK-OUT

## Observations / Interview Themes

### Registration / Check-in (cont'd)

- Patients have a 30-minute grace period in which they can arrive late for their appointment and still be seen.
  - Disruptive to clinic flow and causes back-up/bottleneck that can be difficult to manage.
  - If patients are more than 30-minutes late, they will need to speak to the Clinical Navigator who determines if they can still be seen.
  - Patients who already have appointments are negatively impacted by the walk-in patients who are/will be triaged.
  - Scheduled patients could be delayed.
  - Requires personnel to stay past their allotted shift.

## Recommendations

- Change patient grace period policy.
  - Manage patient grace period by implementing a variety of patient reminder systems.
  - Communicate to patients and staff new standard and enforce at Point of Service (POS).

# REGISTRATION / CHECK-IN / CHECK-OUT

## Observations / Interview Themes

### Registration / Check-in (cont'd)

- Conflicting statements elicited by personnel regarding patient “no show” process.
  - Personnel mentioned that registrars are unaware of when a patient is a “no show”. Clinical staff have to ask registration staff if patient has arrived. If patient does not present, status is changed to “no show”.
  - Perception is that “no shows” are not being followed up by personnel. Some personnel not aware that CCC staff will reach out to “no show” patients to reschedule missed appointments.
- Overbooking has been a pervasive clinic issue due to the high volume of “no shows”.

## Recommendations

- Via “Lunch and Learn” meetings, clarify to staff how CCC handles patient “no shows”.

# REGISTRATION / CHECK-IN / CHECK-OUT

## Observations / Interview Themes

### Check-out

- Only one cashier is available for “check-out” at both clinics.
  - Responsible for collecting payments for clinic services/medical records requests and scheduling of follow-up appointments as needed.
  - Patient payments for immunization and medical records request can be a cumbersome process as patient must go back and forth from cashier to clinic area in order for a payment to be processed.

## Recommendations

- Front desk lead/supervisor should proactively manage front desk and check out personnel to respond to changes in patient flow through clinics.
  - High volume check in occurs in early am and start of afternoon clinic sessions. Adjust personnel assigned at check-in to peak times.
  - High volume check-out occurs in late morning and afternoon sessions. Shift check-in personnel from check in to check-out.
- Cross-train all primary and secondary registration staff on the check-out process including the collection of patient payments and scheduling of subsequent appointments.

# REGISTRATION / CHECK-IN / CHECK-OUT

## Observations / Interview Themes

### Check-out (cont'd)

- Secondary Registration areas in Clinic A and B, within both clinics, do not handle payments from patients.
  - Services (clinical and non-clinical) needing payment, requires that patients make payment first.
  - Patient have to return to clinic area to show proof of payment to secondary registration personnel to have services (vaccines, medical records request, etc.) rendered.
  - Patient touchpoint with staff increases.
- Registration booth handling check-in, typically, do not process check-out related tasks (patient payments).
- Only check-out booth has cash funds and credit card processing machine to take payments from patients.

## Recommendations

- Please reference previous slide for recommendations.

# REGISTRATION / CHECK-IN / CHECK-OUT

## Observations / Interview Themes

### General Observations / Interview Themes

- Patients who need phone related Medical Interpretation services during their clinic visit typically see their appointment duration significantly extended.
- Current patient time slots are 15 or 30 minutes.

## Recommendations

- CCC should ask/note that interpretation services will be needed to accommodate non- English or non-Spanish speaking patients e.g. Burmese or Somali.

# REGISTRATION / CHECK-IN / CHECK-OUT

## Observations / Interview Themes

### General Observations / Interview Themes

- Some clinical/non-clinical staff not aware of:
  - Who is responsible for collecting and entering demographic information (CCC staff, Registration staff or both).
  - What information CCC should be collecting prior to arriving at clinic registration.
    - Perception is that CCC staff not asking/entering insurance information and are simply scheduling patient appointments.
- Some patients will present to the clinic to only schedule their appointments.

## Recommendations

- Establish a “lunch and learn” on a quarterly basis to allow different areas of the clinic to address common errors detected as well as educate staff on critical processes that affect clinic workflows.
- Establish a communications mechanism to encourage patients to use appointment line to schedule office visits.

# HUMAN RESOURCES OVERVIEW

## Observations / Interview Themes

- Mecklenburg County's Human Resources (HR) related Policies and Procedures (P&P) are broad.
- Staff perception is some P&Ps lack sufficient substance.
  - For example, within MCHD SharePoint site, there is a "skeleton" for an attendance policy.
  - However, there is no language specific to tardiness, so addressing this issue with an employee is difficult and unenforceable.
  - Thus, adherence of policies by employees is sporadic.
- Perception is the enforcement of policies are applied inconsistently across departments.
- No clear direction from HR what the process is for repeated violations of this policy.

## Recommendations

- It is the responsibility of MCHD Management to define how the P&Ps will be managed and applied to staff.
- Management needs to clearly define the P&Ps that the staff are expected to adhere to ensure compliance.
  - Communicate P&Ps relevant to the operations of clinics.
- Conduct retraining and educational sessions for management.
- Conduct retraining and educational sessions for staff members who are not complying with policies and procedures.
- Working with HR, clearly define the process in place for disciplining management/employees who do not adhere to policies procedures.

# HUMAN RESOURCES OVERVIEW

## Observations / Interview Themes

- Inconsistent application of policies has been brought to the attention of MCHD management. They have the perception that they are unable to apply the policies developed by HR within their clinic setting. This has been disputed by HR who states that the Health Department can apply developed policies.
  - Example of attendance policy was provided by a manager. This policy is very important for the clinical areas as it affects how the clinic workflow functions.
  - There is a distinct disconnect between HR and Clinical Operations.
- County doesn't recognize Charge RN (Clinical Navigator) role from a salary perspective.
  - Counted and works as a Staff RN.
- High turnover of staff inhibits clinic continuity.

## Recommendations

- MCHD executive leadership must address this issue between County HR and clinic operations.
- Adherence to policies and procedures are paramount to the successful operation of the clinics on a daily basis. Failure to enforce such policies has and will significantly impacted clinic operations, employee morale and satisfaction, and effectiveness of the clinics overall.

# HUMAN RESOURCES OVERVIEW

## Observations / Interview Themes

- Lack of communication/coordination between HR and the Public Health departments in regards to the transfer of employees who have performance issues.
- A RN Supervisor called the Employee Relations line multiple times to resolve an employee issue/incident.
  - Employee Relations took between 4 to 5 days to respond back to RN Supervisor to provide guidance.
  - Employee Relations stated they were down a staff member which led to their late response.
  - RN Supervisor resolved the issue without the assistance of Employee Relations by involving the Assistant Health Director and a Health Manager.

## Recommendations

- MCHD executive leadership must address this issue between County HR and clinic operations.

# HUMAN RESOURCES OVERVIEW

## Observations / Interview Themes

- Limited Part-time staff RN mentioned that she went to New Hire Employee Orientation but was pulled out of the meeting under the directive of HR. Limited Part-time staff are not eligible for benefits. Thus, the employee was notified that they would not need to attend the orientation session.
- Assessing the hiring and onboarding process, we learned the following from a RN:
  - HR waited a long period of time before extending an employment offer.
  - After the employment offer was extended, HR took a long period of time to communicate the following:
    - What position was being offered to the new employee.
    - Specific compensations and benefit details.

## Recommendations

- All employees, regardless of their time designation (FT, PT, Flex, PRN), must be properly oriented, exposed to all training programs, policies and procedures, and clinic culture to ensure proper assimilation and ongoing successful performance.
- Mandatory training in these areas are paramount to the successful operation of the clinics on a daily basis.
- Failure to administer will significantly impacted clinic operations, employee morale and satisfaction, and effectiveness of the clinics overall.

# HUMAN RESOURCES OVERVIEW

## Observations / Interview Themes

- Hours for the position.
- HR wanted the employee to accept the position before she knew the specifics of the employment offer.
- Performance Reviews
  - Perception is that managers are not provided with clear guidance as to how performance reviews should be administered.
- Some PDQs have not been updated from the Carolinas Health System transition to Mecklenburg County.
  - For example, organizational charts within the PDQs have not been updated to represent current operations.
- Newly hired RNs lack specific knowledge related to Public Health.

## Recommendations

- Update PDQ's to reflect Mecklenburg County specific information and requirements.
- Develop clear guidance and conduct educational training regarding performance reviews preparation to conducting the actual performance review.

# HUMAN RESOURCES OVERVIEW

## Observations / Interview Themes

- Staff are not held accountable for their inappropriate behavior or actions by leadership.
  - This inaction provides staff with a negative feedback loop that “bad behavior” is tolerated and there are no consequences for their actions.
- Some managers do not exhibit/model appropriate behaviors for their staff.
  - Staff, also, model these inappropriate behaviors, leading to a bad culture and a inhospitable work environment for staff.

## Recommendations

- Leadership has to be committed to changing inappropriate behavior of their staff with the assistance of HR.
- Leadership should be critiqued anonymously by their peers to see how their actions contribute to the behaviors of their staff/subordinates.
- Executive leadership (Health Director/Medical Director) must hold other members of the executive and management team accountable for their performance, behavior and impact on culture.

# SECTION 6: LABORATORY ASSESSMENT

# METHODOLOGY AND DATA SOURCES

The tables below summarize the methodology used and data sources in the assessment of MCHD Laboratory Services.

