

Mentorship: *Getting by with a little help from our friends*

Most participating health centers recognized the value of mentorship during PVRC. Teams may receive mentorship from: (1) an expert team that coaches health center teams in their redesign efforts using telephone, e-mail, or other support as necessary; and/or (2) a sister team (a health center participating in the collaborative at the same time).

- Mentorship provided teams with support between sessions, when teams felt they needed the most help.
- Many health centers that connected with a sister team felt that this experience helped to build a strong relationship between regional health centers that would not normally have interacted outside PVRC.
- Some teams that chose not to connect with a sister team for fear that geographic distance would present a barrier to effective mentorship and communication now realize that they may have missed out on valuable help and encouragement.

Participant advice:

- Encourage the use of sister teams.
- Consider involving participants from previous collaboratives as mentors for new participants.
- Encourage teams to utilize technology (e-mail, Internet, phone), especially where geographical distance makes it more difficult for participants to meet with others.



Evaluation: *The wheel never ends*

Both a necessity and a challenge, evaluation can provide valuable results to participating health centers before, during, and long after PVRC.

- Many health centers administered quarterly patient satisfaction surveys both during the PVRC experience and after.
- Informal evaluation (conversations with patients and staff) provided some health centers with extremely valuable feedback as they progressed through PVRC.
- Although health centers recognize the importance of collecting on-going data (such as patient visit cycle time and provider productivity), many community health centers believe the task is daunting, or to some, impossible in the community health setting.
- Many health centers now administer staff satisfaction surveys as a result of their PVRC experience.

Participant advice:

- The final collaborative session is not “the end” and should not be treated as such.
- Health centers should continue to monitor staff and patient satisfaction after PVRC and make continual improvements to patient care and organizational culture.
- Even if not all the processes developed during redesign (e.g. use of walkie-talkies) are sustained, health centers should continue to brainstorm new ideas and test those ideas just as they did during PVRC.
- Program planners and presenters should better emphasize some of the positive and negative outcomes that teams might expect in the “post-PVRC” period and offer recommendations for continuous evaluation.

Conclusion: *Lasting Impressions*

The Patient Visit Redesign definitely left lasting impressions in every participating health center. While not all participants viewed their experience positively, many participants viewed PVRC as a great learning experience. Some of the positive outcomes of the PVRC experience include:

- Increased confidence in employees’ abilities
- A decrease in staff turnover since PVRC was implemented, due to management structure changes, employee empowerment, and overall positive changes in organizational culture
- A greater willingness by staff to share their ideas
- The opportunity for patients to get to know the members of a care team and see the *team* as the provider, not just the *doctors*

“It was a lot of work and very rigorous, but we realize now that it was ‘positive pain’.”

Lessons Learned Brief

Prepared by:
Center for Collaborative Research in Health Outcomes & Policy
Michigan Public Health Institute
May, 2003



Introduction

The Patient Visit Redesign Collaborative (PVRC), an initiative of the Bureau of Primary Health Care’s Quality Center, is an innovative approach to improving the quality of today’s health care. Seventy-nine health centers from five regions of the United States participated in PVRC between 1998 and 2001. All participating health centers were given the same goal: to dramatically reduce cycle time for patient visits while increasing productivity. What makes the Patient Visit Redesign Collaborative so innovative and unique is the opportunity for staff to share their ideas, test these ideas, make decisions, and solve problems that may have existed for years within the organization.

Collective Lessons Learned

Participating health centers reported on lessons learned from their experience in the Patient Visit Redesign Collaborative. Because the participating health centers varied widely, many of their lessons learned were unique. However, there were several areas of overlap across participating health centers.

Resistance to Change: *After all these years, you want me to do what?*

The most common barrier to successful adoption, implementation, and institutionalization of PVRC was *resistance to change*.

- Participants in PVRC committed to making major changes, such as formation of care teams, shifting responsibilities, and even changes in direct patient care, but human nature causes us to be apprehensive about change.
- Long-term employees and physicians seemed to be the most resistant to change.
- Some PVRC team members felt resentment from co-workers. For example, some employees felt that the PVRC team members were not handling a fair share of the work while they were testing their redesign ideas and others were expected to carry on as usual.
- Employees at some health centers resisted by saying, “It’s not my job” when asked to take on additional or new tasks during the redesign process.

Participant advice:

- To better prepare for and respond to this resistance, program planners should address the reality of this issue in greater detail during training sessions and within training materials.
- Administrators should hold providers accountable, not just nursing, clerical, and other staff. For redesign to work, it cannot be optional.

- Seek buy-in from all members of the organization, from top administrators to all staff positions.
- Explain to staff why the organization chose to undertake PVRC and assure them that, if done successfully, the program will increase patient and staff satisfaction.
- Involve key management personnel in all activities as to increase administrative and staff buy-in, and involve physicians to decrease resistance among providers.

Financial Challenges: *Making ends meet*

Although most participating health centers felt that the initial monetary investment in PVRC (e.g., travel and equipment costs) was worthwhile, given the nature of health care today, it is no surprise that participating health centers faced financial challenges during their experiences with PVRC.

