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PROMOTING INTERPROFESSIONAL COLLABORATION THROUGH DEVELOPMENT OF AN ORGANIZATIONAL STRATEGY TO IMPROVE INTRA-ORGANIZATIONAL REFERRALS AT SCENIC BLUFFS COMMUNITY HEATH CENTER

A Graduate Project Submitted in Partial Fulfillment of the Requirements for the Degree of Master of Public Health

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PROMOTING INTERPROFESSIONAL COLLABORATION THROUGH DEVELOPMENT OF AN ORGANIZATIONAL STRATEGY TO IMPROVE INTRA-ORGANIZATIONAL REFERRALS AT SCENIC BLUFFS COMMUNITY HELATH CENTER

By Kate C. Noelke

We recommend acceptance of this thesis in partial fulfillment of the candidate's requirements for the degree of Master of Public Health – Community Health Education

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ABSTRACT

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This graduate project details the development of a foundation for organizational strategy aimed at improving the intra-organizational referrals and interprofessional collaboration at Scenic Bluffs Community Health Center in Cashton, WI evolving out of the author's preceptorship-related strategic planning responsibilities. Guided by the identification and prioritization of the need which was identified in alignment with the organization's health care quality improvement and Patient-Centered Medical Home (PCMH) goals, a needs and capacity assessment was completed to identify already-established areas of strength and weakness related to the goal of improving intra-organizational referrals. Based on qualitative focus groups and key informant interviews, pre-pilot and pilot protocols were developed to test specific language and situations and their potential for prompting intra-organizational referral opportunities. Development of a web-based toolkit for defining and improving intra-organizational referrals at SBCHC was guided by the findings from the pilot protocol. It was the intent of the author and of the organization that the toolkit would be available for use by other health centers with the strategic goals of improving health care quality, attaining, and maintaining PCMH status by improving intra-organizational referrals.

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INTRODUCTION

Overview

Description of Scenic Bluffs Community Health Center

Scenic Bluffs Community Health Center (SBCHC) is a federally qualified, not-for-profit, rural, community health center located in Cashton, WI. Established in 1993, SBCHC provides community-based care, serving the Wisconsin counties of Monroe, La Crosse, Vernon and Crawford (see Appendix A for a map of the SBCHC service area). Governed by a volunteer board of directors made up of at least fifty-one percent patient consumers, SBCHC is an integral partner in the communities it serves working closely with local organizations, public health departments, school districts and police and fire departments to forward the wellness of rural Western Wisconsin. As an independent, non-profit primary care clinic known as a federally qualified health center (FQHC) operating under Section 330 of the Public Health Service Act, Scenic Bluffs is an important part of the primary care infrastructure in the U.S. Health Care System (SBCHC, 2014).

SBCHC seeks to provide health care with a focus on holistic health through comprehensive and collaborative medical, dental, chiropractic, behavioral health and pharmacy services in the rural communities for patients who need it no matter whether or how they can pay (Scenic Bluffs Community Health Center, 2014). See Appendix B for a SBCHC Fact Sheet. Scenic Bluffs also seeks to meet the health care needs of the isolated

elderly, Old Order Amish, New Order Amish, Medicaid dental patients, and Spanish-speaking groups in Western Wisconsin. In 2013, SBCHC provided 25,991 appointments to over 8600 patients for medical, dental, chiropractic, and behavioral health services. At the time of this work, seventy-one percent of the patients served lived below one hundred percent of the federal poverty level. Forty-six percent of the patients were eligible for Medicaid coverage. Over six percent of the patients were best served in Spanish, and almost eight percent of the patients were Amish. A summary of 2013 statistics for SBCHC is provided in Appendix C.

Introduction of the Patient-Centered Medical Home Model

Meeting people where they are and providing the highest quality of holistic health care is the continuing challenge and goal for Scenic Bluffs Community Health Centers. Because of the staff's dedication to this mission, SBCHC has achieved the Patient Centered Medical Home (PCMH) recognition from within the health care system. SBCHC is recognized as a level-three Patient Centered Medical Home by the National Committee for Quality Assurance (NCQA). The patient-centered medical home model is a method of organizing primary care and its delivery that emphasizes care coordination and communication measures to make primary care more of what patients want it to be which is a holistic, organized home or center for receiving health care and health education (NCQA, 2014). Peikes, Zutshi, Genevro, Smith, Parchman, & Meyers, (2012), report that the goal of the PCMH model of care is to reinvent primary care to offer Americans with one place or doctor who provides primary care and coordinates care with other providers and specialists. PCMH aims to make primary care "accessible, continuous, comprehensive, and coordinated" while being delivered in the context of

family and community and in doing so, will improve quality, affordability, and patient and caregiver experience as well as health care professional experience" (Peikes, et al., 2012, p.1). It is also widely considered a cost-effective solution for health care (Ewing, 2013) because it emphasizes collaborative care, prevention and continuity of care through close medical provider relationships. It is the management principles of this approach to medicine that have demonstrated lower costs and higher-quality healthcare for patients with chronic disease (Robert Wood Johnson Foundation, 2012).

The NCQA model of PCMH is the most widely used and accepted and has been found to increase quality and reduce costs of primary medical care by a number of research studies (Grumbach & Grundy, 2010; NCQA, 2012; Patient Centered Primary Care Collaborative, 2009; Robert Graham Center, 2007). Through the incorporation of technology and dedication to coordination of care providing a basis for the system, the NCQA model for PCMH's evaluation requirements measure six recognition categories of aspects of care delivery comprised of enhancing access, identifying and managing populations, planning and managing care, providing self-care support and community resources, tracking and coordinating care, and measuring and improving performance (Ewing, 2013; NCQA, 2014). NCQA PCMH recognition is the most widely-used way to transform primary care practices into medical homes. The highest level of PCMH recognition for a medical center (level-three recognition) was earned and achieved by SBCHC on January 29, 2013. It will last for three years until January 29, 2016. As a part of ongoing process and quality improvement, and to maintain PCMH standards and the highest quality of care standards, SBCHC undertakes strategic planning on a tri-annual basis.

Rationale for Conducting the Project

Rapid organizational improvement is a goal of many health care organizations. A method for organizing and documenting improvement, strategic planning refers to the regular process of organizational evaluation, revision and goal setting that define an organization's strategy and direction. Strategic planning also helps companies identify, prioritize and track areas for improvement identified. Strategic objectives are the specific, measureable, attainable, realistic and timed action steps proposed to address specific areas in need of improvement, as identified through strategic planning.

On January 15, 2014, administrative leadership, clinical management, the Board of Directors, and key department managers and personnel at SBCHC began the strategic planning process for the three year timeline for 2014 through 2016. The author was involved in the process of strategic planning as a part of the preceptorship experience. Important components of the strategic planning process for organizational development and quality improvement includes the consideration of how to maintain and improve upon organizational performance standards and protocols. Continued recognition as a level-three PCMH is an ongoing goal of SBCHC and as such, many PCMH criteria and recognition categories are represented in the strategic goals and objectives of this organization. Intra-organizational referrals were identified as an area of organizational improvement that could be improved at SBCHC. Eventually, the need for the graduate project emerged from the author's preceptorship-related involvement in the strategic planning process and the identification of intra-organizational referrals as a priority area for organizational improvement under the auspices of the PCMH guidelines.

Interprofessional collaboration is an important component of a successful health care home operating as a PCMH and also an area of emerging research in health system quality improvement (Agency for Healthcare Research and Quality (AHRQ), 2013; Buhler, Farrell, Fuentes, Scott, Shaffer, &Von, 2011; Capella, 2013; Goldman & Borkan, 2013; Tailani, Bricker, Adelman, Cronholm, & Gabbay, 2013; Wooten, Harno & Repornen, 2003). NCQA's PCMH standard number two outlines team-based care and specifies that in order to meet this requirement, "the practice must provide continuity of care using culturally and linguistically appropriate, team-based approaches" (NCQA, 2014, p.37). Further, the elements specified include continuity, medical home responsibilities, and culturally and linguistically appropriate services, and the practice team (NCQA, 2014).

In each of these elements, interprofessional collaboration is necessary to achieve a passing grade for the PCMH requirements. It is inherent to a PCMH-recognized health center. As such, adherence to the PCMH model and improved patient care are major goals of SBCHC. Objectives set by administrative leadership at SBCHC for the strategic planning preparation as a level-three PCMH include evaluating progress toward quality improvement and systems/protocol maintenance, improvement and implementation of process improvement strategies across all departments within the patient-centered medical home model, as well as improved interprofessional collaboration.

Statement of Purpose

Through the process of strategic planning (described in greater detail in Section II) which was a preceptorship-related responsibility of the author, interprofessional communication, specifically intra-organizational referrals, were identified as a specific

areas of communication strategy that needed organizational improvement at Scenic Bluffs Community Health Centers in March of 2014 for the 2014-2017 strategic plan tri-year timeframe. The identification and further prioritization of this area for improvement as a strategic objective resulted in in-depth evaluation and discussion with SBCHC departmental managers, executive leadership and the SBCHC Board of Directors and the author focusing on what specific strategies could be used to improve intra-organizational referrals within SBCHC. These discussions taking place as a preceptorship-related responsibility of the author evolved into an initiative to improve interprofessional communication within SBCHC. This natural evolution of identifying a need through the strategic planning process shed light on the importance of intra-organizational referrals to SBCHC. In March 2014, the need to address intra-organizational referrals was written into the formal strategic plan document for 2014-2017 as a strategic objective which reads, "Strengthen intra-departmental referral practices and develop protocols to assure patients have access to the range of Health Center services they may need." Specifically, through a discussion which took place between the executive director, the SBCHC Board of Directors and the author, a goal was set to establish a pilot protocol, observe, measure and evaluate progress towards implementation and maintenance of a new system for providing intra-organizational referrals to be implemented before the end of 2014. Based on recent studies and the expectation of the staff at SBCHC, it was intended that increased intra-organizational referrals would lead to increased interdepartmental communication, cross-departmental communication, and better interprofessional collaboration which would in turn lead to better patient retention, better continuity of care, and ultimately improved patient outcomes (Grumbach & Grundy, 2010; PCPCC,

2009; Tailani, et al., 2013; Zuckerman, et al., 2013). In summary, as a result of the identification of the need for an improved process for intra-organizational referrals and the author's desire to contribute to the process of developing a systematic plan to address this issue, the idea for this graduate project evolved from the author's preceptorship responsibilities.

Goals for the new strategy for improving intra-organizational referrals included: improve the progress towards the goals of the patient-centered medical home model, improve interprofessional collaboration, and improve personnel retention. Another goal was for this project to contribute to the efforts of SBCHC to maintain its recognition as a National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home (PCMH). It is significant that improving interprofessional organization and intra-organizational referrals was identified inductively and organically through the strategic planning process as an area that many staff members wanted to improve. There was no prescription to improve these processes. Instead the idea came naturally from the strategic planning conversations with the staff doing the work of SBCHC led by the author as a part of her preceptorship responsibilities. Not only did the idea to improve this area to be improved come from the staff members, but moving into the development of the program as the author's Graduate project (as described in Section II), so did the ideas for how to improve it. This type of organization-wide, collective focus directly supported the PCMH model and what is expected of a community health home, especially one that has achieved the highest level-three PCMH status. This systematic effort could contribute to improvement of the patient-centered focus, as well as the coordinated-care focus of the community health center and PCMH (Grumbach & Grundy, 2010; PCPCC, 2009). It is

significant that through the process of strategic planning as a preceptorship-related responsibility of the author, a need was identified and prioritized by the staff and Board of Directors at SBCHC. The continued interest of the author and the executive director in how to develop a system to address this issue later led to the development of this graduate project by the author. The purpose of this project was to develop the foundation for a new, systematic method for improving intra-organizational referrals at Scenic Bluffs Community Health Centers.

Significance and potential impact. The development and implementation of this project which was to examine and improve the system for making intra-organizational referrals had the potential to lead to improved interprofessional collaboration and communication throughout Scenic Bluffs Community Health Center. Implementation of the new ideas and standards also had the potential to improve the sustainability of the PCMH designation by complementing the important goals of team work, improved continuity of care, process evaluation and improvement within the healthcare organization, improved employee satisfaction and ultimately, improved patient outcomes as delineated by the PCMH guidelines (NCQA,2014).