## Methodology

- Utilized an experienced Laboratory Subject Matter Specialist (SMS) to evaluate laboratory operations and identify areas of improvement.
- Interviewed key stakeholders from Mecklenburg County Department of Public Health (Clinics), as well as the Laboratory Medical Director.
- Conducted on-site observations of MCHD lab facilities to understand laboratory operations, specifically the pre-analytical, analytical, and post analytical service elements; (lab) service levels and operational complexity.
- Evaluated other operational characteristics associated with MCHD laboratory program, such as testing methods in place, time-sensitive testing needs, and reference (test send out) activity.

## Data Sources

### **MCHD Laboratory Services data review included:**

- Q1 (1/1/17 – 3/31/17) test mix and volume (including current send out activity).
- GL Budget Summary FY 2017.
- Staffing and Department Schedule(s)
- Internal lab quality dashboard.
- Relevant CLIA research involving complexity of current testing methods (RPR, GC, Chlamydia, Gram Stain), as well as waived testing.
- Relevant research involving regional and commercial laboratory capabilities in NC involving strategic laboratory management arrangements.
- NC Administrative Code addressing LHD requirements re: laboratory services.

# MCHD ASSESSMENT - LABORATORY

## Background Information:

- MCHD operates highly complex laboratory operation under CLIA '88 accreditation at the Southeast (SEPH) and Northwest (NWPH) clinics. Lab Medical Directorship is provided by Dr. Edward Lipford from an independent pathology group
- The lab handles 50,332 tests annually of which ~29,456 are considered time sensitive and required for immediate patient management; and ~20,876 tests considered non-time sensitive
  - The lab processes and refers to LabCorp an additional 9,996 tests annually (1/1/17 – 3/31/17 data annualized); the estimated annual spend with LabCorp is \$180K (an Avg. of \$18 per test)
- Between January – December 2016, the lab also referred 20,171 tests to the NC State lab, including a combination of tests performed in-house but requiring confirmatory testing (e.g. syphilis and GC), as well as other tests such as HIV, Hepatitis B & C, Lead, and Herpes cultures)
  - HIV testing represents 81% of the tests referred to the NC State Lab
- The overall test mix includes primarily STD testing, including ~ 34% RPR (syphilis), 32% GC/Chlamydia (molecular), 5% GC cultures, 14% wet preps, 3% gram stains, 3.5% urine pregnancy; the remaining volume includes HIV screens, parasitology, urinalysis and hemoglobin

# MCHD ASSESSMENT - LABORATORY

## Background Information, Continued...

- The laboratory staff consists of 10 FTEs (budgeted), including: 1 Lab Manager (vacant); 2 MT, 3 MLT, 2 Phlebotomists, and 2 Lab Assistants – *the Lab Manager position as well as one MLT position are currently vacant*
  - Staff cross-training is active in the technical areas and staff commonly rotate between the SEPH and NWPH laboratory facilities
- The laboratory is currently under interim management provided by a Senior Medical Lab Tech who handles the technical aspects of the lab operation (and performs bench work)
  - Administrative & Personnel-related activities are currently handled by the clinic Medical Director
- Operationally, not having a permanent Lab Manager presents operational challenges including limiting MCHD's ability effectively address inconsistent staff performance, tardiness and absenteeism, as well as maintaining a smooth lab integration to support clinic operations
  - For over 6 months MCHD has found it difficult to recruit a permanent Lab Manager and the few applicants for this position have not been suitable for this role

# MCHD ASSESSMENT - LABORATORY

## Assessment

### **Pre-Analytical:**

- The laboratory utilizes Cerner (Pathnet) for the management of tests done in-house, as well as work referred to LabCorp.
  - Specimens referred to LabCorp are ordered electronically, barcoded, time stamped, and tracked (including Pap smears) from the time the lab receives the specimens until results are transmitted electronically back to the clinic
  - On the other hand, specimens referred to the State lab are ordered using traditional paper forms due to the lack of a laboratory interface

### **Analytical:**

- The laboratory (time sensitive) test menu in place for immediate patient management is appropriate and aligned with the clinical services offered by the clinic. This includes urethral gram stains, wet preps, screening RPRs (for syphilis), and urine pregnancy and hemoglobin tests.
- The non-time sensitive test menu in place (tests requiring extended time to analyze) including GC cultures, stool cultures, and molecular assays (which are batched for testing) is not typically found in clinic-based laboratory operations.
- Tests done in-house requiring confirmation, as well as HIV, Lead, Hepatitis B & C, Lead and Herpes are referred to the NC State Lab. These tests are not interfaced, thus requiring manual transposition of each result – such practice creates operational inefficiency and increases the risk for errors. The clinic Medical Records department eventually scans reports in patient charts.

# MCHD ASSESSMENT - LABORATORY

## Assessment, Continued ...

### **Analytical Continued -**

- Any other lab orders such as chemistry, hematology, coagulation and other more specialized (lab) procedures - typically found in high complexity lab operations - are referred to LabCorp. Test results from LabCorp are reported electronically via interface with the Lab Information System (LIS).
- The laboratory methods utilized by the MCHD laboratory require minimal automation to complete, which is appropriate considering the stated in-house menu, except for molecular testing
  - The molecular testing in place utilizes a BD Viper analyzer, which is currently used for batch testing of GC/Chlamydia – this advanced molecular technology is designed for larger lab facilities – not for clinic-based operations
- The current (lab) workflow and processes in place appear to be adequate considering the (limited) in-house test menu
- The clinics perform Point of Care (POCT) lab testing including urine pregnancy and hemoglobin and hold a separate (waived) CLIA license. This is appropriate and in alignment with patient flow improvements, but operational standardization is recommended
  - For example at SEPH hemoglobin and urine tests are performed by a MA in a mini-lab (located at the nursing unit), while at NWPH the lab collects urine specimens for pregnancy testing, then holds the sample for a MA (from the unit) to run the test in the lab, yet lab techs perform hemoglobin testing– this practice should be standardized

# MCHD ASSESSMENT - LABORATORY

## Assessment, Continued ...

### Post Analytical:

- The systems in place (forms, protocols, downtime forms) for result reporting done in-house seem appropriate for the previously stated scope of services
- The systems in place for result reporting for work referred to LabCorp are on-par with leading practices utilizing an interface for electronic transmission of results directly to EHRs
- The test reporting systems in place for work referred to the NC State lab are outdated – the manual transposition of test results (from paper reports to Cerner) is outdated and can generate errors (most lab errors do not occur in the analytical area, but involve pre-analytical and clerical tasks)
- The laboratory Quality program in place meets standard regulatory requirements (such as maintaining test quality control records, temperature charts, preventive maintenance, proficiency testing for various analytes, corrected report records, and competency testing records)
  - The laboratory needs to implement a Service Level Standard dashboard to monitor service expectations are met by reference laboratory providers (LabCorp and State Lab), including: Turn Around Time (TAT), past due reports, lost and rejected specimen monitors

### Lab Financial Highlights:

Annual Lab Budget (FY2017)	
Salary and Benefits	\$ 624,804
Non-Labor (Excludes Reference Lab)	\$ 277,746
Total	\$ 902,550

Test Volume (Jan - Mar 2017 annualized)	50,332
Cost/UOS	\$ 17.93

Reference Laboratory Cost**	\$ 180,416
Reference Lab Volume*	9,996
Cost/UOS	\$ 18.05

\* Annualized from actual Jan - March 2017

\*\* Reference Lab cost is budgeted in Clinic Ops, not lab

# LABORATORY ASSESSMENT QUALIFICATION

Leading Practice	Current Practice	Rating
Appropriate lab patient registration, order entry processes for blood draws	Patients reporting for lab draws are registered, orders documented in patient encounter forms; orders are interpreted and handled by laboratory personnel	
Lab orders electronically transferred to the laboratory for processing	Pathnet-Cerner enabled order entry is in place	
Centralized receiving and specimen processing is performed by support personnel	Single entry point for laboratory accessioning and receiving is in place	
Laboratory equipment/methods/work flow are appropriate for level of testing	The laboratory test menu is limited (primarily STD-related testing) - methods for time sensitive testing (RPR, gram stain, wet preps) are appropriate. Methods for non-time sensitive testing are scientifically appropriate but not needed in clinic-based laboratory (e.g. molecular)	
Laboratory Management/Supervision is appropriate for level of service	The laboratory currently operates without a permanent and seasoned Manager and has been under Interim technical management for several months	
Laboratory Medical Directorship and CLIA accreditation are appropriate and in compliance for current service level	Laboratory medical directorship is rendered by an outside (seasoned) Pathologist and the laboratory is duly accredited CLIA and achieved satisfactory performance in most recent survey	

-  **Navigant utilized an overall risk ranking system as outlined below:**
-  • **High Risk - Significant Concern**
  -  • **Moderate Risk - Areas of Concern Identified**
  -  • **Minimal Risk - Few Issues Identified**