- Turnover is naturally high in the community health setting, and can present a major challenge during the PVRC process.
- Because PVRC typically involves the formation of care teams (one provider and several nurses and assistants), leave time becomes an issue. For example, when a member of a care team takes sick leave, it disrupts the care team system.
- PVRC is difficult to implement and sustain without adequate staffing and proper computer (information technology) and telecommunication systems.

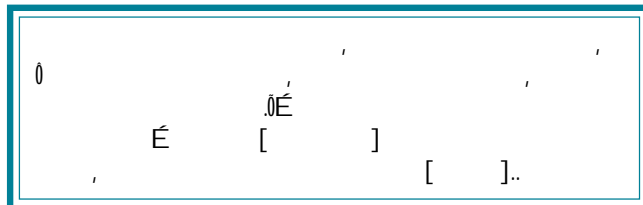
Participant advice:

- To raise awareness and provide participating health centers the chance to prepare for financial challenges, program planners and collaborative presenters should address these particular issues during collaborative sessions and within program materials.
- Although financial challenges are inevitable, it is possible to make up for initial financial investments by seeking special funding in the form of grants and awards. At least two participating health centers received grants in recognition of their innovative efforts to improve health care.

Adapting PVRC to Meet Local Needs: *Apples and oranges*

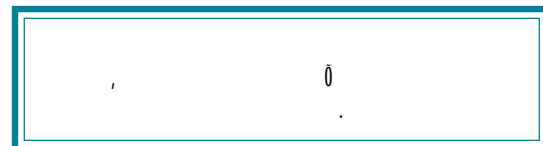
Many health centers entered the Patient Visit Redesign Collaborative without a firm understanding of the model and the need to adapt it to meet specific local needs.

- The PVRC model is just that; a model. However, when they first started PVRC, some health centers expected all aspects of the model to fit perfectly into their unique situations.
- Although participants were encouraged during collaborative sessions to insist that administration meet their needs, many became frustrated because (1) administrators did not fulfill these requests, (2) they lacked knowledge about how to carry out PVRC without this support, and (3) if they were not successful, they looked like failures.
- According to some respondents, collaborative presenters also advised participants to terminate employees who refuse to adapt to or go along with PVRC. However, this may not be possible at rural or remotely located health centers due to a lack of qualified healthcare workers in the area. These health centers were often left to ask the question, “What now?” when faced with opposition from a staff member.
- Organizations that rotate providers and other staff between sites may have a slight disadvantage in the PVRC process because not all sites may use or even be familiar with PVRC.



Participant advice:

- Prior to starting PVRC, health centers must understand that no two health centers are exactly alike—what works at one center may not work at another.
- From the beginning, PVRC teams must not expect to receive everything they are promised, but have a back-up plan ready.
- Teams should tell administrators, from the start, if they cannot provide



the requested resources and support, they must communicate that in an honest fashion to the PVRC team.

- Program planners and presenters should avoid imposing unrealistic expectations on participants. Instead, give them the opportunity to create their own expectations, by choosing only those ideas from the model that will fit appropriately with their local situation.
- During collaborative sessions, program planners and presenters should address ways in which health centers can fit “rotating” staff into PVRC.

Team Member Selection: *Eeny, meeny, miney mo..*

Teams typically consist of one team leader and four team members. Selecting team members may seriously influence how the team functions and thus the success of PVRC.

- Teams led by a very organized person tended to be more successful.
- Some team members felt that their team experience was not as beneficial as it should have been. For example, some team members were frustrated because they had little flexibility or free-time on trips to collaborative sessions; others felt that they were not fairly compensated or recognized for their efforts and contributions to the organization.
- Teams that included a member of management or administration generally believe that this was a good decision because (1) the more visible an administrator, the more staff felt that there was strong organizational support for their efforts; (2) managerial-level decisions were made in a timely manner, and (3) all levels of employees would be held accountable for the changes occurring through redesign.

Participant advice:

- Select a very organized person to be team leader—one who can delegate tasks, commit to the position, and pick up other team members’ slack when needed.
- Empower team members by giving them the recognition they deserve and the chance to be a part of the travel-planning process.
- Include administrators in the PVRC team (as members, not leaders)

A Realistic Scope: *Think big, but start small*

Some participating health centers felt that their biggest mistake was attempting to implement PVRC in too large a setting.

- Many participating health centers are not stand-alone clinics. Instead, they are just one site within a larger organization or health care network. The term commonly used during collaborative sessions was “clinic,” however the use of this term caused confusion among some participants.
- For example, one health center was confused by the term “clinic,” since their building houses several clinics (pediatrics, adult, etc) that are all part of one organization. Were they to redesign all clinics, or choose one and work their way out to all others?
- Another health center tried implementing PVRC in all of the clinics within the organization at once. Afterward, they realized they had “bitten off more than they could chew.”
- A third example of starting too large is the health center that implemented PVRC at their largest clinic (the one with the greatest number of problems) but later realized that this was a poor decision.

Participant advice:

- Program planners and presenters should clarify what they mean by “clinic,” or use another word altogether when describing the redesign process. Perhaps presenters can work with each participating team to determine how large or small a scope is most appropriate for their local circumstances.
- In addition, program planners should discuss this issue with participants before team member selections are made, so teams are made up of organizational members from the appropriate site.
- Although the largest site within a multi-site organization may experience the most problems, organizations may benefit by first trying PVRC in a smaller site.