Direct impacts of the initiative to improve intra-organizational referrals included:

- Increased opportunities for staff training (as requested by staff members in strategic planning interviews)
- Prioritization and action toward addressing areas for improvement as identified by the staff members
- Increase engagement of staff through the Plan-Do-Study-Act (PDSA) process for developing, testing and evaluating a change

- Improved organization-wide communication and employee satisfaction
- Improved continuity of care, care coordination and patient care outcomes

These potential impacts to SBCHC represented significant changes that were initiated by the staff members through the sharing of opinions during the strategic planning interviews which took place during the author's preceptorship. These potential impacts also represented significant potential change that was guided and evaluated by the staff members though the process of pre-piloting and piloting new ideas during the development of the author's graduate project. Ultimately the potential changes were identified, explored, evaluated and revised with input from the staff at SBCHC. This type of staff -initiated organization-wide change was guided by feedback collected in careful steps which included prioritization of issues, development, and implementation of the pilot testing ideas for change. These systematic steps were also effective measures that could contribute to the leadership goal of improving transparency and communication within the organization having included the staff in each step of the process which was important to SBCHC managers and staff members.

Definition of Important Terminology

Anthropological Methodology: Anthropology explores the complexity of human interactivity (Goldman & Borkan, 2013). Combining humanist and social sciences, ethnography is "the qualitative process of exploring in depth the whys and hows of human culture, behavior and expression" (Goldman & Borkan, 2013, p. 1). Using this method, researchers gain insights by studying a topic "in person, in situ, over time, and from diverse perspectives" (Goldman & Borkan, 2013, p. 1). In the context of health care, this can include interviewing and observing doctors, nurse practitioners, dentists,

registration professionals, clinical assistants, dental hygienists, office managers, and patients to explore the ways in which they experience and understand concepts such as care coordination or quality improvement (Goldman & Borkan, 2013).

Interprofessional: a term for exchange of knowledge, cooperation, collaboration, efforts or communication between separate professional groups. For example, communication between a physician and a pharmacist in reference to an individual patient or topic are interprofessional communications.

Intra-organizational: a term for exchange of knowledge, cooperation, collaboration, efforts or communication between different departments or persons within one organization. For example, a referral made from a hygienist in the dental department for a dental patient of SBCHC to a health care practitioner in the behavioral health department of the same organization for counseling treatment is an intra-organizational referral.

Intra-organizational Referral at SBCHC: a referral to any service, department, provider, community event or activity put on by SBCHC and SBCHC staff members, whether or not an appointment was made, not exclusive to billable services such as an appointment with a physician for throat pain, or a chiropractic adjustment, but also including referrals to enriching or prevention services such as community wellness activities, monthly specials, workshops and health fairs.

Motivational Interviewing: Motivational interviewing (MI) is defined by Miller and Rollnick as a collaborative conversation style designed to resolve ambivalence and strengthen a person's own motivation and commitment to change (2013). MI is described as a counseling style whereby a person's values, goals and inherent motivations are explored in an effort to elicit the change process from the person's own ideas and

reasons. It is significant that MI practitioners use open ended questions, reflective listening, empathy, and do not judge the patient to create a constructive, open atmosphere for these conversations to take place in (Miller & Rollnick, 2013).

PDSA Cycle: PDSA is a four-stage problem solving model used for improving a process or carrying out a change (Minnesota Department of Health, 2013). When applying PDSA, three questions are asked which include: what are we trying to accomplish, how will we know the change is an improvement, and what changes can we make that will result in an improvement (Minnesota Department of Health, 2013). PDSA provides a framework for identifying and implementing rapid cycle improvement.

Strategic Planning: a method for organizing and documenting improvement, strategic planning is the regular process of organizational evaluation, revision and goal setting that is used to define an organization's strategy and direction. Strategic planning also helps companies identify, prioritize and track areas for improvement (McNamara, 2013).

Literature Review

Introduction

As a preceptorship-related responsibility of the author, the strategic planning process provided the context for establishing a priority and setting a goal to improve intra-organizational referrals within the larger organization. Transparency and staff involvement in strategic system improvement are important factions of communication and engagement at SBCHC. The staff initiated idea which led to the effort led by the author to develop a systematic method to improve intra-organizational referrals included input from key staff members of the health center throughout every step of the process. Having the staff members engaged in improving the processes they would use on a daily

basis to do the work of SBCHC had great potential to be achieved at SBCHC during the process of development of a model. This effort also had the potential to lead to improved interprofessional collaboration and this type of collaboration is strongly tied to the daily operation of the PCMH. Further, the implementation of a systematic program designed to improve intra-organizational referrals had the potential to contribute to the collaboration between professions at SBCHC.

Collaboration maintains the highest degree of connectivity of strategies for working together as presented by the Himmelman model for relationships. Collaboration includes extensive time commitments, very high levels of trust; enhancing collaborating partners' capacity to achieve a common purpose is the goal. As compared to networking, coordinating and cooperating, collaborating is formal and requires full sharing of resources, risks, responsibilities and rewards (Gilmore, 2012). Interprofessional collaboration is what the staff members at Scenic Bluffs told the author they wanted as described during the strategic planning process.

Guided by the preliminary, preceptorship-related strategic planning, a systematic toolkit for providing and improving intra-organizational referrals was established as a working component of how to improve the greater performance and quality of care provided by Scenic Bluffs Community Health Centers. In order to understand fully what different methods and protocols have been used successfully by other organizations and health centers, a review of literature was completed. Multiple studies' outlined the importance of intra-organizational referrals and findings included positive outcomes that resulted from efforts to prioritize and systematically complete intra-organizational referrals.

When protocols and strategic systems are in place for mediating interprofessional communication and intra-organizational referrals, these systems can lead to great successes for organizations. Maurer, Bartsch and Ebers (2011) did a study of 218 projects and found that the transfer of knowledge between organization members mediates organization performance outcomes of growth and innovative performance. Further, that accounting for and mediating process steps that translate social capital and interprofessional communication into organizational performance outcomes are needed (Maurer, et al., 2011). Another study that supports the strategic goal set by SBCHC staff members and leadership to improve intra-organizational referrals states that healthcare practices require interprofessional communication, referral and patient follow-up services to provide the highest quality of care. To highlight the importance of this practice, Buhler, Farrell, Fuentes, Scott, Shaffer, and Von (2011) call for health profession schools to train students to be prepared for the reality of the interprofessional healthcare workplace by offering referral training education.

McDonald, Davies and Harris (2009) suggest that improving collaboration and coordination in community health and primary care settings is a national priority. The PCMH model requires a great degree of care coordination and interprofessional communication. Patrick, Bisgaier, Hasham, Navarra, and Hickner (2011) state that "coordination of specialty care is a core function of the primary care medical home," and further suggest there is a need for focused systems to improve intra-organization referrals and interprofessional communication in the current health care system (p. 1303). This study supports the frustration felt by the staff members and providers at SBCHC with regards to the referral process and results.

The Interprofessional Education Collaborative Expert Panel (2011) provides best practices for improving collaborative health care practice. The Core Competencies for Interprofessional Collaborative Practice document (available for viewing at http://www.aacn.nche.edu/education-resources/ipecreport.pdf) aligns best practices for interprofessional communication with strategies, values and competencies for health care practitioners and health center personnel. The competency domains outlined by this group include values/ethics for interprofessional practice; roles/responsibilities; interprofessional communication; and teams and teamwork. Each of these domains outlines the importance of understanding of the roles and referrals between departments to the greater health care center. Specifically domain three, interprofessional communication, is dedicated to enhancing understanding between people and departments to provide the optimal level of care for the patient.

Interprofessional Care/Case Conferencing

Guided by the spirit of these competencies, some of the most successful strategies used by other health care organizations to remedy the referral problem and fill this need are simple and succinct. Strategies suggested include interprofessional care/case conferencing, the use of written or electronic care plans as a tool, designating care or referral coordinators (sometimes health educators) to manage patient referrals, engaging in office-based peer review, using electronic referral software, development of checklists for use during exams, development of standardized referral forms, organizational retreats, journal clubs and education “rounds” within an organization. Each strategy is uniquely aligned with the goal of improving referrals to improve interprofessional collaboration and ultimately the level of health care provided and patient health outcomes.

One strategy for improving intra-organizational referrals is to initiate interprofessional care conferences with regard to specific patients of a health center. For example, within a health care organization, before a patient's annual health exam date, his/her primary care physician would meet with his specialist, dentist, and chiropractor or other involved health care practitioner to discuss and prepare how to best serve the health care needs of the individual. Goldman, Meuser, Rogers, Lawrie, and Reeves (2010) describe organizational initiatives to enable interprofessional dialog and report that interprofessional case conferences or case management rounds wherein members of the greater health care team from multiple departments met to discuss, develop and adjust interprofessional care plans for individual patients improved intra-organizational referral likelihood. The collaborative case review program brought success in that study as a first step toward improving interprofessional collaboration. Similarly, findings from a Capitation Management Report show the cost savings associated with peer review systems of cases within a greater health care organization and also the improvement on referrals between departments (2000). From the author's perspective, these studies suggest that regular, interprofessional review of cases and patients can also improve provider empowerment whereby the doctors, nurses and professionals involved in patient care gain greater connection to their respective purposes and individual roles in patient health outcomes. These studies also suggest that improving interprofessional collaboration also may result in observed reduction of the costs associated with the health care system in the U.S. (Goldman, et al., 2010).

A potential barrier to this method is the segregation of departmental resources within some organizations. For example, resources such as time and money are

sometimes managed so closely within organizations that sharing is discouraged by the division of such resources. Health care providers may feel that these interprofessional conferences should be contributed by or paid for by one department versus the other.

Using the Electronic Medical Record

Another strategy to improve intra-organizational referrals is the implementation and consistent use of interprofessional care plans and referral protocols through the electronic medical record (EMR). In this strategy, the EMR of an individual patient is available to all health care practitioners and a protocol is developed wherein referrals are sent between departments and specialty areas and associated with an email or some type of notification to the intended department. Shared EMR usage and e-referrals are referenced in several contemporary studies as an expected component of an effective protocol (Goldman, et al., 2010; McDonald, Davies & Harris, 2009; Wootton, Harnoa and Reponen, 2003; Heimly, 2009).

In one example, Goldman et al. (2010) report a successful use of the EMR for referrals in which a physician, nurse and dietician entered and shared patient information thereby avoiding duplication of effort as an added benefit of this system (2010). For example, a patient is seen by his nurse and during the appointment after his weight is measured, he expresses to the nurse that he wants to address his weight by learning healthier eating habits. The nurse discusses the option of making an appointment with the dietician with the patient and makes note in the EMR of her discussion and the referral. The nurse then sends a personal communication or the referral tool provided in the EMR, to a dietician within the organization with instructions to call the patient to set up a time to meet. Through the EMR, the dietician can see the notes the nurse made about the

discussion regarding maintaining a healthy weight. For this to work, each health care practitioner must be able to count on the consistent use by other providers within the organization of the EMR for communication and improvement of the individual patient's continuity of care. A potential barrier to this system identified is the differing functions of EMRs used within certain health care homes. For example, this method would be challenged in a PCMH where the dental EMR is separate from the medical EMR.

Standardized Referral Forms

Among the simplest of protocols for improving referrals within an organization are the development of a standardized referral form template and the development of a checklist template to be used by health care practitioners during exams. Both of these strategies rely upon a printed form developed to be between health care departments during a client's appointment. A checklist is developed to be used during a patient's annual dental exam including standard exam procedures and a reminder for the heath care practitioner make a referral if appropriate. This method was referenced in the study completed by Goldman et al. in 2010.

Jones, Lloyd and Kwartz (1990) provide an historical perspective of the effectiveness of a standardized referral form and also a best practice for developing one. These two simple strategies represent low-tech ways to engage staff and health care providers in continued communication around patient care by promoting use of tools that can be highly personalized to the needs of the health care organization and the individual patients. A barrier to a paper-based approach to referral making is the greater shift toward electronic resources including the electronic medical record in the health industry and automated license plate registration at the department of transportation.