# LABORATORY ASSESSMENT QUALIFICATION

Leading Practice	Current Practice	Rating
Point of care (waived) testing is appropriate for the size/scope of services performed and overseen by the laboratory	Clinics hold their own CLIA waived license, under separate medical directorship for hemoglobin and urine pregnancy testing; operational variation exists in handling the actual testing (needs standardization)	 
Staff is cross-trained in multiple areas to maximize flexibility	Lab personnel are cross-trained to function in all areas of the laboratory; staff routinely rotate between clinics	
Staff skill mix and Span of Control (SoC) are appropriate based on laboratory test mix, volume, and overall lab complexity	The laboratory skill mix includes an even split between MLTs and MTs; a Senior Med Tech handles day to day technical operations; the Clinic Medical Director handles personnel/administrative matters. The department lacks a permanent Manager; one MLT position is vacant	 
Test results are transmitted electronically back to ordering provider	Tests performed in-house and referred to LabCorp (commercial lab) are reported electronically upon completion; outstanding report logs are in place as well as remote printer (from LabCorp) to provide electronic and paper copies of reports	
	Tests referred the NC state laboratory are reported in paper reports, which then require manual transposition (by the lab); then scanning (of the report) by medical records personnel	
There's evidence of an active Quality Assurance Program	Current quality control monitors meet regulatory requirements; this includes test quality controls, temperature charts, preventive maintenance records, and corrected report records. Evidence of active SLA monitors for tests sent to NC state lab and LabCorp was not found	 

# LABORATORY ASSESSMENT – KEY OBSERVATIONS

## Observations / Interview Themes

1. The laboratory current state-of-affairs is not sustainable in the long term due to the increasing requirements to operate a High complexity (CLIA) laboratory that lacks a permanent Lab manager and performs (in-house) molecular assays and traditional GC/other plated cultures. Operational challenges are further compounded with the manual transposition requirements of tests referred to NC State Lab, which require paper ordering & reporting due to the lack of an interface, while experiencing service issues.
- The clinic needs to consider a two-phase approach that appropriately aligns laboratory and clinic services (based on client clinical needs), and establishes an appropriate strategy for future lab services and operations:

## Recommendations

1. **First**, change the laboratory CLIA accreditation level from “High” to “Moderate” complexity and realign the lab scope of services to retain only retain time sensitive in-house testing (gram stain, wet prep, RPR, HIV screen, and waived tests). Concurrently outsource all non-time sensitive testing including molecular assays, cultures, other, as well as tests currently referred to the NC State Lab. **Second**, consider a new strategy to manage the laboratory in the long-term (now as a Moderate Complexity lab operation):

**Option 1 (ideal):** Establish a strategic Laboratory Management Affiliation with an experienced and reputable external lab provider to manage the remaining in-house lab operations. This provides a solid basis for the laboratory to remain atop of transformational changes required to deliver high quality laboratory services, including dedicated and experienced lab administrative and technical oversight.

- An option is to leverage the existing Agreement with LabCorp and extend it to provide on-site services (aligned with time sensitive tests), while referring non-time sensitive tests to their commercial lab facility, and providing lab medical directorship.

# LABORATORY ASSESSMENT – KEY OBSERVATIONS

## Observations / Interview Themes

*CONTINUED...*

2. Evidence of active SLA monitors for tests currently referred out was not found.
3. There's operational variation between clinics handling POCT – urine pregnancy and hemoglobin.

## Recommendations

- Option 2 (less ideal):** Retain in-house a limited in-house test menu required to support immediate patient needs. Leverage established reference testing services with LabCorp to refer all non-time sensitive tests and tests currently referred to the NC State lab. Place remaining (limited scope lab operation) oversight under the Clinic administrative oversight and Medical Directorship.
2. Develop and implement a Service Level Standard (SLA) dashboard to monitor service expectations are met by reference laboratory providers [e.g. Turn Around Time (TAT), past due reports, lost and rejected specimen monitors].
  3. Standardize POCT lab testing protocols between the clinic and the laboratory.

# LABORATORY ASSESSMENT – OPPORTUNITY PRIORITIZATION

Recommendations	Tentative Time Line	Key Implementation Requirements	Potential Risks
Re-align the In-house test menu - retain only time sensitive tests	3 – 6 months	<ol style="list-style-type: none"> <li>1. Make Decision/Operational transition planning</li> <li>2. CLIA accreditation change</li> <li>3. Modification of lab policies/protocols</li> </ol>	1
Discontinue in-house molecular and plated culture testing; refer to commercial lab	2 – 4 months	<ol style="list-style-type: none"> <li>1. Make Decision/Operational transition planning; pricing agreement with commercial lab</li> <li>2. CLIA accreditation change</li> <li>3. Modification of lab policies/protocols</li> </ol>	2
Limit referrals to NC State lab; leverage existing commercial lab capabilities	2 – 4 months	<ol style="list-style-type: none"> <li>1. Make Decision/Operational transition planning</li> <li>2. Reach pricing agreement with commercial lab</li> <li>3. Update internal lab policies/protocols</li> </ol>	3
Implement SLA dashboard	1 – 3 months	<ol style="list-style-type: none"> <li>1. Make decision/Agree on applicable SLAs</li> <li>2. Develop dashboard and tools (forms)</li> <li>3. Establish governing policy/update lab protocols</li> </ol>	4
Pursue a strategic laboratory Management Affiliation with external partner for remaining in-house laboratory operations	6 – 12 months	<ol style="list-style-type: none"> <li>1. Make decision and develop action (work) plan</li> <li>2. Complete required due diligence of tentative commercial lab partner(s) – note: data sharing will be required after NDA is established</li> <li>3. Formalize Lab Management arrangement (based on due diligence findings)</li> <li>4. Complete transition plan</li> </ol>	5

1 – Low risk: Test menu for time sensitive services remains intact; non-time sensitive services would be outsourced

2 – Low risk: Test referral arrangement, interface, and logistical arrangements already exist

3 – Low risk: An interface with LabCorp and a pricing agreement are already in place

4 – Low risk: SLAs – used to monitor timely completion of tests referred out – will complement the current Lab QA program

5 – Some risk exists that test volume/spend could be deemed too low to firm up external Lab Management Partner relationship

# LABORATORY – STRATEGIC AFFILIATION BENEFITS

## Key Benefits Include:

- Standardized and advanced testing methodologies for all lab assays
- Improvements in turn-around times
- Seamless test result order entry and reporting to health clinic EMRs
- Dedicated 24/7 hr customer service support
- Provides more stable, predictable lower cost structure
- Eliminates future capital investments in the laboratory, freeing up capital for other higher priority needs
- Reduces risk and liability associated with the performance of laboratory testing
- Enhanced abilities to leverage laboratory data for quality improvement initiatives

SECTION 7:  
QUALITY & COMPLIANCE  
ASSESSMENT

# OBJECTIVES OF THE QUALITY AND COMPLIANCE ASSESSMENT

This report presents the results of a high level quality/compliance assessment performed by Navigant of Mecklenburg Clinic using the following Institute of Medicine (IOM) definition of quality.

- Requires leadership framework for governing quality.
- Provides an infrastructure to support the improvement and delivery of quality.
- Provides six dimensions of quality for all conditions (safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity).
- Access to credentialed clinicians to provide the care.
- An understanding of how to measure and improve processes and outcomes of care that are most important to the clinical and psychosocial needs of the patients and their families.

Navigant evaluated Mecklenburg's leadership on how they demonstrate their accountability to the following major responsibilities:

- Demonstrates a top-level, corporate commitment to quality and compliance.
- Requires that objective measures be used to gauge the quality of care and services being provided.
- Ensures that quality assurance and improvement processes are in place and working effectively to monitor and improve quality tied to the strategic direction of the organization.
- Ensures a compliance program effectiveness.

## KEY QUESTIONS THAT LEADERS ASK THEIR ORGANIZATION TO ENSURE A FOCUS ON QUALITY AND COMPLIANCE:

- Do the board, leaders and staff understand that the definition of quality and compliance must go beyond just meeting regulatory requirements and doing no harm?
- Do our approaches and processes meet/exceed the needs of those we serve and those that regulate us? How do we know?
- Is quality and compliance tied to the strategic plan and integrated into the operational processes throughout Mecklenburg County Clinic so we can be strategically focused on improving public health and operationally successful in doing so?
- Are our operational processes designed to meet the needs of our clinic patients and capable of being consistently accurate, efficient and effective?
- Are our results predictable and sound in that they produce outcomes that are important to those we serve?
- Is our organization continually learning, innovating, and improving?
- Does everyone in the organization realize that quality and compliance is everyone's responsibility and that it is not to be delegated to an individual(s) or a department?

# QUALITY ASSURANCE AND IMPROVEMENT FINDINGS

- The organization met its last accreditation survey status and was accredited for a full 4 years with no restrictions.
- Efforts are being made on an ongoing basis to meet the requirements of the Consolidated Agreement that Mecklenburg County Health Department made with the North Carolina Department of Human and Health Services, Division of Public Health (the State) and its 9 addendum agreements for the purpose of maintaining and promoting the advancement of public health. The efforts have successfully met the regulatory compliance requirements.
- The current definition of quality and compliance appear to be one of meeting regulatory requirements (QA), doing no harm and meeting efficiency standards that seek to increase access to clinic visits, but not the expanded definition of quality as denoted by the IOM.
- An improvement in quality is not well tied to the strategic plan and integrated into the operational processes throughout Mecklenburg County Clinic to drive a strategy focused on improving public health or ensuring operational successful.

# QUALITY ASSURANCE AND IMPROVEMENT FINDINGS

## Standard 1: Monitor health status and understand health issues facing the community.

- The organization has regularly met standards for the state required annual State of the County Health (SOTCH) report and the every 4-year Community Health Assessment (CHA). During the most recent CHA, 1,888 residents participated in the community opinion survey, 117 individuals attended the community priority setting event and 131 individuals representing the community and 59 different agencies participated in community action planning.