A Role Dedicated to Care Coordination

A final strategy to improve intra-organizational referrals outlined in the related literature involves establishing a position for a person on the health care team who is dedicated to care coordination and referral coordination for patients of a health care organization. For example, after a patient checks in with the registration personnel at a clinic, he or she is greeted by their "care coordinator" who discusses the reasons for the visit, and asks if there are any other needs or concerns that need to be discussed. This person provides a front-line solution to improving communication with patients, and also takes on the role of a staff member who is held accountable for the continuity of care provided to the patients of a clinic. This person may refer a client in for a dental filling to a primary care provider if they are concerned that they might have strep throat. This referral or care coordinator is also responsible for completing referral follow-ups, appointment setting and continued communication between departments on the behalf of the patient.

Significantly, the certified health education specialist is an appropriate candidate for this new position because of his/her likelihood to participate in intra-organizational teams because much of the day-to-day work of the health educator is done in interprofessional teams (Lovelace, Bibeau, Donnell, Johnson, Glascoff, & Tyler, 2009). This method was found to be effective in urban community health centers (Patrick, et al., 2011). The major barrier to this strategy is the financial burden of hiring additional health center personnel as well as the introduction of a new position into established office politics of health care organizations (Tailani, et al., 2013).

Conclusion of Literature Review

This review of related literature demonstrates that there are several different strategies, systems, and protocols in use by health care organizations that aim to promote the improvement of intra-organizational referrals and also that each has benefits, as well as challenges. For SBCHC, the alignment of staff members' ideas for what will work for SBCHC with protocols that are being used elsewhere in the industry is an important consideration of the leaders of SBCHC goals for this initiative. Because of this important consideration, when developing a prototypic system for improving intra-organizational referrals at SBCHC, staff members were asked what strategies to improve intra-organizational referrals they thought would work at SBCC and these findings were compared to these strategies identified through review of related literature.

SECTION II

METHODOLOGY

Administrative Considerations

Introduction

During the period between January 15 and August 15, 2014, the author served as a preceptee to the executive director of SBCHC. The work for this project took place at her preceptorship site and evolved out of her preceptorship-related involvement in the three-year strategic planning process. Beginning in April, 2014, the author began the graduate project-related activities. She developed and coordinated a tool kit that provided systematic strategies that could be implemented and sustained to improve intra-organizational referrals and interprofessional communication at SBCHC. As a result of her preceptorship-related responsibilities, the idea for this graduate project emerged and took form.

Using descriptions of the data collected from in-depth, qualitative, key-informant interviews with the staff members and focus groups, evaluation of these needs and capacity assessment activities, and comparison between strategies available in contemporary literature with the ideas elicited from the staff, the author designed a pre-pilot, pilot and a protocol based on the identified priority to improve intra-organizational referrals at SBCHC. The author also provided findings from the pilot studies, evaluation of these findings, conclusions and recommendations based on the findings from the needs and capacity assessment and pilots to the executive director and staff at SBCHC for how

to implement the protocol into the daily activities already taking place at SBCHC. Related studies published in peer-reviewed health care journals served to support or challenge strategies chosen and implemented by SBCHC staff members (Goldman, et al., 2010; Jones, Lloyd and Kwartz, 1990; Lovelace, et al., 2009; McDonald, Davies & Harris, 2009; Heimly, 2009; Patrick, et al., 2011; Tailani, et al., 2013; Wooton, Harnoa & Reponen, 2003).

Management Support

Administrative support that was needed for development of this protocol and toolkit was comprised of cooperation and participation of staff members who were supported by their managers. This management support came from the culture already established at SBCHC to support the extra efforts of employees which also resulted in the support of the author's work aimed to improve processes within the organization. Without organization-wide support for this project, it might have failed and this type of organizational culture based on improvement is a building block of successful integration of this process improvement system. For example, managers of departments who didn't support open communication on the part of their employees might have resulted in incomplete or inaccurate data being collected by the author. Existing support at SBCHC for this initiative was strengthened by the culture of improvement, improving outcomes, and respect that was already strong and present at SBCHC that was perceived by the author throughout her experience.

Transparency

Transparency throughout all processes of conducting business was, and continues to be, an important administrative concern of SBCHC leadership. This project supported

the goal to improve transparency within SBCHC. It also improved communication which in turn assisted in sustaining transparency by incorporating staff involvement throughout the process.

Specific Personnel Responsibilities

Implementation of this initiative was dependent on continued participation by the general staff members during strategic planning and needs assessment phases. It also was dependent on the open and helpful attitudes of the PCMH coordinator, the executive director and the registration professionals during development and implementation of the pre-pilot and pilot programs. Finally, it was dependent on the ability of the staff to take responsibility for implementing a strategy they helped to develop, evaluate and choose within their daily work-lives at SBCHC.

Organization-wide acceptance and support for the implementation of the needs and capacity assessment, pre-pilot and pilot was necessary for a successful pilot implementation and subsequent evaluation of findings from the aforementioned methodological components. Individuals involved in focus groups and key informant interviews for the needs and capacity assessment included Jamie Mlsna, DevorahYahne, Jenny Nottestad, Colleen Daines, Terry White, Tricia Van Beek, Barb Mlsna and Sarah Havlik. Key informant interviews involved Dr. Trevor Lyons, Sherry Harris, and Terri Komay. The author also received special guidance from specific department managers involved in development of this proposal and protocol including Sara Martinez, a registered nurse and health educator from the medical department who led the efforts to achieve and maintain PCMH status, Colleen Daines, the dental department manager, and Mari Freiberg, the executive director of SBCHC.

The key staff members who participated in the needs and capacity assessment focus groups and key informant interviews and the development of the prototype, the pre-pilot, and the pilot were:

- Kate Noelke- author, preceptee
- Mari Freiberg- Executive Director
- Sara Martinez- PCMH accreditation leader, RN, health educator
- Jenny Nottestad- medical department manager
- Jamie Mlsna- clinical assistant
- DevorahYahne- laboratory professional
- Colleen Daines- dental department manager
- Terri White- dental assistant
- Tricia Van Beek- Registered Dental Hygienist
- Terri Komay- Registered Dental Hygienist
- Barb Mlsna- operations manager
- Sarah Havlik– registration professional
- Dr. Trevor Lyons- Doctor of Chiropractic
- Sherry Harris- Family Nurse Practitioner

With the guidance and assistance of these key staff members, the author was able to gain a clear understanding of the processes and procedures currently used at SBCHC as well as to collect the ideas for improving the procedures had by the staff.

Budget

The budget for this project was simple. All of it was provided in-kind by the author and the SBCHC organization because of the alignment with normal business and

quality improvement practices, and the author's preceptorship responsibilities. Budget considerations included transportation, presentation materials, and printing costs. A budget document is presented in Appendix D.

Transportation costs included gas mileage for the author to and from Cashton, WI for twice weekly trips from January 15 through August 15, 2014 based on the Wisconsin State business mileage rate is $0.56 per mile. The 31.4 mile trip to Cashton, WI can be accessed here: https://goo.gl/maps/D5Rw4. The total cost of transportation was $2,180.42 and was provided in-kind by the author.

Presentation materials were professionally printed by DigiCopy of La Crosse. DigiCopy was selected because of the established business relationship with UW-La Crosse and a student discount that was available. Presentation materials included a three foot by four foot poster board, three black and white, bound copies of the protocol, and ten spiral-bound, color tool kits with plastic covers. The poster board cost $78.00. The printed reports cost $16.00 each multiplied by three to equal $48.00, and the toolkit cost $9.15 each multiplied by 10 to total $91.50. The total cost of the presentation materials was $217.50.

Finally, although the toolkit was designed for dissemination via the world-wide web, printing costs were incurred when the report was drafted, and also when the forms for the pre-pilot and pilot were printed. The number of black-and-white sheets printed was 400 pages at $0.06 per page totaling $24.00. These printing costs were donated in-kind by SBCHC.

The total budget for the development of this protocol and toolkit was $2,421.92. Of this total, $2,397.92 was donated in-kind by the author, and $24.00 was donated in-

kind by SBCHC. The author was too late to submit a grant proposal regarding graduate student research at the University of Wisconsin-La Crosse.

PDSA Cycle Introduction

The Plan-Do-Study-Act (PDSA) cycle was an established method for process improvement within the SBCHC culture (see SBCHC PDSA Cycle Worksheet in Appendix E). Management and staff members were familiar with the description and the basic process of this method for documenting rapid change efforts. The systematic effort to improve intra-organizational referrals followed the framework provided by the PDSA cycle and as such reinforced familiarity with that organizationally-established process. Using the PDSA cycle as a guide for process improvement, recommendations and protocol development increased staff knowledge of the PDSA cycle and how it works while garnering buy-in from staff members who were already familiar with the process. The author chose to follow the PDSA framework because of the familiarity that the staff of SBCHC already had with the idea of this approach to rapid organizational improvement.

Timeline

The timeline for this project is outlined in a Gantt chart presented in Appendix F. The timeline ran from January 15, 2014 through August 15, 2014 which coincided with the commitment of time made by the author to SBCHC. It is important to note that the development of this protocol included looking backward at processes taking place related to the author's preceptorship as well as forward, planning a systematic organizational improvement.

Retrospective and prospective components. One consideration of the proposed methodology for this initiative was the inclusion of knowledge and insights gained from important retrospective as well as prospective perspectives. Retrospective perspectives look backwards at events that took place over time in the past. The author looked back in time to draw insights from the strategic planning activities in retrospect. Prospective components of this study moved forward in time from the date when intra-organizational referrals were identified as an area for improvement, prioritized by the executive director and the Board of Directors, and the author made the decision to base her graduate project protocol and toolkit upon this need.

Retrospective components of this protocol include the strategic planning process and all of the interviews and focus groups that the author conducted during this process as a preceptorship-related responsibility. The preliminary strategic planning process began in January of 2014 as a duty related to the preceptorship responsibilities of the author. It lasted through April 1, 2014. Many strategic planning-focused meetings with departmental management and leadership of SBCHC took place between January 15 and April 1 to inspire the methodology and establish administrative goals and parameters for improving intra-organizational referrals. These events were retrospective to the preparation of this project, and were significantly important to the development of the methodology. The selection of the priority to improve intra-organizational referrals by the executive director and the Board of Directors based upon input from the author was established after the focus group discussions and interviews that took place during this time frame and represents the turning point between the author's preceptorship-related responsibilities and the development and preparation of this protocol and toolkit.

Prospective components of this protocol were completed after the focus was narrowed to improving intra-organizational referrals. Having identified intra-organizational referrals as a priority area, the author conducted reviews of related literature and developed methodology between April 1 and June 30. Prospective components included multiple focus group discussions and interviews conducted to brainstorm ideas, identify strategies and prioritize those strategies. It also included planning and implementation of a pre-pilot and pilot of selected strategies to improve intra-organizational referrals, as well as the development and evaluation of a strategic toolkit based on the findings from the pilot protocol. Finally, the development of this protocol to support the toolkit and provide recommendations for its use was a prospective component.

Prototype Development Methodology

Introduction

Methodology for this effort was guided a well-documented approach to research and also by a scientifically-based framework for process improvement. The approach to research used was the anthropological approach as described by the Agency for Healthcare Quality and Research (AHQR) (AHQR, 2013). This approach was recommended as a method for studying health centers with PCMH designation by the AHQR. It uses multiple data collection techniques that were in alignment with the inductive strategic planning approach already used by SBCHC. The other approach is the Plan-Do-Study-Act method to documenting a test of change for breakthrough improvement as described by the Institute for Healthcare Improvement (2014). This

approach was used as a framework because it was already a trusted model for measuring and evaluating rapid organizational change by SBCHC.

Anthropological Approach

The anthropological approach has been used as a guide for evaluating, implementing and reporting outcomes of patient-centered medical homes (PCMH). As described by Goldman and Borkan (2013), anthropology explores the complexity of human interactivity and culture. Research methodology based in anthropology combines humanist and social science strategies and ethnographic methods help anthropologists uncover insights that are most effectively gained by studying a topic "in person, in situ, over time and from diverse perspectives" (Goldman & Borkan, 2013, p.1). Further this methodology explores the ways of human culture, behavior and expression and in a health care setting can include interviewing and observing doctors, nurses, registration professionals, dentists and patients to understand and explore the way they understand and interact with concepts such as PCMH, intra-organizational referrals and community health centers (Goldman & Borkan, 2013).

This methodology uses multiple data collection techniques including participant observation, interviews, focus groups and textual analysis to construct a view of the subject matter (Goldman & Borkan, 2013). Anthropologists combine subjective information about people's thoughts and opinions with information collected by observation of social systems and interactions. This model supports the use of largely qualitative data resulting from the in-depth and varied data collection techniques, and was deemed by the author and executive director to be an appropriate methodological guide for the initiative described. This approach was also appropriate for studying the PCMH

system changes because it considered underlying factors in the practice, among patients and in the community that drive how processes and systems change and decisions are made within the community health center model of primary health care. All of these considerations were consistent with the manner in which the initiative to develop a system for improving intra-organizational referrals at SBCHC was to occur. This model also provided structure and framework to identify the multilevel impact of transformation efforts across all levels of involvement of staff and stakeholders at Scenic Bluffs. As described by Goldman and Borkan (2013), this method provides the potential to uncover unexpected insights by studying a topic from diverse perspectives and over time.

Focus groups and key informant interviews. Focus groups and key informant interviews were used in both the strategic planning processes related to the author's preceptorship as well as in the needs and capacity assessment phase designed to explore what the current processes and tools were for making intra-organizational referrals and to elicit ideas for improvement. Focus groups and key informant interviews were chosen by the author with guidance from the executive director because of their applicability to this project and to support consistent communication within SBCHC. These two methods are strongly supported by the anthropological approach to research which was a guiding methodology for the author.

Focus groups were chosen as an appropriate method for assessing staff opinions regarding three-year strategic planning because of several advantages and also because of the depth of qualitative information that can be explored. According to Gilmore (2012), advantages of the focus group include the low cost, flexibility, convenience, and ease of clarification, or an atmosphere that allows the moderator to seek clarification by creative

means, if appropriate. Disadvantages of using focus groups include limited representativeness, dependence on moderator skill, potential lack of participant involvement, and focus on preliminary insights. These disadvantages were outweighed by the large number of SBCHC staff participants and the creative means by which the author, with direction from the executive director facilitated focus groups.

Key informant interviews also were also used during both the strategic planning process and the subsequent, more focused needs and capacity assessment. Key informant interviews provided the author who facilitated these discussions with convenience to reach the individuals during their normal work days, and also the opportunity to delve more deeply into subjects that the key informants experienced on a frequent basis. Gilmore (2012) describes the advantages of interviewing to include flexibility in terms of formality: interviews can be formal or informal depending on skill of the facilitator and the needs of the assessment. Interviews also offer opportunities to pursue insightful participant responses in greater depth, to ask follow-up questions to gain clarity, and also the opportunity to skip to the most relevant of interview questions if the interviewer is pressed for time (Gilmore, 2012). Disadvantages to interviewing include the difficulty of data analysis, the need for in-depth understanding of the subject matter by the interviewer and the potential greater cost (Gilmore, 2012). All of these disadvantages were considered during the data analyses phase of the strategic planning stage (aligned with the author's preceptorship-related responsibilities) and also during the needs and capacity assessment processes, and appeared to be outweighed by the advantages of these approaches.

PDSA Cycle Framework

The methodology for this project was guided by the PDSA cycle model which provided a framework based on the scientific method for identifying and carrying out organizational change. The PDSA cycle was adopted for process improvement within SBCHC and its use by the author supported already accepted processes for improved understandability being used at SBCHC. The PDSA cycle is shorthand for testing a change by planning it, trying it, observing the results/the process, and acting on what is learned (Institute for Healthcare Improvement, 2014).

PDSA provides a framework for asking what is the overall goal of the initiative, how change was measured or how it is identified if the change is an improvement and what changes might be made/what strategies can be brainstormed that will lead to that improvement. The cycle includes planning the change and doing the change in a systematic way. This systematic way utilizes hypothesis testing. Finally, the PDSA cycle includes studying the change and acting on the change (revising, implementing the method for change as-is or scrapping the method for change completely).

The PDSA cycle has been used to enact change in many different scenarios in chronic care management. For example, the PDSA cycle was used in clinical information systems to identify patients needing diabetes education (National Diabetes Education Program [NDEP], 2014). Another way the PDSA cycle can be used is as a delivery system design to implement use of a registry for monthly reports and pop-up reminders for follow-up and care planning (NDEP, 2014). PDSA cycles also can be used in community outreach, for example to implement new programs to designate case managers to refer patients to community resources (NDEP, 2014). The model provides

flexibility and a simple template to use to measure and evaluate change that can be adapted to many health care settings. The PDSA cycle worksheet used for implementing rapid change at SBCHC is included in Appendix E.

Gorenflo and Moran describe PDSA as a framework for quality improvements that is both simple and powerful: simple because it is systematic, straightforward and flexible and powerful because it relies on the scientific method including development, testing, and analyzing hypotheses (2010). Gorenflo and Moran provided a flowchart for the PDSA cycle and permission for the author to use it as a methodology for developing a system for improving intra-organizational referrals at SBCHC. This flowchart is featured in Figure 2.1. It is important to note that the title PDCA is used in the flowchart provided by Gorenflo and Moran meaning Plan-Do-Check-Act. PDCA was the first shortening reference of the cycle based on the "Shewhart cycle" made popular by Dr. W. Edwards Deming. It was noted early that plan, do, check, act was wording used by early Japanese participants, but that Deming preferred plan, do, *study*, act because when translated from Japanese to English, "study" is more aligned with Shewhart's intent than "check" (Gorenflo & Moran, 2010). In the flowchart provided by Gorenflo and Moran in Figure 2.1, the start of the study phase of the PDSA cycle is represented by an oval with the words Check/Study. Keeping with the Shewhart cycle, the plan will be referred to as PDSA or plan, do, study, act for the purposes of this protocol.

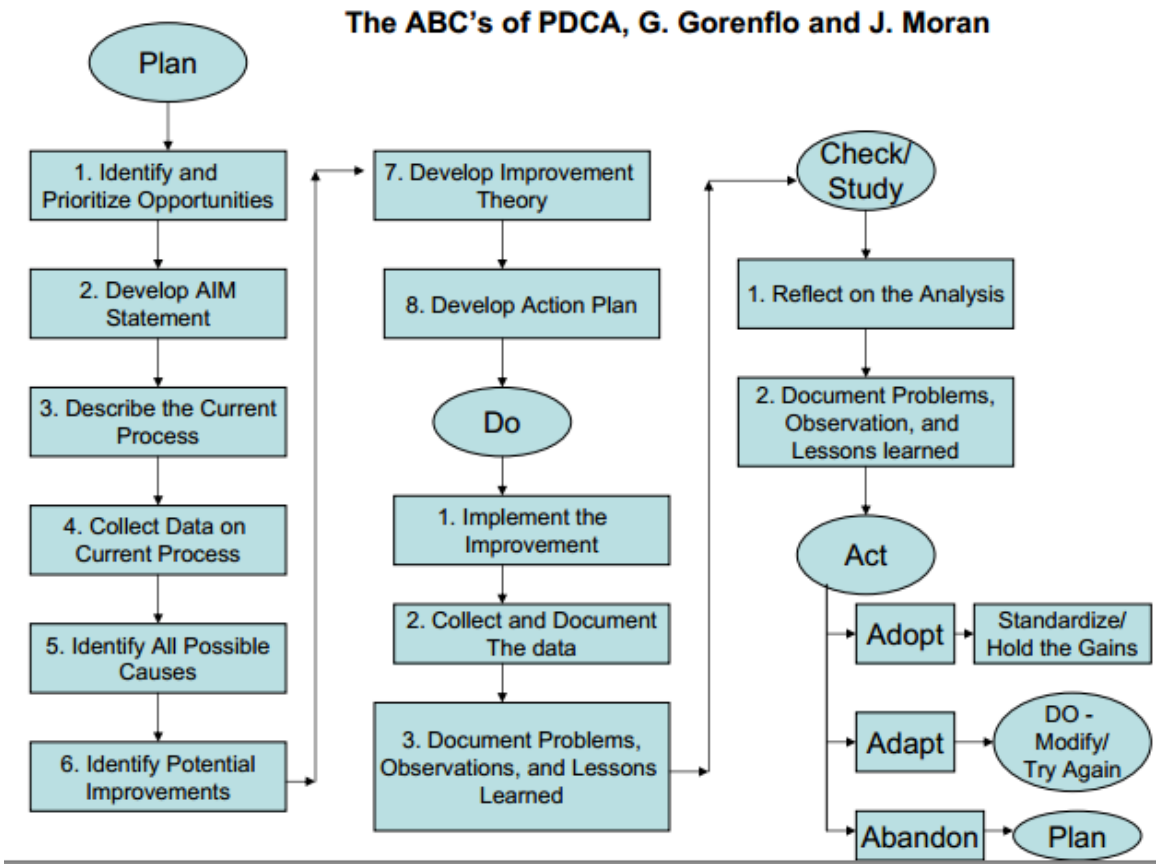

Figure 2.1. The ABC's of PDCA. Gorenflo, G., & Moran, J. (2010) Used with the permission of J. Moran.

PDSA framework provided a systematic, science-based method for the author to use as she guided the process of developing a system for intra-organizational referrals at SBCHC. Following the PDSA framework also fit naturally with the author's preceptorship-related strategic planning experiences resulting by allowing her to align retrospective and prospective phases of the investigation at the onset of the protocol development phase in Section II. This graduate project evolved out of the strategic planning process naturally. The author was able to look back on her preceptorship-related strategic planning work during January through April of 2014 in order to align all of the phases within the PDSA cycle.

Sections II and III of this graduate project align and address all of the phases of the PDSA framework. Because of its simplicity and strength, many of the phases aligned with the P or plan stage of the PDSA framework were completed when the author identified the PDSA as the design framework for the project and could easily be identified as planning phases. For example, the strategic planning process and needs and capacity assessment processes were designed to identify areas for organizational improvement, and to brainstorm ideas on how to go about making the improvement fit under the "P" or "plan" stage of the PDSA framework. The "D" or "do" stage of the framework was designed to align with the pre-pilot and pilot of strategies identified during planning. The "S" or "study" stage was designed to align with data analysis and pilot evaluation, and finally the "A" or "act" stage was designed to align with Section III and the development of a toolkit as a resource for guiding intra-organizational referrals at SBCHC. PDSA headings guide this protocol as the PDSA cycle guided the development of a toolkit to improve intra-organizational referrals at SBCHC.

Plan: Investigate and Develop Potential Solutions

Phase One: Identify and Prioritize Opportunities

Need Identified Through Strategic Planning Process. Phase one was the completion of in-depth focus groups and key informant interviews for the purpose of strategic planning for SBCHC, a preceptorship-aligned responsibility of the author which took place from January 15 through April 1, 2014. In order to set and prioritize the goals for organizational improvement, the executive director at SBCHC outlined a process for the review and revision of the strategic planning document and direction for the community health center that placed high importance on staff input. Staff input is

regarded highly by SBCHC managers and executive leadership and as such, transparency in processes and rationale is of utmost importance to the smooth operation of this health center. It is important to SBCHC managers that staff people understand why something is changing and how to manifest that change. Asking for the staff members' opinions regarding strategic planning was an important way to support these organizational values.

A list of qualitative interview questions was developed by the executive director somewhat based on a SWOT (or strength, weakness, opportunities and threats) analysis to guide interviews and focus groups during the strategic planning phase. The list was designed to elicit the current concerns, needs, wants and desires of the people doing the work of Scenic Bluffs Community Health Center at every level of the organization from part-time registration professionals to full-time physicians and specialists (see Appendix G.) The author, working as preceptee to the executive director, was a motivational interviewing-trained master of public health graduate student. The author was selected by the executive director to administer the strategic planning interviews and to assist in the strategic planning process as a major component of her preceptorship experience. As such, the list was reviewed and used by the author to guide interviews and focus group sessions during the strategic planning process for the goal of identifying areas for improvement during the next three years of operation.