## Standard 2: Protect people from health problems and health hazards.

- Onsite epidemiology staff well versed in local health, state and national health data.
- Communicable Disease staff well trained in investigation and response.
- Established EpiPreparedness team involving communicable diseases, clinical, environmental, epi, policy & prevention, communication staff meet monthly to be informed of prevalence of communicable disease in community and plan/practice incident response activities. Additional multiple additional examples exist.

# QUALITY ASSURANCE AND IMPROVEMENT FINDINGS

## Standard 3: Give people information they need to make healthy choices.

- Strong County Public Information platform that supports Public Health through website, social media, press releases, press conferences, video production and media contacts.
- Seek ongoing input from community members for planning targeted activities and to disseminate information (Ebola example).
- Office of Policy and Prevention and the Office of Community Engagement work in the community with youth, the faith community, geographic areas defined by low educational attainment and poverty, workplaces, the schools, communities.

# QUALITY ASSURANCE AND IMPROVEMENT FINDINGS

## Standard 4: Engage the community to identify and solve health problems.

- Community Health Assessment includes the development of Community Action Plans with the participation of community members to address identified priority health issues.
- Partnering with community groups like Smoke Free Mecklenburg informs advocacy for specific health issues.
- Village HeartBEAT works with congregants of faith-based organizations to assess their health needs and identify policies and programs that help them prevent chronic disease.
- PH worked actively with the Chamber of Commerce Healthy Charlotte initiative to provide education, policy, and programming ideas as well as means for identification of issues and assessment of progress.
- The Uplifting Families initiative, grew out of work by Public Health and UNCC to engage the community.
- Presentations to the BOCC and the Board's Health and Human Services Committee are made by Dr. Plescia to make them aware of public health issues.
- Office of Policy and Prevention engages youth in developing health policy as well as health promotion. Community youth recently developed artwork to illustrate public health issues.

# QUALITY ASSURANCE AND IMPROVEMENT FINDINGS

## Standard 5: Develop public health policies and plans.

- PH community projects and interventions focus on policy change through government as well as individual organizations (school, healthcare, faith community, workplace etc. Examples include:
  - Passage of local county ordinance for smoke-free government grounds and a public health rule for tobacco free public parks as well as tobacco free schools, tobacco free universities and tobacco free hospitals. The CHS decision to move mental health facilities to tobacco free status represented a large policy change.
  - Working with the Housing Authority to establish smoke-free housing.
  - Village HeartBEAT Program engages the Faith Community in developing policies to promote chronic disease prevention within their faith-based organizations.
  - Partner with the school system in the School Health Advisory Committee to promote whole child health including physical activity and healthy school lunches.
  - Work with opioid prevention group to promote policies for providing buprenorphine.

# QUALITY ASSURANCE AND IMPROVEMENT FINDINGS

## Standard 6: Enforce public health laws and regulations

- Robust Communicable Disease program investigates; treats where appropriate treats and / or puts prevention plans into place for communicable disease incidents. Example: In FY16 the CD program conducted 3,816 investigations of communicable diseases and animal bites.
- Environmental Health staff annually conduct nearly 12,000 restaurant, lodging, nursing home and child care center inspections and perform close to 1,600 public pool inspections. In FY16, they conducted 14,582 mandated regulatory inspections and issued 1,669 permits. Environmental Health is responsible for enforcement of smoking ordinances for restaurants.

## Standard 7: Help people receive health services.

- Public Health provides selected clinical services on a sliding scale as well as screening and treatment of conditions of public health significance (e.g. STDs, TB, HIV testing) at no charge.

# QUALITY ASSURANCE AND IMPROVEMENT FINDINGS

## Standard 8: Maintain a competent public health workforce.

- Mecklenburg County offers a wide array of training on technology, skills building and individual development to all employees at no charge.
- Funds are budgeted for staff to attend specific public health trainings for required skills building as well as state and national meetings to maintain a current awareness of leading practices.
- All staff are trained in ICS and NIMS with level of training determined by job responsibilities.

## Standard 9: Evaluate and improve programs and interventions

- The Quality Improvement Team works with programs to assess or evaluate practice, design, and implement practice changes.
- Examples include:
  - Building capacity in adult health clinics to serve more people.
  - Implementation of electronic health record and process streamlining for Community Services Case Management.
  - Streamlined processes in Refugee Clinic to ensure patients are seen within 30 days of arrival to United States.

# QUALITY ASSURANCE AND IMPROVEMENT FINDINGS

## Standard 9: Evaluate and improve programs and interventions continued:

- PH works closely with local universities to engage evaluators for interventions. Example: The use of a UNCC evaluator to look at public response to the Tobacco Free Parks ordinance.

## Standard 10: Contribute to and apply the evidence base of public health.

- Office of Policy and Prevention chooses evidence based and evidence informed programs and practices for community interventions.
- Collaborate with local universities/hospitals in participatory research projects.
- The Academy for Public Health Innovation, is a collaborative between Public Health and UNCC to investigate, assess and make recommendations for addressing public health issues.
- Serve as adjunct faculty teaching public health related classes at local universities.
- Serve on Advisory Board for Public Health Science at UNCC.
- Partner with universities in research projects. Examples include working with Chapel Hill on recruiting low income clients for fecal occult blood testing as a means of colorectal cancer screening and Duke for combining HIV and syphilis screening with Hepatitis C testing at substance abuse treatment centers.

# QUALITY ASSURANCE AND IMPROVEMENT FINDINGS

- The current focus on quality, from an organizational perspective, is to fix what is broken and to meet minimal state requirements vs. continual improvement and to exceed state requirements. There is little knowledge of systems capability; operational processes are not continually improved and are not capable of being consistently effective or capable of delivering predictable outcomes.
- The majority of monitoring of clinical outcomes is focused on efficiency tied to access (number of patient visits in the family planning clinic) and less about improving clinical care, being accurate or effective in meeting needs.
- There is a cultural mindset that quality and compliance should be delegated to resources in the quality department and is not seen as everyone's responsibility.
- Current data collected is limited in its use to measure, analyze, and improve organizational performance therefore it is difficult to build an effective and supportive workforce or engage them in achieving a high-performance work environment.
- Operating practices are reactive and driven by problems vs. proactive with a focus on process improvement therefore, results relative to success are missing, not used or are randomly reported.

# QUALITY AND COMPLIANCE FINDINGS

- There is minimal focus on designing, managing, or improving key work processes therefore it is difficult to be operationally effective.
- There is evidence that quality and compliance policies and procedures exist and are communicated to staff through appropriate channels that address the critical compliance requirements.
- It is not evident that the organization has a complete and formal compliance program that addresses:
  - The organization's business activities and consequent risks;
  - Provides ongoing education to those persons who could have material impact on those risks;
  - Includes auditing and reporting functions designed to measure the organization's actual compliance and the effectiveness of the program to identify problems as quickly and efficiently as possible;
  - Provides for the prompt remediation of problems which are identified and contains enforcement and discipline components that ensures that employees take seriously their compliance responsibilities.
- There is not a written plan for auditing and monitoring that includes subject, method and frequency of audits based upon key functional areas and potential associated risks.

# COMPLIANCE SPECIFIC FINDINGS

- There is not evidence of an active compliance committee comprised of appropriate representatives from each relevant functional business unit and / or department as well as senior management. This minimizes the ongoing communication to employees regarding compliance related policies and procedures on internal audits, coding, billing and clinical departments.
- The compliance officer is too low level of a resource to carry out the required responsibilities of expected authority such as direct access to the governing board, all senior management and legal counsel.
- It is not evident that the compliance officer provides routine reports to senior leadership and the board about the compliance program.
- It is not evident that the organization has completed a comprehensive risk assessment to identify relevant compliance risk areas other than what is required under the state accreditation process.

# COMPLIANCE SPECIFIC FINDINGS

- There is evidence that policies and procedures exist and are communicated to staff through appropriate channels that address the critical compliance requirements such as the following:
  - Compliance and Quality Department
  - Compliance Program
  - Privacy and Security
  - Code of Conduct
  - Mechanism or proof of policy dissemination, specifically for a code of conduct to employees and non-employees.
  - Hotline operating P&P's related to Investigation, Response and Prevention
  - HR Policies and procedures related to discipline enforcement that represent what you need to do to be in compliance with the state.
  - Monitoring and Auditing for Compliance related work P&P's.

# QUALITY ASSURANCE AND IMPROVEMENT FINDINGS

- Based upon interviews with leadership and staff, the current definition of quality and compliance appear to be one of doing no harm and not the expanded view as denoted.
- Current efforts focus on meeting the basic needs of state regulators required through the accreditation process (QA) and meeting efficiency standards that seek to increase access to clinic visits.
- An improvement in quality is not well tied to the strategic plan and integrated into the operational processes throughout Mecklenburg County Clinic to drive a strategy focused on improving public health or ensuring operational successful.
- The current view of quality is to focus on what is broken vs. continual improvement, therefore operational processes are not continually improved and are not capable of being consistently effective or capable of predictable outcomes.
- The majority of monitoring of clinical outcomes is currently focused on efficiency tied to access (number of patient visits in the family planning clinic) and less about improving clinical care, being accurate or effective in meeting needs.