As the next step in the responsibilities related to the preceptorship experience, the author performed a series of qualitative, in-depth interviews whereby feedback, ideas and critiques were gathered from individual full time and part time staff members from each of the departments of SBCHC which include medical, dental, pharmacy, chiropractic, behavioral health and administration in order to identify areas the staff wanted to improve

in the next three year period. Interviews were administered by the author in the Scenic Bluffs buildings. The style of motivational interviewing guided the author's discussions during which open-ended questions were used to explore the wants, needs and ideas of the staff members in focus groups and key informant interviews. Personnel were invited to focus groups and interviews that took anywhere from thirty minutes to sixty minutes. During her preceptorship experience, the author conducted the strategic planning interviews from January 15 through April 1, 2014 with the goal of exploring the wants, needs, and priorities of the staff members regarding the business of SBCHC for the next three years (2014-2017) from which the conversations about intra-organizational referrals began early on.

Continuing in preceptorship-aligned responsibilities, the author took notes during the interviews, wrote interview transcripts, and analyzed and organized the data for each department. A draft of the interview transcript was sent back to the participants for review and approval. Recurring key words and concepts were identified in the interview transcripts and trend data was pulled from the interview data and examined. Key words or phrases came up in many of the strategic interviews. This information was noted. The data were organized by department and also entered into a master codex for all departments (see Appendix H) which was summarized and focused further by the author before being broken down into the simplified form in Appendix I which was used to communicate the findings to the members of the Board of Directors.

Intra-organizational referrals emerge as priority of staff. The interviews were intended to identify ideas and strategies by which SBCHC could improve organizational processes and strategies over the next three years as described by the staff people. Several

strategic ideas and trends emerged from the interviews across departments during these conversations. One trend that emerged and was acknowledged by many individuals was the need to improve intra-organizational referrals at Scenic Bluffs Community Health Centers. The staff members perceived that the potential results of such an effort would lead to improved communication, improved employee satisfaction and improve continuity of care and patient outcomes (see data in Appendices H and I). Personnel from every department at SBCHC noted that to improve internal cooperation and communication and to better serve the mission of SBCHC in the 3-year strategic plan, a systematic method for intra-organizational referrals needed to be developed.

Some of the specific staff comments supporting the need for this focus on intra-organizational referrals included in Appendix H are listed below.

- "We need to improve ancillary services and in-house referrals and collaborations."
- "Can we use all provider meetings differently to increase communication and integration with other departments?"
- "We need to tap into individual professional strengths in clinical care and channel specific patients to them. This could also generate more income."
- "We need to make collaboration [between departments] at regular appointments regular and not spotty. Doing this will help strengthen intra-organizational communication."
- "Different departments have the attitude of 'this is our patient.' We need to share the patients and further enrich the experience of our patients at a Patient Centered Medical Home."

Involving the Board of Directors in strategic planning. Staff input was an important consideration during the strategic planning process as a preliminary, preceptorship-related duty of the author and it also informed and helped govern the focus of the health center's community-based leadership. Another important group that had to be considered when setting strategic goals was the members of the community-based Board of Directors. The next phase of the strategic planning, preceptorship-related responsibilities of the author was to gather the current concerns, needs, and wants of the Board of Directors of SBCHC as expressed in focus groups and interviews.

At a strategic planning task-focused meeting on March 8, 2014, the author presented the focus group questions (Appendix G) discussed with the staff to the Board of Directors. Board opinions were explored and discussed, and in-depth notes were taken. The summarized and organized data collected from the strategic interviews with the staff (Appendix I) was presented to the board of directors to provide insight for the Board regarding the perceived strengths, needs, wants and priorities of the staff.

Phase Two: Develop AIM Statement

The AIM statement answers what are you seeking to accomplish, who is the target population, and what is the specific, numeric measures you are seeking to achieve (Gorenflo & Moran, 2010). The AIM statement was identified when the information from the staff strategic planning focus groups and interviews was discussed with the Board of Directors and compared and contrasted to that group's strategic planning areas of concern. The Board of Directors' concerns and strategic goals for the organization in many cases matched the wants, needs and priorities of the staff members. At this important intersection of information and opinions of two separate groups of

SBCHC stakeholders (the staff and the Board of Directors), the need for a system for intra-organizational referrals and interprofessional collaboration was identified and reinforced.

With the input of the staff as well as the Board of Directors, the SBCHC 2014-2017 strategic plan document was written including a goal for improving interprofessional collaboration within the organization. It read, "Strengthen intra-departmental referral practices and develop protocols to assure patients have access to the range of Health Center services they may need." This strategic objective to improve intra-organizational referrals was designed to be measured by an increase in intra-organizational referrals made by staff members and an increase in the amount of patients who are seen in greater than one department at the Scenic Bluff Community Health Centers. In 2013, six patients were seen in behavioral health, chiropractic, medical and dental departments at SBCHC. The very specific goal of the effort to improve intra-organizational referrals at SBCHC was to raise that number to ten people in 2014 and to twenty people by the end of the strategic planning cycle in 2017. Those were measureable improvements in patient utilization by a 66.7 percent increase in patients using behavioral health, chiropractic, medical and dental departments in the first year (by 2014) and a 233 percent increase in patients using behavioral health, chiropractic, medical and dental departments during the 3-year strategic planning cycle (by 2017). The author and her mentors sought to build the foundation for a systematic method for improving intra-organizational referrals by providing SBCHC with a toolkit providing specific language, training tools, prompts and situational suggestions based on the findings from the action plan discussed in Section III.

Phase Three: Describe the Current Process

Needs and capacity assessment. In order to understand the current processes whereby intra-organizational referrals were being made at SBCHC and to identify areas for improvements, the author completed a needs and capacity assessment which consisted of focus groups and key informant interviews, echoing the methods used in the strategic planning stage. Data collection methodology consisted of focus groups and key informant interviews and was designed promote consistency throughout all the stages of in data collection. Keeping with the same method also provided consistency for the staff in terms of information and input gathering techniques used by the author.

Using the document provided in Appendix J to guide these interviews and focus groups with key staff members, the author explored the staffs knowledge of current processes and efforts to improve intra-organizational referrals, discussed capacity (what was already happening well), and also explored and brainstormed ideas for improving intra-organizational referrals within the organization. Focus groups and key informant interviews were facilitated by the author from April 22 through May 27 and took approximately thirty minutes. Focus group and key informant interview participants were identified by the executive director as people who were actively engaged in quality improvement activities in their daily job duties and also people who would provide straight, clear and honest answers and opinions to the questions that were discussed.

Three focus group sessions were scheduled and one was unscheduled. The scheduled focus groups took place during arranged appointment times. The author provided a list of the questions (Appendix J) to the participants and used the tool to guide the conversations. During the scheduled focus groups, the author took notes as the

participants shared their opinions. The unscheduled focus group took place during a staff-training lunch-break during which the author engaged in light conversation with several of the staff members who asked about her project. Each staff member had unique insights and opinions about the way intra-organizational referrals were made at SBCHC. The author took the opportunity to ask the focus group questions that had been established in Appendix J from memory and recorded her observations after the lunch conversation by typing up a transcript of the conversation. Each of the participants in the spontaneous focus group agreed to provide further insight to the author for clarification purposes when she was writing the transcript from memory.

Two key informant interviews were scheduled. During the key informant interviews, the author provided a copy of the discussion questions (Appendix J) to the participants. The author also took notes during the interviews which she wrote into transcripts immediately after the key informant interviews.

Focus groups and key informant interviews were conducted in private offices and meeting rooms at the Cashton and Norwalk facilities. Participants were drawn from medical, administrative, registration, dental, and chiropractic professions at the clinic. The author facilitated the interviews taking detailed, hand-written notes which she then transcribed into the summaries provided in Appendix K.

Key informants and focus group participants identified strengths and weaknesses to current processes for making intra-organizational referrals at SBCHC. Prior to the author's project, intra-organizational referrals were encouraged, but no training for how to make them was provided. Two documentable methods were reported during the needs and capacity assessment.

Referrals could be made within the EHS electronic medical record (EMR), but the process was considered to be long and tedious and participants reported that they often did not complete the referral through EHS because of the difficulty of the process and time it took. Alternatively, a paper-based referral form was used for referrals coming from the dental department outwards to other departments within the organization. The paper-based method was not used to make referrals from other departments within the organization and had been used inconsistently by what the participants reported was a great minority of staff at SBCHC.

Other ways intra-organizational referrals were made involved walking the patient that was being referred to a registration person to make an appointment with a health care provider in another department. For example, when a chiropractor encountered a patient with pain that he perceived he could not managed with his expertise alone, he walked that patient to the registration professionals and made an appointment with the physician at SBCHC so that she might be able to provide alternative medical expertise for this patient. This specific scenario unfolded in real-time during one of the focus group sessions conducted by the author.

Another example of a way intra-organizational referrals were made at SBCHC that were discussed during the needs and capacity assessment focus group interviews involved the medical assistants taking a lead role in continuing care for the patient in another department. For example, a doctor saw a patient and during a strep-throat culture discovered that the patient had an obvious dental carry. The doctor completed her exam of the patient, verbally told the patient that she recommended seeing one of the dentists to have the cavity repaired, and noted her referral in the patients EMR. The doctor then took

the patient to the medical assistant for check-out and told the medical assistant to help the patient make the dental appointment with the registration professional. In this scenario, commonly referenced during the needs and capacity assessment, the medical assistant would then walk the patient to the registration professional and help them make the appointment or the patient would refuse the referral. Needs and capacity assessment participants reported that intra-organizational referrals were made when it was perceived that patients needed care that could not be provided by, or expertise outside of the realm of the provider making the initial contact with the patient.

Phase Four: Collect Data on Current Processes

Because of the difficulty and inconvenience of inputting intra-organizational referrals into the EMR and the inconsistent use of the paper-based referral system, a consensus was achieved by the participants of the needs and capacity assessment stating that there were no data available that represented close to or the actual number of intra-organizational referrals made at SBCHC. Further, the definition of these referrals to be understood organization-wide was unclear. In order to measure the effect of intra-organizational referrals at SBCHC and to get a baseline data set representative of the effect of intra-organizational referral making, a report was run by Amy Schanhofer, Director of Operations. This report provided information on the number of patients who were seen in more than one of the four (medical, chiropractic, dental and behavioral health) departments within SBCHC in 2013. These data are available in Appendix L.

During 2013, six patients were seen in the four departments (medical, dental, chiropractic and behavioral health) at SBCHC. The number of patients seen in four departments, as described in the AIM statement in Phase Two of the Plan Stage, is the

baseline measure that the author and her mentors plan to compare again in order to measure increases to the number of patients seen in at least four departments during 2013-2014, and throughout the three-year strategic planning cycle taking place 2014-2017. Appendix L specifies how many patients were seen in at least three departments and at least two departments at the SBCHC in 2013 as well. The number of patients seen in at least three departments was 101 patients who were seen in chiropractic, medical and dental departments. The number of patients seen in at least two departments (medical and dental departments), were 991 patients of a total of 8,664 patients seen at the SBCHC in 2013.

Phase Five: Identify All Possible Causes of the Problem

Barriers to effective intra-organizational referral making. During the needs and capacity assessment focus groups and key informant interviews, the staff shared the feeling of frustration with being unable to track conveniently the intra-organizational referrals that they were making. The EMR provides the foundation for patient encounter and health history notes, and it was frequently discussed that the capacity for convenient tracking within the EMR determined the likelihood of improvement in inputting intra-organizational referrals at SBCHC into this documentable system. The staff reported that the EMR used at SBCHC did not support the capacity that they felt they had to make intra-organizational referrals.

The staff also reported the perception that intra-organizational referrals had to come from medical providers such as physicians, chiropractors, dental hygienists and dentists. This perception supported the report that there was no organizational definition of what an intra-organizational referral was or what constituted one such referral to

another department within SBCHC. There was no mention of an intra-organizational referral as a helpful reference to community wellness events such as the annual health fair or the ongoing workshops and support groups supported by SBCHC and facilitated by SBCHC staff members, or a brief discussion about the benefits of using SBCHC as the patients primary medical home.

Other reported barriers to making effective intra-organizational referrals that were reported by the participants of the needs and capacity assessment focus groups included the negative reception often encountered by a staff member receive the referral. A participant provided a scenario to describe this type of negative reception: when a dental hygienist walks a patient to the medical department in order to make a referral to a doctor or nurse practitioner, sometimes the case load of the recipient of that referral causes reception to be clouded with negative "I'm too busy to talk to your patients right now" kind of attitudes. The participant reported, and was supported by colleagues, that the experience of a negative reception when the referrer was trying to provide the best care for the patient by making the intra-organizational referral caused the referrer to consider not making another one in order to avoid the negative interaction with the staff member from another department. Barriers identified by the author during the literature review came from miscommunication and staff disinterest in participation in a new strategy to improve processes within their organization echoed this reported sentiment.

Other barriers identified through focus group discussion and interviews included the general acceptance within departments at SBCHC to operate as "siloed" units. For example, some respondents stated that they felt other professionals within the building were not interested in improving interprofessional collaboration or job performance. It

was reported that participants often felt that the individual departments operated without concern for the partner departments within the Scenic Bluffs Community Health Centers organization.

Barriers to making intra-organizational referrals observed by the author included challenges presented by the general expectation of people to do more with less time and resources and to be responsible for tasks that are not perceived to be standard tasks for the specific position personnel were hired to fill. For example, a registration professional is expected to provide excellent customer service, to take and validate insurance information, to take payment for services, to answer incoming phone calls, to be the first face of the health center that patients see and many other tasks. This barrier was reduced by the author's methodology which included the registration professionals in the process of developing, evaluating and selecting which strategies to implement. It was also made clear by the author's intention to improve employee satisfaction, interprofessional communication and team work and ultimately to improve patient collaboration at SBCHC which was demonstrated in her goals to provide consistency, honesty, and transparency throughout all of the stages.

Phase Six: Identify Potential Improvements

After the needs and capacity assessment focus groups and interviews were completed, the PCMH accreditation leader at SBCHC, Sara Martinez, was invited by the Executive Director, Mari Freiberg, to help the author analyze the information she had gathered through the interviews and to prioritize a strategy to test within SBCHC. Sara Martinez was identified as an appropriate partner because of her ongoing leadership and innovation in the efforts to improve and maintain PCMH accreditation at SBCHC. The

summaries of the needs and capacity assessment interviews (Appendix K) were shared with Sara Martinez by the author. A meeting was scheduled between the author and Sara Martinez during which the findings provided in the summaries were discussed and a strategy for improving intra-organizational referrals in a pre-pilot and pilot were identified.

During this teleconference, the author and the PCMH accreditation leader compared and contrasted the findings of the summaries of the needs and capacity assessment focus groups and interviews, looking for common trends identifying potential ideas for new ways to improve intra-organizational referrals at SBCHC. The major ideas identified by the staff members were then compared and contrasted with the strategies identified in the review of literature completed by the author. The prominent idea that was considered by the PCMH accreditation leader and the author and was supported by the literature review, but was not selected, was to make large-scale amendments to the intra-organizational referral tracking capacity of the EMR system used at SBCHC. This idea was out of the scope of the timeline of the PDSA cycle, beyond the scope of expertise of the author, and perceived by the author and the accreditation leader to be very expensive and was rejected.

The idea that was determined to be most interesting and as such was identified and selected for examining in a pre-pilot and pilot protocol to be completed by the author was to test the language of referrals to discover what questions, word-tracks, or conversation starters led to an opportunity to make an intra-organizational referral. Both the PCMH accreditation leader and the author agreed that understanding more about what language improved intra-organizational referral opportunities for SBCHC staff was

significant to improving the number of intra-organizational referrals made and the number of patients seen in all four (medical, dental, behavioral health, and chiropractic) departments at SBCHC. The PCMH accreditation leader and the author shared the decision with the executive director who supported the rationale and agreed that the information would be useful for the purposes of improving intra-organizational referrals at SBCHC.

Phase Seven: Develop Improvement Theory

According to Gorenflo and Moran, an improvement theory is a statement that clearly identifies the anticipated effect that the improvement or change will have on the problem (2010). As a result of analyzing the findings from the pilot protocol designed to explore what types of language results in better opportunities to make intra-organizational referrals, it was expected that the author would be able to provide recommendations for specific word tracks, cues, conversation starters and general language that would lead to increased numbers of intra-organizational referrals being made by SBCHC staff from every department. By trying out different ways to open a conversation and identifying appropriate cues in conversation and measuring the effects of these different word tracks, it was expected that the author would share this information with the staff in the form of a toolkit for improving intra-organizational referrals to be located on the SBCHC website. This project aims to build the foundation for a systematic method for improving intra-organizational referrals by providing SBCHC with a toolkit providing specific language, training tools, prompts and situational suggestions based on the findings from the action plan discussed in Section II.

Phase Eight: Develop Action Plan

Development of a prototype for pre-pilot and pilot studies. In order to experiment and measure the effectiveness of different intra-organizational referral language, the author, with guidance from the PCMH accreditation leader designed a pre-pilot protocol. As a part of regular expectations for employees based on customer service standards, it was expected that clinical and administrative staff engage with patients when passing them in the hall, making eye contact in the waiting rooms, or helping them to and from appointments in different areas of the buildings. Deep, personal conversations were not the goal, but brief, polite, professional exchanges were the expectation. Because of the author's natural tendency toward providing customer service, engaging with patients when in the clinics was a normal part of her experiences at SBCHC from her preceptorship-related experiences, through the summer in other roles within the organization.

It was decided that during the pre-pilot the author would continue to have brief interactions with patients waiting for appointments in the waiting room at the Cashton location, and she would observe how the patients reacted to different word tracks and key words when approaching subjects that could lead to intra-organizational referrals. The brief interactions were to be completed during the normal business day as the author moved about the clinic working on other projects for the organization. The pre-pilot was designed to last for two days, June 3 and June 4, and the goal was set for the author to have a brief interaction with ten patients per day and observe their reactions to specific language. In order to delimit the study to the patients in the dental department (the largest department at SBCHC in staff, patients and appointments), for the first day of the pre-

pilot, the author was aligned with a dental hygienist (Terri Komay) and spoke to the patients coming in to see Terri on Tuesday, June 3. On the second day of the pre-pilot the author was aligned with a dentist (Dr. Julie Graf-Domeyer) and a family nurse practitioner (Sherry Harris). This alignment was discussed with the PCMH accreditation leader, the dental department manager and the dental hygienist and all agreed it was a worthy and appropriate delimitation. During the pilot, that took place for four days the following week, Monday, June 9 through Thursday, June 12, the author would stay aligned with the patients of these three health care professionals.

Pre-pilot and pilot success was to be measured by interactions that led to intra-organizational referrals to departments and services within SBCHC outside of the dental department (as that is where all the patients were being seen on the first day of the pre-pilot). The goal continued to be for the author to be able to recommend word tracks, cues and language that worked well for making intra-organizational referrals at SBCHC. It was decided by the author, with guidance from the PCMH accreditation leader and the executive director, that intra-organizational referral would be defined as referral to any service, department, provider, community event or activity put on by SBCHC and SBCHC staff members, whether or not an appointment was made. The definition of intra-organizational referrals would not be exclusive to billable services such as an appointment with a physician for throat pain, or a chiropractic adjustment, but would also include referrals to enriching or prevention services such as community wellness activities, monthly specials, workshops and health fairs. It is important to note that these enriching services that are not directly billable for the community health center provide important relationship building potential and also the prevention-based efforts toward

population health within the communities served by SBCHC. Referrals to both types of services are very important and as such were included in the definition of what an intra-organizational referral was for the pre-pilot.

The pre-pilot was evaluated based on the goal of improving the process. Process evaluation was the major consideration for the result of the pre-pilot. Results from the pre-pilot were to be analyzed according to the ease of use of the specific prompts/language provided in Appendix M, the number of intra-organizational referrals made during the pre-pilot per day and the author's perception of the patient's reception of the intra-organizational referral but important only secondarily to the evaluation of the process. The pre-pilot was designed to allow the author to practice using Appendix M and to follow the process outlined in Figure 2.2. Any process changes or edits to the tools would be adopted for the pilot protocol. The pilot would be evaluated based on the number of intra-organizational referrals made, the author's observation of the patient's reception of the language leading toward intra-organizational referrals, and what specific language worked or didn't work to guide conversations about services offered by SBCHC. In summary, the pre-pilot was designed to test the methods, which were to be revised and edited and were subsequently used to collect results and observations of intra-organizational referral language usage in the pilot protocol.

A tool was created by the author and approved by the PCMH accreditation leader which listed the different word tracks and language to be tested. That tool is available in Appendix M. The interactions were intended to be brief (no more than 5 minutes unless additional assistance was needed) and the author was to ask only one or two questions of the patients in order to understand briefly their perceptions and experiences. The author

did not use the form during the interactions, but instead committed to memory the interaction and after its conclusion, filled out one evaluation (Appendix M) for each patient with whom she had a discussion. People under the age of 18 years of age were not included in the interactions and the author estimated age before engaging in conversation. If the age of the patient was unclear, the author did not approach that patient for the sake of the research but still provided excellent customer service to all patients at SBCHC as was the expectation. A goal was set to speak with twenty-five people, or all of the patients aligned with a specific health professional, per day.

Do: Implement Action Plan

The D or "do" phase of the PDSA cycle began with the implementation of the pre-pilot protocol and was followed by the implementation of the pilot. The D phase of the PDSA cycle has three steps including implement the improvement, collect and document the data, and document problems, observations and lessons learned. Because of the development of a pre-pilot and a pilot protocol, the D phase was adjusted to include five steps whereby phases one and two were repeated after the pre-pilot for the pilot protocol.

Phase One: Implement the Improvement

Pre-pilot. The pre-pilot program lasted for two days (Tuesday, June 3 and Wednesday, June 4) at the Cashton clinic location of SBCHC. The author followed the tool provided in Appendix M illustrated by the flowchart in Figure 2.2. The beginning of the author-patient interactions were guided by the style of motivational interviewing that the author was familiar with as described below. First, the author greeted the patient. Next, the author introduced herself and told the patients that she was a student and intern

at SBCHC looking into how Scenic Bluffs is utilized by the patients and community so that we can improve the help and services we offer. Next, and importantly, the author asked the patient's permission to ask a couple of quick questions to get their insights. If the patient did not give the author permission to ask a couple of questions, the offer of assistance was made, the patient was thanked and the conversation ended.

If the patients agreed to have a short conversation with the author, she chose no more than two of the "questions about services" listed in Appendix M, the interview tool, which she had memorized to discuss with the patients. As appropriate, the author followed up the questions with a referral to specific services, workshops, departments or community initiatives SBCHC could provide. During the interaction, the author was also instructed to offer assistance to the patient by offering to help fill out health history or intake forms, get the patients water or coffee, or answer any other question they may have had about their visit. This offer of assistance naturally fell at the end of the conversation, though it was listed in the middle of the tool (Appendix M). After the conversation was closed, the author moved into the office space provided adjacent to the waiting room and used the tracking tool provide in Appendix M to record her observations during the conversation and what language she used.

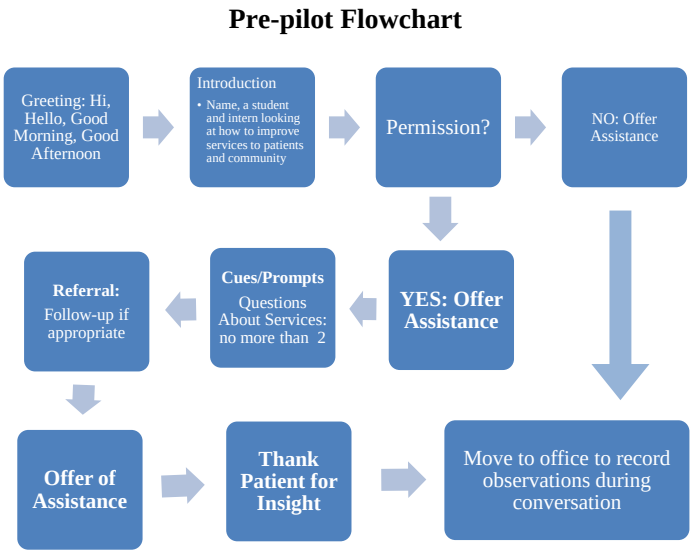

Figure 2.2. Pre-pilot Flowchart. Scenic Bluffs Community Health Center (2014).