# QUALITY ASSURANCE AND IMPROVEMENT FINDINGS

- Interviews pointed to a cultural mindset that quality and compliance is delegated to resources in the quality department and not seen as everyone's responsibility.
- Current data collected is limited in its use to measure, analyze, and then improve organizational performance therefore it is difficult to build an effective and supportive workforce or engage them in achieving a high-performance work environment.
- The organization is operating in a reactive mode characterized by activities to respond to rather than by a focus on process improvement and the reactions are largely driven by problems. Therefore results that are important to the organization's ongoing success are missing, not used or are randomly reported.
- There is minimal focus on designing, managing, or improving key work processes therefore it is difficult to be operationally effective.
- There is a need to move towards a more proactive process for continually improving quality which must begin with the board and executive leadership driving this process.

# THE BOARD OF HEALTH UNDERSTANDS ITS ROLE FOR QUALITY AND COMPLIANCE

- Demonstrates a top-level, corporate commitment to high quality and organizational compliance.
- Requires that objective measures are used to evaluate the quality of care and services provided.
- Ensures that quality and compliance are integrated in the strategic business plan.
- Ensures that quality and compliance are monitored and improved.
- Ensures that the County Manager carries out the oversight for these responsibilities.
- Ensures that the Health Director carries out these responsibilities per the direction of the County Manager.

# RECOMMENDATIONS FOR THE BOARD OF HEALTH LEADERSHIP: 3 PRIMARY ROLES

1. **Establish policies** that define focus and differentiate responsibilities among the board and management ensuring more efficient board functioning and effective management.
2. **Make significant / strategic decisions**
  - a. Regarding the organization's vision, mission, and strategies.
  - b. Delegation of non-governance types of decisions to others.
3. **Provide oversight vs. management of the organization's activity**
  - a. Demonstrate commitment to Quality and Compliance.
  - b. Establish committees or processes to monitor quality and compliance.
  - c. Support the public health clinic in meeting regulatory standards.
  - d. Ensure that the County Manager and the Health Director carry out these responsibilities.

# LEADERSHIP RECOMMENDATIONS FOR BOARD, COUNTY MANAGER, HEALTH DIRECTOR AND EXECUTIVES

## **Create Vision and Build Will**

- Create a clear and compelling vision for the organization's future tied to organizational strategic goals.
  - Identify a few mission critical improvement projects tied to these goals.
- Engage the leadership at all levels in adopting system-wide aims for reducing patient harm and delivering the right clinical care to improve team culture and build organizational alignment while ensuring that the board provides support for difficult changes that are necessary.
- Create an urgency around the need for and acceptance of change. Move from reactive norms and practices to a proactive mindset for continual improvement.

# RECOMMENDATIONS FOR HEALTH DIRECTOR AND EXECUTIVES

## Develop Capability and Deliver Results

- Develop/maintain the organizational structure, people, policy, budget, and resources that support the organizational capability for embracing change/innovation.
  - Develop basic improvement knowledge for all levels of employees.
  - Engage front line staff in the identification of opportunities for improving quality and compliance and provide support for changes in policy and process.
  - Establish the focus for setting and managing priorities.
  - Establish breakthrough performance goals vs, minimal targets.
  - Develop a portfolio of high-priority projects to support the breakthrough performance goals.
  - Deploy resources to projects that are appropriate for the aim.
  - Provide leadership sponsorship and support for each project.
  - Assure the development of key measures that align with the IOM dimensions of quality based upon the need of those to be served.
  - Establish an oversight and learning system to increase the chance of producing the intended results.
  - Reward the intended and positive leadership/employee behavior as well as team efforts.

# SECTION 8: CERNER ASSESSMENT

# CERNER OVERVIEW

## Observations / Interview Themes

- The current EMR that was purchased when the Health Department transitioned in 2013 is inadequate for the following reasons:
  - Current version of Cerner PowerChart and Specialty Practice Management is an inferior product compared to the version used by CHS.
  - Key stakeholders (e.g. NP's, RN's, Clinical Assistants) were not involved in the product selection.
  - Clinic leadership is not adequately participating in the management and evolution of the present applications.
    - No defined, on-going EMR optimization plan exists historically or presently.

## Recommendations

- Create a Health Information Technology (HIT) Steering Committee, led by clinicians, with decision-making power. The committee will be responsible for the following:
  - Develop a health information technology strategic vision.
  - Oversight of clinical documentation requirements assessment.
  - Oversight of Cerner PowerChart and SPM in-depth assessment of current functionality.
  - Develop an EMR optimization plan.
  - Develop a Meaningful Use (MU) strategy – must be in place by the end of 2017 to attest for MU in April 2018.

# CERNER OVERVIEW

## Observations / Interview Themes

- Lack of ownership to drive accountability:
  - Adherence to the “use” policies and procedures.
- Clinical requirements for documenting in the EMR for each of the clinical programs were not clearly understood or properly vetted, before implementation, which has resulted in an ineffective EMR.
- Clinical staff are documenting in multiple systems (e.g., Avatar, NCIR, NC EDSS, etc.) and / or are using a combination of paper and PowerChart which is very time-consuming, inefficient and ineffective.
- Due to design flaws paper documentation forms are filled out and scanned into the patient’s EMR.

## Recommendations

- Develop a patient portal strategy– must be in place by the end of 2017 (one of the MU criteria).
- Develop a strategy to connect to NC HealthConnex (State-wide Health Information Exchange) – must be in place by February 2018 to receive Medicaid reimbursement.

# CERNER OVERVIEW

## Observations / Interview Themes

- Family Planning and STD clinics use PowerChart for placing orders and inputting charges.
  - Approximately 75% of their clinical documentation is completed in Cerner but there are several paper forms being used as well and scanned into PowerChart.
- TB, Travel and BCCCP clinics use PowerChart for placing orders and inputting charges.
  - There is some clinical documentation in Cerner but a majority of the documentation is done on forms which are scanned into PowerChart.

## Recommendations

- Conduct an in-depth assessment of the critical clinical documentation requirements that must be captured to deliver quality patient care and meet all state and federal reporting requirements:
  - Create a Documentation Forms working group whose purpose will be to obtain a clear understanding of all documentation requirements for each clinical program/SPM, as well as state and federal reporting requirements.
  - Gather all forms currently in use in each of the clinical programs and SPM – log all forms into a database by clinical program.
  - Assess all forms for commonality and differences.
  - Establish final documentation requirements necessary to deliver quality patient care and meet all state and federal reporting requirements for each clinical program.

# CERNER OVERVIEW

## Observations / Interview Themes

- Refugee clinic uses PowerChart for placing orders and inputting charges.
  - Approximately 75% of their clinical documentation **for adults** is completed in PowerChart.
  - Approximately 25% of their clinical documentation **for children** is completed in PowerChart – the remainder is completed on paper forms and scanned into PowerChart.
  - Other software applications that are being used routinely:
    - TB clinic inputs data into NC Detect and NC EDSS.
    - BCCCP program inputs data into Avatar.

## Recommendations

- Once documentation and reporting requirements have been established, conduct an in-depth assessment of current PowerChart and SPM functionality to determine if system optimization will meet your needs.
- **If** current PowerChart and SPM functionality will not meet your needs, **consider** replacing PowerChart and SPM with one of the following:
  - Upgraded version of Cerner.
  - Epic EMR provided by Novant's Community Connect program.
  - EMR specific to Public Health.

# CERNER OVERVIEW

## Observations / Interview Themes

- Immunization clinic uses PowerChart for placing orders, documentation of allergies, medication history and tobacco use and inputting charges.
  - Additional visit information is documented in the NC Immunization Registry (NCIR).
    - Forms are printed from the Immunization Registry and scanned into the patient's electronic medical record.
    - Nurses document their assessment note on a paper form and scan into patient's medical record.
- Functionality to create a patient encounter outside of a scheduled visit is not available.

## Recommendations

# CERNER OVERVIEW

## Observations / Interview Themes

- There are limited options for customizing the current Cerner PowerChart and SPM versions.
  - PowerChart forms can only be created by Cerner.
- MCHD is dependent on Cerner for building additional functionality, which in the past, has been met with resistance by Cerner and also constrained by bureaucracy at the County level (e.g. a documentation form submitted to Cerner last December for build has still not been completed).
- Functionality will likely become more constrained as time goes on. There is also a risk that at some point in the future Cerner may decide to “**sunset**” your current version.

## Recommendations

# CERNER OVERVIEW

## Observations / Interview Themes

- It is the opinion of IT personnel that an upgraded version of Cerner will cost 3 million+ dollars and will require additional IT resources for build and future maintenance.
- PowerChart does not interface well with other necessary Public Health documentation software programs (e.g. Avatar which is used by the BCCCP program; NC EDSS, disease surveillance program used by the TB clinic; NCIR, immunization registry program used by the Immunization clinic).
- Prior to 60 days ago, no formal PowerChart or SPM training program existed.
  - New staff were forced to learn “on the job”.

## Recommendations

- Review all applications in use by MCHD clinical departments and explore options for interfacing with PowerChart and SPM to minimize duplication of data entry.
- Optimize network performance to minimize slow connection and freezes of Cerner environment.
- Develop on-going PowerChart and SPM refresher training for current employees and providers.
- Revise Nurse Informaticist job description.
  - This position should be the bridge between health information technology and clinical workflow.
  - This position should report to nursing.