Phase Two: Collect and Document the Data

Evaluation and revision of pre-pilot. During the first few minutes of the pre-pilot protocol conducted on Tuesday, June 3rd, the author observed inherent challenges in the pre-pilot design. The delimitation to only one health care provider within a specific department was a significant barrier to interacting with patients because the patients did not know the first name of the person they were coming to see. For example, the first three appointments of Terri Komay's day were made for a family of adults who did not know her name. The registration professionals who were working went out of their ways to signal to the author which patients she should try to touch base with, but during busy times, it was not possible to identify the patients who were checking in for appointments with specific personnel. The author followed the pre-pilot design with help from the registration professionals during the first day. At the conclusion of the day, the author had spoken with ten of eleven patients who had come in for dental cleanings with Terri

Komay with extensive help from the registration professionals who already had many job-related duties to perform.

Evaluation of the pre-pilot took place between the author, the PCMH accreditation leader Sara Martinez and the executive director. The author and Sara shared a personal email communication (see Appendix N), and also met in person to consider how the pre-pilot could be improved upon for the pilot protocol, what should stay the same and what should change. The changes that were adopted in the pilot included adjustments to both pages of the tool (Appendix M), adjustments to the delimitation to specific providers, a telephone component was added, and adjustments to the proposed number of patients the author was to speak with during each day of the pilot.

The first change that was made for use in the pilot protocol was to remove the delimitation to specific provider by opening up potential interactions to all patients seeing all providers in the waiting room. The registration professionals played a large role in the success of the first day of the pre-pilot and were open to helping, but the intention was not to impede the normal work duties of other SBCHC staff people. It was agreed to by the author and the PCMH accreditation leader that it was not ideal to rely so greatly on interacting with the registration professionals at the onset of each patient check-in. Instead, the author was to delimit the pilot protocol to specific time-slots. Specifically, during the pilot protocol the author was responsible for interacting with patients in the waiting room in designated three hour time slots throughout the day.

Another change that was made for the pilot protocol was the increase in the goal number of patient interactions that the author sought to have and record observations from every day. The goal was set at twenty-five per day which totaled 100 patients per

week for the pilot protocol, a number representative of 60 percent of patients seen at SBCHC during an average week in 2013. This change was suggested by the author because of the ease and short duration of the conversations that took place during day one of the pre-pilot.

A telephone component was added to the study for the pilot process. During the pre-pilot, the author had a conversation about what she was doing with the operations director who suggested that it would be helpful to determine if the specific language being tested in person could also be used in telephone conversations with patients. Two weeks before new dental patients come in for their first appointment, a call is made from SBCHC where a staff members discusses with the new patient options for appointment reminders, the Healthy Neighbor Plan (sliding fee scale option), and confirms contact information. After this call is made, the new patient is mailed a packet with necessary forms and information about SBCHC. It was decided that the author would make the new dental patient calls during the week of the pilot protocol.

Finally, changes were made to the worksheet that the author used to guide interactions for the pilot protocol which can be seen in Appendix O. On page one of the tool, changes were made to the prompts. Prompts for discussion about services and activities at SBCHC that were added included the Viroqua dental expansion, sports physicals, and work physicals. No changes were made to the questions about services. During the pre-pilot, the author observed that each was easy to use and appropriate for brief conversations. The author perceived engagement from patients with the established questions about services.

On page two of the tool, areas to mark the time and duration were included so the author could note the approximate time and duration of the interactions. Gender was also added so that the author could note the observed gender of the patients with whom she spoke. The yes or no area was created that asked whether or not a referral was made.

A final change to the worksheet used to guide interactions and recording of observations by the author (Appendix O) was to include an area to record estimated age range. The author used this area to record her estimated observation of young-adulthood, middle-aged adulthood and older-aged adulthood. The age categories were based on an estimate based on the author's observation of the patients. Adults estimated by the author to be 18-29 years of age and 30-49 years of age were categorized as young adults. Adults estimated by the author to be 50-64 years of age were considered middle-aged adults and persons estimated to be 65 years of age and older were categorized as older-aged adults.

In the column area, the offer of assistance was moved to the end of the column as it naturally took place at the end of the conversation. Greeting designations were removed and permission was standardized as the author observed her own consistent use of "may I have permission to ask you a couple of quick questions."

All of these changes, except the telephone calls, were initiated during day two of the pre-pilot. The process improvements were significant. The registration professionals did not have to exceed the expectations of their normal job duties and the author was able to easily talk to twenty individuals without dealing with the confusion that came as a result of patients not knowing what specific provider they were at the clinic to see. The number of conversations had by the author increased from ten to twenty one observed interactions. The revisions made to the Appendix O also held up well during day two of

the pre-pilot, providing a more comprehensive guide and tracking tool which provided improved observed impacts.

At the end of day two of the pre-pilot, the author evaluated the changes with the PCMH accreditation leader in a face-to-face conversation. In the author's experience, the changes were conducive to natural interactions and provided smooth transitions between the short conversations with patients. No patients in the waiting room were excluded if they were perceived to be interested in speaking with her. The PCMH accreditation leader was pleased that the registration professionals didn't have to be as involved in the process, although they were glad to help and expressed interest in the results. It was decided that the pilot would move forward with the changes made for implementation during the second day of the pre-pilot.

Phase One: Implement the Improvement

Pilot. The pre-pilot protocol provided a practical opportunity to iron out the wrinkles in the initial design of the intervention in both process and observed impact. With the tested and approved revisions made, the pilot protocol provided the author a natural transition back to phase one of the D or "do" stage of the PDSA cycle framework. Repeating this select area of the framework, the pilot protocol moved back into the phase one stage where the improvement was implemented.

The pilot protocol took place over four days from Monday, June 9 through Thursday, June 12 2014. It was implemented at the Cashton clinic location of SBCHC and took place in the waiting room and an adjacent private office space that had recently become unoccupied. The location of the office directly off of the waiting room was a significant convenience. The author could move easily between the waiting room where

the brief interviews were conducted and the private office where the observations were recorded.

The author implemented the intervention during specified three-hour time slots during the day. This design provided framework for a task-focused attempt to engage in natural, brief conversations with patients that wasn't overkill for the author: she was able to complete other internship-related tasks during the day as well as meet the goal of the study which was to speak to at least twenty-five individuals per day. This time-based intervention design paralleled the every-day job expectations of the staff members at SBCHC and supported the effort to improve intra-organizational referrals as it would realistically fit into the regular days of the staff.

The schedule for the pilot week was designed by the author and the PCMH accreditation leader. On Monday, June 9, the author was scheduled to interact with patients in the waiting room from 7:00am until 9:45am and again from 1:00pm until 4:00pm. On Tuesday, the blocks were 7:00am until 10:00am and 10:00am until 1:00pm. Wednesday, the blocks were scheduled from 9:00am to noon, and 1:30pm to4:30pm, and Thursday, the final day of the intervention, the blocks took place from 8:00am to 11:00am and 1:00pm-4:00pm. The blocking off of the day allowed the author time to complete other tasks at SBCHC related to her preceptorship such as teaching senior exercise classes, meeting with one of the behavioral health specialists concerning a handout regarding sport-related physical examinations for children and youth, and meeting with her mentor. The block scheduling also allowed the author sufficient time to reflect on the brief interactions she had with patients and then to record her observations.

During the pilot, the author was guided by Appendix O which was the tool revised as a result of the pre-pilot. The author did not carry the tool with her during patient interactions, but memorized the questions and prompts and after the conversations ended, returned to the private office to reflect and record her observations. One page was used for each patient interaction and each phone call.

Each pilot interaction followed the steps illustrated by the flowchart in Figure 2.3 which echoed the flow of the pre-pilot. During the pre-pilot, the author gained experience and confidence with the flow of the conversations and as a result, they were smooth and brief. The SBCHC patients understood that their insights and experiences were important to the author and to the organization. At times, because of the busy nature of the waiting room, patients from adjacent seating areas shared their insights with the author, having overheard the greeting, introduction, and request for permission.

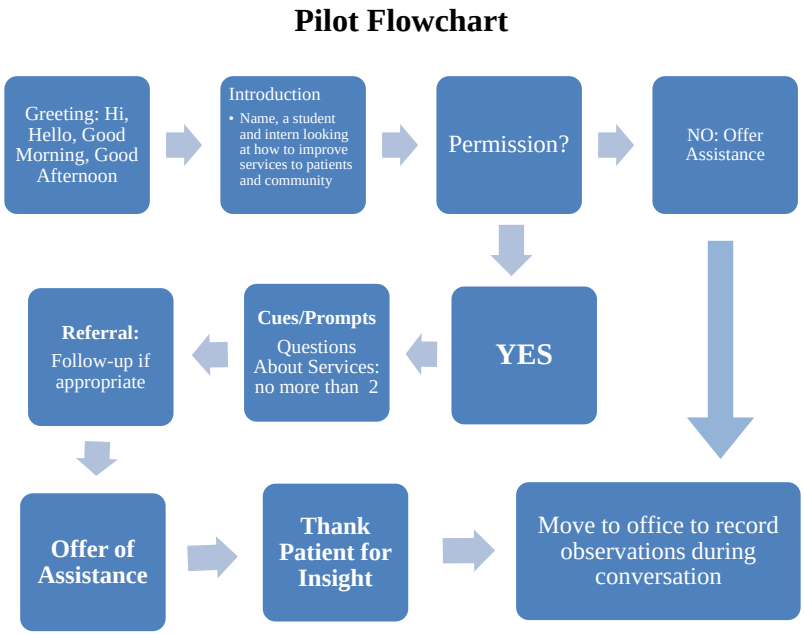

Figure 2.3. Pilot Flowchart. Scenic Bluffs Community Health Centers (2014).

Continuing to follow the pre-pilot flow in the pilot protocol, the author-patient interactions were guided by the style of motivational interviewing whereby the author introduced herself and her purpose and then asked permission before proceeding. Following Figure 2.3, first the author casually greeted the patient, introduced herself and told the patients that she was a student and intern at SBCHC looking into how Scenic Bluffs is utilized by the patients and community so that we can improve the help and services we offer. The author then asked the patient's permission to ask a couple of quick questions to get their insights. If the patient did not give the author permission to ask a couple of questions, the offer of assistance was made, the patient was thanked and the conversation was closed. This followed the natural flow of the pre-pilot and was supported by the revisions made to Appendix O.

If the patients agreed to speak briefly with the author, she chose one of the "questions about services" listed in Appendix O, the interview tool. As appropriate, the author followed up the questions with a referral to specific services, workshops, departments or community initiatives SBCHC could provide. During the pilot, the author prepared herself with materials to support the information and services she was explaining. For example, one of the follow-up prompts was to tell the patients about the August Health Fair whereby they could receive free health screenings. Another was to tell patients about the *July: Kids' Health Month* at SBCHC during which their children could come in and have a custom-fit sports mouth guard made for only $10. When the author mentioned these services during the pilot protocol, she also provided the patients with the flyers. Materials used to support these prompts were created by the organization's Health Center Promotions Department and are available in Appendix P.

As in the pre-pilot, near the end of the conversation, the author offered assistance to the patient. This offer provided a natural transition to move toward the close of the conversations. After the conversation was closed with a sincere thank you to the patients for sharing their experience and insight, the author either moved to another patient depending on the crowd in the waiting room, moved into the office space to used the tracking tool provide in Appendix O to record her observations during the conversation, what language she used, her observations of the patient's reception of the conversation.

The final pilot experience, not practiced during the pre-pilot was the opportunity for the author to call new dental patients and to use some of the language during these calls, enhancing the phone script used by SBCHC staff who normally made these phone calls. The telephone script is available in Appendix Q. The author was given the list of new dental patients. During the pilot, they were all children, so the author was instructed to talk to the parents. Following the telephone script, the author confirmed contact information, explained the packet that would be mailed, and described the healthy neighbor plan. Taking off from the discussion on the Healthy Neighbor Plan (sliding fee scale), she also offered additional insight into activities and services provided by SBCHC, specifically Kids' Health Month activities and well-child visits. She used Appendix O to document these calls and noted that the interaction took place over the phone, instead of face-to-face.