# CERNER OVERVIEW

## Observations / Interview Themes

- As reported by clinical staff, current PowerChart EMR was not designed well.
  - Flow of inputting data is not intuitive.
  - Too many screens to move between.
  - Does not meet their needs in its current format.
  - Slow and freezes up – staff must log-off and on taking up valuable time.
- No patient portal available within existing Cerner EMR.
- MCHD does not participate in Meaningful Use (MU).
- Recent attempt at attestation for Adopt, Implement and Upgrade (first step towards MU) was rejected by Medicaid. Medicaid stated they were unable to validate reported patient volumes.

## Recommendations

SECTION 9:  
PROVIDER PRODUCTIVITY  
ASSESSMENT

# PROVIDER PRODUCTIVITY – MGMA BENCHMARK

## Recommendations Based on MGMA 2016 Benchmark Standards:

- Initiate actions to increase provider productivity.
- Identify barriers to schedules, access, and provider assignment to clinics and execute necessary changes.

Provider	FTE	Start/Term Adjusted FTE	Annualized Total Encounters <sup>(9)</sup>	MGMA Median Encounter Standard <sup>(7)(8)</sup>	Encounter Opportunity <sup>(4)</sup> (Median)	Financial Opportunity <sup>(5)</sup> (Median)	MGMA 75th %tile Encounter Standard <sup>(7)(8)</sup>	Encounter Opportunity <sup>(4)</sup> (75th %tile)	Financial Opportunity <sup>(5)</sup> (75th %tile)	FTE Adjusted Productivity %tile	Above/ Under Benchmark
<b>Summary</b>	<b>6.96</b>	<b>6.31</b>	<b>14,926</b>	<b>16,507</b>	<b>2,429</b>	<b>\$ 48,585</b>	<b>21,960</b>	<b>7,034</b>	<b>\$ 140,690</b>	<b>40</b>	<b>Below</b>

<sup>1</sup>Per Rick Ricker Lisvel FTE still to be determined

<sup>2</sup>Termed personnel

<sup>3</sup>Not employed during first half of FY2017

<sup>4</sup>Calculated by taking Median/75th %tile Encounter Standard - Annualized Total Encounter

<sup>5</sup>Calculated by taking Encounter Opportunity (Median & 75th %tile) x \$20 (Avg Charge/Encounter)

<sup>6</sup>Adjusted for clinic days (3-days/w week) and administrative days (2-days/w week)

<sup>7</sup>MGMA Family Medicine without OB related visit statistics for MDs and NPs/PAs.

<sup>8</sup>MGMA 2016 benchmark using 2015 survey data

<sup>9</sup>Clinic encounters annualized using data from July 1, 2016 to December 31, 2016

# PROVIDER PRODUCTIVITY – PUBLIC HEALTH STAFFING STANDARDS

Recommendations based on NC Department of HHS Public Health Staffing Standards:

- Initiate actions to increase provider productivity.
- Identify barriers to schedules, access, and provider assignment to clinics and execute necessary changes.

Provider	FTE	Start/ Term Adjusted FTE	Annualized Total Encounters <sup>(9)</sup>	Adjusted Public Health Staffing Encounter Standard <sup>(7)(8)</sup>	Encounter Opportunity <sup>(4)</sup>	Financial Opportunity <sup>(5)</sup> (Median)	FTE Adjusted Productivity of Standard %tile	Above/ Under Benchmark
<b>Summary</b>	<b>6.96</b>	<b>6.31</b>	<b>14,926</b>	<b>30,280</b>	<b>15,354</b>	<b>\$ 307,089</b>	<b>49%</b>	<b>Below</b>

<sup>1</sup>Per Rick Ricker Lisvel FTE still to be determined

<sup>2</sup>Termed personnel

<sup>3</sup>Not employed during first half of FY2017

<sup>4</sup>Calculated by taking Adjusted Public Health Staffing Encounter Standard - Annualized Total Encounter

<sup>5</sup>Calculated by taking Encounter Opportunity x \$20 (Avg Charge/Encounter)

<sup>6</sup>Adjusted for clinic days (3-days/w week) and administrative days (2-days/w week)

<sup>7</sup>Assumed standards were Median visit related statistics for MDs and NPs/PAs.

<sup>8</sup>Data pulled from NC Dept. of HHS (<http://publichealth.nc.gov/lhd/>).

<sup>9</sup>Clinic encounters annualized using data from July 1, 2016 to December 31, 2016

# SECTION 10: STAFFING ASSESSMENT

# SUPPORT STAFF PER 10,000 ENCOUNTERS – ALL ENCOUNTERS

- Existing patient encounters for FY2017 indicates that MCHD is overstaffed by 2.5 FTE. However, if provider productivity is increased to MGMA Median benchmark standard, MCHD will better leverage its existing FTE count appropriately.
- Recommendations: 1) Initiate actions to increase provider productivity; 2) Identify barriers to schedules, access, and provider assignment to clinics and execute necessary changes.

Support Staff FTEs Analyzed			
Front Office Support FTEs	18.4		
Clinical Support FTEs	11.2		
Ancillary Support FTEs	9.3		
Business Operations Support FTEs	9.6		
<b>Total Staff Analyzed</b>	<b>48.6</b>		
Support Staff FTE Opportunity			
	Conservative <sup>(2)</sup>	Midpoint <sup>(3)</sup>	Aggressive <sup>(1)</sup>
Front Office Support FTEs	0.8	1.1	1.5
Clinical Support FTEs	-	-	-
Ancillary Support FTEs	0.5	0.8	1.0
Business Operations Support FTEs	-	-	-
<b>Total FTE Opportunity</b>	<b>1.3</b>	<b>1.9</b>	<b>2.5</b>
Financial Opportunity including 25% benefits			
	Conservative <sup>(2)</sup>	Midpoint <sup>(3)</sup>	Aggressive <sup>(1)</sup>
Front Office Financial Opportunity	\$ 37,463	\$ 56,195	\$ 74,927
Clinical Support Financial Opportunity	\$ -	\$ -	\$ -
Ancillary Support Financial Opportunity	\$ 43,219	\$ 64,828	\$ 86,438
Business Operations Support Financial Opportunity	\$ -	\$ -	\$ -
<b>Total Potential Opportunity</b>	<b>\$ 80,682</b>	<b>\$ 121,023</b>	<b>\$ 161,364</b>

<sup>1</sup>Aggressive = MGMA Median Benchmark

<sup>2</sup>Conservative = 50% of MGMA Median Benchmark

<sup>3</sup>Midpoint = 75% of MGMA Median Benchmark

<sup>4</sup>MGMA Multispecialty Clinic with Primary Care Staffing Benchmark Used in Analysis

<sup>5</sup>MGMA 2016 Benchmark using 2015 survey data

#### Other Key Assumptions:

- Incorporates all MD, NP and RN profile encounters.
- WIC and Dental Services data encounter/personnel excluded.

SECTION 11:  
LEADERSHIP & MANAGEMENT  
ASSESSMENT

# LEADERSHIP / MANAGEMENT OVERVIEW

## Observations / Interview Themes

### Overview

- Does not have the pulse of staff perceptions.
- Not listening to the employees concerns.
- Management attending meetings from building to building with little time to address issues.
- Management has done a poor job of addressing staff performance issues.
  - Rather than disciplining staff, they shift these poor performers to other areas within the Health Department.
- “Span of Control” is large for Management.
- A RN Supervisor mentioned that she contacted Health Manager about CCC personnel entering incorrect demographic information. This continues to be an issue.
- Staff perception/comments and their comments regarding MCHD leadership:
  - Have been around for a long time.
  - Have not been proactive in instituting change.
  - Do not want to take extra burden or the extra step to improve clinic operations.

# LEADERSHIP / MANAGEMENT OVERVIEW

## Observations / Interview Themes

- Certain managers have stayed in their position so they can be fully vested in their pension.
- Unresponsive to managers comments regarding their heavy work loads.
- Management does not meet as a collective group to share ideas and discuss issues.
  - Thus, silos have developed.
  - Nursing management staff meet very infrequently.
- A manager mentioned that leadership needs to:
  - Establish a focus and a mission for nursing.
  - Personnel need to understand “why they are doing what they are doing” and “how their actions impacts everyone upstream and downstream within the clinics”.

# LEADERSHIP / MANAGEMENT OVERVIEW

## Observations / Interview Themes

### Executive Leadership

- Management has, at times, behaved inappropriately with Executive Leadership.
- Both Executive Leadership and Management have not served as a good role models for their subordinates.
- Executive Leadership and Management does not acknowledge bad behavior and do not hold personnel accountable for their actions.
  - For example, staff who are acting unprofessionally/inappropriately in a meeting and personnel whose performance is not meeting set expectations, are not being counseled to change their behaviors.
  - Thus, there is a perception that bad behaviors are allowed/tolerated.
  - This lack of holding personnel accountable for their negative actions has been a long term problem.
- Executive Leadership and Management do not exert their influence and power to drive changes.
- Senior leadership is not visible in clinics.

# LEADERSHIP / MANAGEMENT OVERVIEW

## Observations / Interview Themes

### Executive Leadership

- Health Director wants to be involved in a more strategic nature instead of being “hands-on” to improve clinic operations.
- Health Director needs to support management in instances where they have to hold staff accountable for their roles and responsibilities.

### Medical Directors

- Roles of the Medical Director and Assistant Medical Director are somewhat ambiguous.
- Medical Directors have not exerted their influence to bring about change.
- Medical Directors need to be more present and assertive in accomplishing goals / objectives. (e.g. meetings agendas are accomplished).

### Director of Nursing

- Director of Nursing (DON) has been a significant barrier regarding changes presented by the Quality team.
- No connection between DON and Clinical Operations.
- Perception of staff is that DON instills a level of fear within the clinical staff.

# LEADERSHIP / MANAGEMENT OVERVIEW

## Observations / Interview Themes

### RN Supervisor Role

- RN Supervisors are not visible in the clinic due to the numerous meetings they are attending.
  - Not available in the clinic during busy/peak times.
  - Unable to execute clinic duties.
  - Staff's perception is that they attend too many meetings.
- Providers have stated that the RN Supervisor role has not been properly used within the clinic setting.
- RN Clinic Supervisors are not exhibiting critical thinking skills to better direct traffic within the clinic.
  - Lack of forethought regarding how busy the clinic is.
  - For example, when the STD clinics are not busy, RN Clinic Supervisor does not flex staff from this area to assist the Family Planning clinic when it is really busy.

# LEADERSHIP / MANAGEMENT OVERVIEW

## Health Director

- Provides leadership and sets vision for Health Department and new innovative programs.
- Directs the public health department including its assets and resources.
- Recruits and manages senior management staff for clinics.
- Supervises executives / others.
- Overseer of services - Responsible for the 31 programs under the Public Health Department
- Directs large-scale health program operations, strategic planning, resource allocation and clinical operations.
- Planning and organizing programs.

## Medical Director

- Provides leadership and guidance of the clinical programs (including dental), pharmacy and laboratory.
- Assures the development of appropriate policies that meet medical and clinical practice requirements.
- Designs and establishes clinical programs, and assure the measurement and monitoring for compliance and operational results.
- Provides coordination and communication within the medical community, health care systems, MEDIC EMS, the public, neighboring counties and the NC Division of Public

## Division Director

- Provides executive management leadership and guidance, responsible for the policy development, and oversight for the Clinical Services Division.
- Supervises the clinic managers for the Department.
- Authorized to perform critical decision making and the independence and discretion to establish and manage programs (Immunization, TB, Travel, Refugee, Family Planning, BCCCP, Women's Health, STD/HIV testing and treatment, Dental Services) within the Division as well as serve as a resource to other entities within

# LEADERSHIP / MANAGEMENT OVERVIEW

## Health Director

- Finance and budget planning.
- Communications and networking.

## Medical Director

- Health for normal public health functions and public health response situations.
- Share responsibility for the research, contract negotiation, management and evaluation of services that may be provided via a contracted vendor.
- Responsible for the development/authorization of medical records/standing orders and appropriate medical policies and procedures.
- Provide medical consultation for all programs.
- Identify clinical needs and assure effective administration of programs.

## Division Director

- the Mecklenburg County Human Services Agency.
- Serves as the Director of Nursing for MCHD, providing oversight of nursing scope and assurance of nursing practice for the Department.
- Assure appropriate scope of nursing practice.
- Assure Nursing Standing Orders, Policies, Procedures and Protocols meet NCBON, State Agreement Addendum (AA) requirements and established standards for clinical services leading practices to maximize revenue collections and increased efficiency and productivity of licensed personnel.

# LEADERSHIP / MANAGEMENT OVERVIEW

## Health Director

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## Medical Director

- Establish clinic priorities and assure the means of meeting those priorities.
- Oversee the development of program staffing, policy and procedures, and training.
- Develop and / or modify MCHD Clinical Services policies to ensure compliance with federal, state, local or other regulations and requirements.
- Make consolidated and comprehensive decisions that result in recommendations to governing bodies on new policies or the modification of existing policies, implementation of approved policies.

## Division Director

- Command an operational/business knowledge of clinic environment.
- Develop and implement organizational goals and strategies for Clinical Services Division and ensure compliance with federal, state and local rules and regulations.
- Responsible for the research, contract negotiation, management and evaluation for services that may be provided via a contracted vendor; in coordinated with the Meck. County Procurement department.
- Interface with NC Board of Nursing.

# LEADERSHIP / MANAGEMENT OVERVIEW

## Health Director

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## Medical Director

- Demonstrate effective leadership skills to ensure success of the Division and the Department.
- Determine and implement effective relationship building and communication methods.
- Work with Clinic Director on the development of MCHD Clinical Services Division operational and capital budgets and pursue federal/state/local grant funding opportunities.
- Make decisions and / or recommendations related to personnel, hiring/firing, budget processes, safety programs, job classifications, workforce diversification, technology.

## Division Director

- Design and establish clinical programs, and assure the measurement and monitoring for compliance and operational results.
- Identify clinical needs and assure effective administration of programs.
- Establish program priorities and means of meeting those priorities.
- Oversee the development of program staffing, policy and procedures, and training.
- Determine and implement effective relationship building and communication methods.

# LEADERSHIP / MANAGEMENT OVERVIEW

## Health Director

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## Medical Director

- Determine how to integrate program activities within the department in order to provide comprehensive, efficient and coordinated service delivery.
- Interface with the NC Board of Medicine as needed.
- Provide direct medical coverage for the Tuberculosis Clinic.
- Provide back-up/direct medical services as needed.

## Division Director

- Develop and / or modify MCHD Clinical Services Division policies to ensure compliance with federal, state, local or other regulations and requirements.
- Make consolidated and comprehensive decisions that result in recommendations to governing bodies on new policies or the modification of existing policies, implementation of approved policies.
- Demonstrate effective leadership skills to ensure success of newly restructured Division and Department.

# LEADERSHIP / MANAGEMENT OVERVIEW

## Health Director

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## Medical Director

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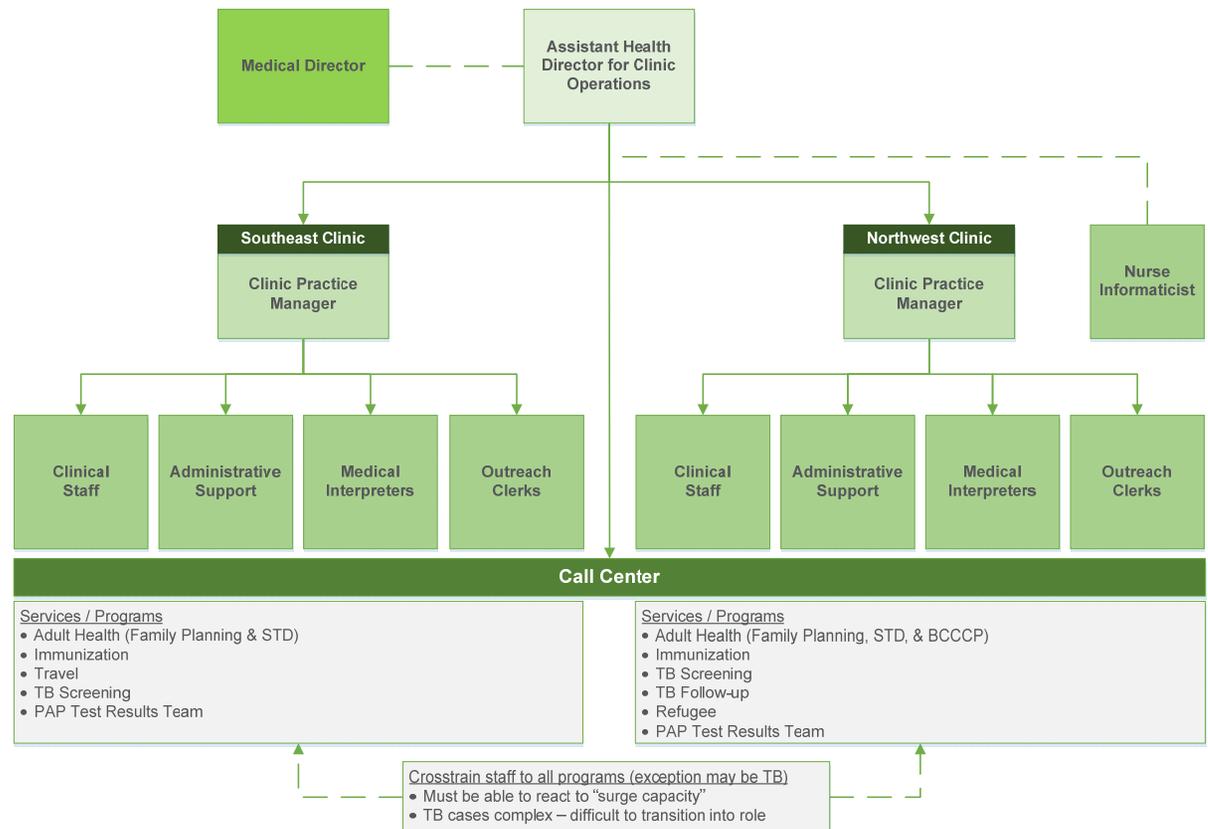
## Division Director

- Develop Clinical Services Division operational/capital budgets and pursue federal/state/local grant funding opportunities.
- Make decisions and / or recommendations related to personnel, hiring/firing, budget processes, safety programs, job classifications, workforce diversification, technology.
- Determine how to integrate program activities in order to provide comprehensive, efficient and coordinated service delivery.
- Determine the effectiveness and efficiency of support service(s) and how to integrate these functions effectively.

# OPPORTUNITIES THAT SHOULD BE CAPITALIZED UPON ...

## Proposed Management Structure

- Restructure Management team:
  - Medical Director
  - Assistant Health Director for Clinic Operations
  - Other Practice Managers/Supervisors
- Proposed Structure:
  - Clinical
  - Administrative
  - Interpreters
  - Outreach
- Adjust Span of Control for Management.



Note: Medical Director position same as Dept. position.

# LEADERSHIP / MANAGEMENT OVERVIEW

## Recommendations

- Institute a communication plan that addresses overall perceptions of staff and managers.
  - Once organizational structure are formalized, communicate roles, duties and responsibilities and authority to employees.
  - “Lunch and Learn” on a scheduled basis which will provide a forum to share information regarding goals, objectives, and updates (Quarterly).
  - Breakfast with the Health Director (Monthly).
    - Purpose of this meeting is to allow employees to meet directly with the Health Director to present questions, issues, and concerns.
  - Develop an employee newsletter for the clinic departments.
    - Newsletter members should consist of employees (Distribute monthly).
  - Institute mentee/mentor sessions (Monthly).
- Evaluate meeting structure, purpose and attendees.
  - Revamp to include authorized representatives who have the authority to make decisions for clinical and operations functions.
- Institute 100% adherence to HR policies for all employees.
  - Management will ensure compliance.

# LEADERSHIP / MANAGEMENT OVERVIEW

## Recommendations

- Formalize performance review process, to include updated job descriptions, review meetings with personnel (initial, mid-year, annually).
  - Disciplinary policies should be strictly adhered to ensure actions are uniformly and consistently followed.
  - Deviations in adherence increase risk to MCHD.
- Executive leaders and management should “round” in clinics routinely.
  - Not just walking through clinics on their way to meetings or patient clinic.

# SECTION 12: IMPLEMENTATION PLAN

NAVIGANT

# OPPORTUNITY PRIORITIES

Priority	Opportunity
1	Enhance <b>EMR</b> performance to maximize clinic performance, maximize patient management, eliminate multiple documentation approaches, and minimize risks.
2	Restructure current <b>Clinical Care Model and Delivery</b> resulting in improved patient satisfaction and patient access, implement alternative methods to deliver care, and improved financial performance of the clinics.
3	Resign <b>Customer Contact Center / Call Center</b> to maximize centralization and standardization of patient registration, prior authorizations and precertification, scheduling of patient appointment types and procedures and enhance Clinical Nurse Triage.
4	Pursue a strategic <b>Laboratory Management Affiliation</b> with an external partner for remaining in-house laboratory operations.
5	Redesign <b>Clinic Management</b> structure.
6	Enhance <b>Quality Programs</b> to permeate clinic organization and exceed state requirements.

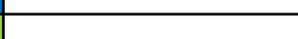
# OPPORTUNITY ASSESSMENT RISK

Based upon Navigant's extensive knowledge and experience working with clinic organizations, we utilized an overall risk ranking system as outlined below:

-  High Risk - Significant Concern
-  Moderate Risk - Areas of Concern Identified
-  Minimal Risk - Few Issues Identified

Criteria	Minimal	Moderate	High
EMR			
Clinical Care Model and Delivery			
Clinic Contact Centralized Program (CCC)			
Practice Standardization			
Lab Ops / Management Affiliation			
Care Delivery Structure			
Management Structure			
Quality and Compliance			
Providers / Staffing			

# IMPLEMENTATION INITIATIVES

Category	Low	Medium	High
EMR	 	 	 
Clinical Care Model and Delivery	 	 	 
Clinic Contact Centralized Program (CCC)	 	 	 
Practice Standardization	 	 	 
Lab Ops / Management Affiliation	 	 	 
Care Delivery Structure	 	 	 
Management Structure	 	 	 
Quality and Compliance	 	 	 
Providers / Staffing	 	 	 

Based upon Navigant's extensive knowledge and experience working with clinic organizations, we utilized an overall implementation estimation as outlined below:

 Potential Economic Value

 Difficulty of Implementation

# PROPOSED IMPLEMENTATION PLAN

	Phase I Assessment	Phase II Design and Build	Phase III Implementation
Goal	Define Opportunities	Develop Solutions	Deliver Results
Project Activities	<ul style="list-style-type: none"> <li>• Create project charter</li> <li>• Identify and engage MCHD stakeholders for assessment, schedule interviews</li> <li>• Conduct best practice review</li> <li>• Submit data request</li> <li>• Conduct current state situational assessment</li> <li>• Conduct qualitative review (interviews and process observations)</li> <li>• Conduct quantitative review (benchmarking, data analysis, span of control &amp; validation).</li> <li>• Identify magnitude of improvement opportunities (gap between current state and target benchmark for each functional area)</li> <li>• Define implementation Workstreams</li> </ul>	<ul style="list-style-type: none"> <li>• Conduct further due diligence to support design</li> <li>• Design, build, and test people, process and technology solutions and identify realization schedule for solutions/recommendations</li> <li>• Define scope and scale of pilot</li> <li>• Determine scaling timeline/ramp-up across organization</li> <li>• Create detailed implementation plans for each of the approved solutions/recommendations</li> <li>• Develop staff training plan and materials</li> </ul>	<ul style="list-style-type: none"> <li>• Conduct pilot per design</li> <li>• Conduct full rollout of solutions/ implementation of approved recommendations</li> <li>• Monitor actual quality, operational and financial performance against realization schedule</li> <li>• Develop plans to achieve targets when targets are not being met</li> <li>• Monitor and reassess risk and impact</li> <li>• Transfer knowledge and capability to MCHD</li> </ul>
Deliverables	<ul style="list-style-type: none"> <li>• Project charter</li> <li>• Current state situational summary</li> <li>• Gap analysis between current state and target benchmark</li> <li>• Identification of process improvement opportunities</li> <li>• Prioritized initiatives and implementation Workstreams</li> <li>• Desired performance expectations/ targets – financial, quality and operational</li> </ul>	<ul style="list-style-type: none"> <li>• Solutions and/or design specifications including workflows, process maps, governance structure, etc.</li> <li>• Benefit realization methodology and plan</li> <li>• Detailed implementation work plan</li> <li>• Training plan and materials</li> </ul>	<ul style="list-style-type: none"> <li>• Updated implementation work plan</li> <li>• Risks and Issues log</li> <li>• Project dashboard and status report</li> <li>• Value realization</li> <li>• Transition plan</li> <li>• Lessons learned</li> <li>• Monthly measurement updates</li> <li>• IMPLEMENT!</li> </ul>
	<b>Completed Phase I Assessment</b>	Work with County Leadership team to identify the best resources for Phase II & III.	

# PHASE II – DESIGN AND BUILD FUTURE STATE

## Design and Build Future State

- The second phase of the engagement is to “Design and Build” the future state.
- During this phase, Navigant staff will design and develop practice processes and infrastructure that will be implemented in the clinics to support the new model of operations.
- This may include and is not limited to the development of the following:
  - Organizational charts
  - Job descriptions
  - Clinic workflows
  - Clinic policies and procedures
  - Job aids, and training materials.
- This work will be done on and offsite, and we anticipate this work will take 4 to 5 months to complete.

# PHASE III – IMPLEMENTATION

## Implementation

- The Navigant team will return onsite to the clinics and begin the implementation phase of the engagement.
- This is the culmination of all previous work and results in the actual realization of the future state design in the clinics.
- The Navigant team will provide overall project management, guidance, support, and work side by side with clinic leadership and staff to implement the new processes.
- Once implementation is completed, we will transition all activities to the clinic leadership and staff.
- We anticipate the implementation phase will last approximately 6 to 8 months.

# ESTABLISHING PROJECT ORGANIZATION

- Navigant team will report directly to the MCHD Executive Sponsor.
  - Navigant's Engagement Director will be the primary point of contact, meeting with MCHD Leadership Team on a recurring basis to provide status updates pertaining to our team's progress and accomplishments during the tenure of this engagement.
- We envision the development of a small Steering Committee (5 - 6 individuals), led by an Executive sponsor, that is composed of internal stakeholders representing various constituencies (by staff level and skill set) from the Mecklenburg County Health Department and clinic whose responsibilities will be to provide overall direction and oversight of the project.
- We would propose the creation of implementation teams for each of the six Workstreams.
  - Each Workstream will be responsible for the following: providing bi-weekly status updates, conduct integration sessions to identify synergies and opportunities, prioritize initiatives, and execute improvement actions across their functional areas.
  - Workstream leader will partner with specific clinic leader to:
    - Conduct a deeper dive analysis.
    - Engage appropriate individuals directly with future state design.
    - Obtain support involving implementation actions / initiatives around each of the Workstreams.

# ENGAGEMENT TIMELINE FOR PHASE II AND III

	2017						2018		
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
<b>Phase II: Design and Build Future State</b>									
<b>Workstream</b>									
Electronic Medical Records (EMR)	█	█							
Clinical Care Model and Delivery	█								
Customer Care Center	█	█	█						
Laboratory Management Affiliation Option	█	█	█						
Executive and Management	█	█	█						
Enhance Quality Programs	█	█	█						
<b>Phase III: Implementation</b>									
<b>Workstream</b>									
Electronic Medical Records (EMR)			█	█	█	█			
Clinical Care Model and Delivery		█	█	█	█	█	█	█	█
Customer Care Center				█	█	█	█	█	█
Laboratory Management Affiliation Option				█	█	█	█	█	█
Executive and Management				█	█	█			
Enhance Quality Programs				█	█	█	█	█	█

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