Phase Two: Collect and Document the Data

Because both the process and the impact of the pilot protocol were important, the author made considerable effort to reflect and record the interactions within 5 minutes of having them. Appendix O provides the format used for recording each individual

conversation and the observations made by the author. Guided by Appendix O, the author kept the AIM statement in mind whereby the results of the findings of the pilot protocol were to determine what kind of language resulted in better opportunities to make intra-organizational referrals, and then to provide recommendations for specific word tracks, cues, conversation starters and general language that would lead to increased numbers of intra-organizational referrals being made by SBCHC staff from every department.

Using the form in Appendix O, the author noted after each interaction with a patient which conversation starters, questions about services and prompts were used, and what the level of patient receptivity was. She also noted the date, time, and duration of the interaction, the observed gender and estimated age range of the patient, and who or what department the patient was visiting that day. The author noted whether or not an intra-organizational referral was made, who it was made to, whether or not a firm-time appointment was made as a result of her conversation with the patient. As stated, an intra-organizational referral was defined as a referral to any service, department, provider, community event or activity offered by SBCHC and SBCHC staff members, whether or not an appointment was made, not exclusive to billable services such as an appointment with a physician for throat pain, or a chiropractic adjustment, but also including referrals to enriching or prevention services such as community wellness activities, monthly specials, workshops and health fairs. In the space provided for notes, the author made notations appropriate for fulfilling the expectation that she would be able to share the information gathered with the staff. She noted any details that reflected engagement or disengagement by the patients that she observed and also any notes or important, specific comments made by the patients.

Finally, in the six-column section of Appendix O, the author noted her observation of the patient's level of engagement as denoted by the following indicators: very interested, interested, ambivalent, uninterested, and rejected the idea. The author marked "very interested" if a patient was the first to initiate contact, verbalized their strong interest, or if the patient asked follow-up questions or for specifics regarding any part of the conversation. The author considered a person "interested" if that person made consistent eye contact, used body language to lean into the conversation, shared openly, or was perceived to have made a connection with the information being shared. Ambivalent was circled when the person made inconsistent eye contact, was perceived to have entered into the conversation out of good manners, or made it clear with body language that it didn't matter to them whether or not the author continued on after any section of the conversation. Uninterested was circled when the patient did not make eye contact, continued to play with smart phones, or verbalized disinterest. Finally, "rejected the idea" was circled when the author was not invited into conversation, or a person verbally or physically made it clear that he/she did not want to speak to the author. These cues in the form of body language, eye contact, and direct verbalization guided the author to make a selection under each of the six columns in Appendix O.

The questions about services used and prompts were coded and were also circled when the author went back to the private office to record her perceptions of the interactions. For example, if the author asked a patient, "Are you aware of additional services and events at Scenic Bluffs?" and then followed the answer with information about the *July: Kids' Health Month* and Well-Child checks, she circled number 8 under the questions about services column of Appendix O, and also numbers 9, 16, and 14 in

the prompts column. In this manner, the author recorded what specific word-tracks led to the opportunity to make specific intra-organizational referrals.

Phase Three: Document Problems, Observations, and Lessons Learned

During the pilot protocol, the author followed the flowchart presented in Figure 2.3 with confidence. Conversations were brief and often led to the opportunity to speak with someone else in the waiting room who had overheard the conversation. The author perceived that people were genuinely willing to provide their insights and also that the conversations that took place around enriching services like community engagement, health fairs, special discounts, and the new events at Scenic Bluffs engaged the patients in the conversations while providing them information that they were interested to find out about and could ultimately help them maintain health and communication with SBCHC as their health care home.

Several conversation prompts were added in the "other" category of the prompts section during the pilot protocol. These topics included the *July: Kids' Health Month*, the August Health Fair, the HELP Team, the Healthy Neighbor plan, Chiropractic services, and Behavioral Health services. Additionally, the following question was asked: "Are you aware of all the health and community events we've created for our patients this summer?"

The pilot provided the author an opportunity to use a well-practiced script speaking with patients. Aside from the additions of prompts and questions about services, the author perceived that the pilot ran smoothly, was carried out as it was planned, and that the goal of speaking with 25 patients per day for a total of 100 patients during the pilot protocol was easily achievable. The author perceived that she would be able to share

some unique insight, best practices, word tracks and specific language with the staff to help make intra-organizational referrals with more confidence, direction and know-how. A brief discussion with the PCMH accreditation leader after the final day of the pilot protocol included positive evaluation for process and interest in the results of the discussions. Both the author and the PCMH accreditation leader found the pilot itself to be useful not only for a method for data collection, but because during the week of the pilot, over one hundred SBCHC patients were provided with excellent health care customer services and also were able to connect with another person whose aim was to improve the patient experience at Scenic Bluffs. It was also a benefit for the staff members to see a student working in the clinic engaging in a positive way with their patients, providing further insight into all of the ways SBCHC tries to provide the highest quality of health care, preventive services and community wellness to its patients and the communities it serves.

SECTION III

FINDINGS

Introduction

The pilot protocol provided insight into what specific language and prompts resulted in conversations about intra-organizational referrals at SBCHC and also insight into the ease and situational appropriateness of making intra-organizational referrals by measuring the level of interest observed by the patients when specific language was used or information presented. In Section III, findings and their alignment to the purpose statement are discussed. The findings are discussed in relation to the tool used to collect them provided in Appendix O. The measure from each question and area on the tool was recorded.

The findings related to the questions in Appendix O are divided into three categories. The first set of findings represents the demographic data and the overall success of the pilot. The questions from Appendix O represented in this section include success and demographics. The first section is titled, "Success and Demographics".

The second category represents the data that relate to the situations in which intra-organizational referrals were made and what the author observed in terms of the difficulty or level of ease of making the referral. The questions from Appendix O represented in this section include time, duration, referral success, set appointments, current department specifics, referrals made to departments, observed reception of greeting, observed

reception of introduction, and observed reception of permission request. This second set of findings is titled, “Ease of Use and Situation.”

The third category represents the data relating to the specific language and prompts used that resulted in intra-organizational referrals. The questions from Appendix O represented in this section include questions about services and observed reception, and prompts used and observed receptivity. This third set of findings is titled, “Specific Language and Prompts.”

Guided by the data collection tool (Appendix O) designed to address specific components of the AIM statement and the purpose of the action plan, these findings assisted the author in providing description of the pilot and recommendations for specific word tracks, cues, conversation starters, and general language that were tested and designed to lead to increased numbers of intra-organizational referrals being made by SBCHC staff from every department, thereby building the foundation for a new, systematic method for improving intra-organizational referrals at SBCHC.

Continuing in Section III, the results of the telephone component of the pilot are discussed and finally, the development of the toolkit is described in alignment with the S or “study” component of the PDSA cycle. The S stage has two steps. During the first step which is intended to reflect on the analysis, the findings are described and analyzed further in alignment with the development of the web-based toolkit. The second step also is aligned with the development of the toolkit and is intended to document lessons learned, knowledge gained, and unanticipated results that emerged.

Description of Findings from the Pilot: Success and Demographics

Protocol completion success. During the four-day pilot, the author communicated briefly with 106 patients at SBCHC. She spoke with 101 people in person individually or in small groups, and had telephone conversations with two individuals. This result was slightly higher than the goal of speaking to 100 people in a week which represented 60% of the patients using SBCHC services during an average week in 2013, as stated in the AIM statement discussed in Section II. The 101 patients the author spoke with in person were used for calculations. The two telephone conversations were not included in calculations because the author determined that accurate observations could not be made over the phone. Based on the number of interactions held compared to the goal of 25 per day as discussed in Section II, the action plan was successful in reaching more than 100% of the patients it was designed to reach.

Demographics. This information provided a descriptive measure only and is referred to as observed demographic data because the author did not ask patients directly what their age ranges or preferred gender category was during the pilot protocol. The author spoke with 39 patients observed to be male (38.6%), and 62 patients observed to be female (61.4%). Of the patients the author spoke with, 46.5 percent were estimated to be young adults, 28.7 percent were estimated to be middle-aged adults, and 24.8 percent were estimated to be older-aged adults. The observation of age categories was an estimate based on the author's observation, as described in Section II. There were no specific demographic goals outlined for the action plan for improving intra-organizational referrals.

Description of Findings from the Pilot: Ease of Use and Situation

Time. The interactions all took place during the normal business day. The clinic did not offer evening or weekend hours at the time of the study. During the scheduled time slots described in Section II, the earliest conversation that the author had with a patient took place at 7:15am and the latest took place at 3:46pm. During the four days of scheduled patient interactions, starting at 7:15am, 77.2 percent of interactions took place before noon, and a consecutive total of 92.1 percent of the patient interactions took place before 2pm. There was a marked decrease in the number of interactions that took place over the lunch hour from noon to 1pm on any day. These findings illustrate the author's greater success interacting with people earlier in the day when compared to later in the day.

Duration. The length of interactions varied for each conversation. The shortest interactions took less than one minute and the longest took more than ten minutes. Thirty conversations took less than 1 minute, representing 29.7 percent of the total patient interactions. The most common were 40 conversations that took between 1 and 2 minutes, representing 39.6 percent of the interactions. Twenty conversations lasted 121 seconds up to 3 minutes and 59 seconds, representing 19.8 percent of the interactions. Conversations that lasted greater than 4 minutes numbered 11, and represented 10.9% of the total patient interactions. The findings are shown in Table 3.1.

The findings representing the duration of the interactions provides insight into the commitment needed to make informed, solid intra-organizational referrals. It was clear from the findings that a very short conversation lasting three minutes or less can result in a successful intra-organizational referral.

Table 3.1. Findings: Observed Duration of Patient Interactions at Scenic Bluffs Community Health Centers (2014)

Duration (Seconds)	Frequency	Percent	Cumulative Percent
<61	30	29.7	29.7
61 to 120	40	39.6	69.3
121 to 239	20	19.8	89.1
240 to 420	3	3.0	92.1
> 421	8	7.9	100
Total	101	100	100

Referral success. Using the definition of intra-organizational referral as outlined in Section II, (a referral to any service, department, provider, community event or activity put on by SBCHC and SBCHC staff members, whether or not an appointment was made, not exclusive to billable services such as an appointment with a physician for throat pain, or a chiropractic adjustment, but also including referrals to enriching or prevention services that are not directly billable such as community wellness activities, monthly specials, workshops and health fairs), the author successfully made 98 intra-organizational referrals which represented 97% of the patient interactions. The author was unable to make an intra-organizational referral during only 3 of 101 conversations. The high percentage of successful intra-organizational referrals made by the author during the pilot illustrates that a simple, direct conversation with a patient consisting of two to three questions can result in significantly greater intra-organizational referrals within an organization.

Set appointments. Of the 98 intra-organizational referrals that were made, only one resulted in a firm-time appointment. This appointment was made within minutes after the author had a brief interaction with the patient as a result of the conversation. It represents one percent of the total conversations resulting directly in a patient

appointment in a department other than the one he/she was in to see that day. These findings show that a broad-based intra-organizational referral results in lower likelihoods of patients immediately making an appointment within the referred department.

Current department specifics. Of the 101 patient interactions that the author conducted, 36.6 percent of patients were at the clinic to visit a provider in the medical department, and 59.4 percent were in the clinic to see a dentist or hygienist in the dental department. One percent of the patients the author spoke with were there to see Dr. Trevor Lyons, the chiropractor, and three percent of the patients were there to talk with a pharmacist. These data provides information that supports the distribution of patients between departments at SBCHC, an organization heavily supported by patients using the dental department services. Specifically the dental department has the most patients followed by medical, pharmacy, behavioral health, and chiropractic departments.

Referrals made to departments. Of the 98 successful intra-organizational referrals that were made, 25 were made to community wellness opportunities representing 24.8 percent of the referrals. Sixteen were made to the dental department which represented 15.8 of the referrals. Fifty-three were made to medical department opportunities representing 52.5 percent of the referrals made. Finally, seven referrals were made to the chiropractic department representing 6.9% of the total referrals made. These findings are illustrated in Table 3.2 and illustrate the focus of the specific intra-organizational referrals made by the author during the pilot by use of the prompts.

Table 3.2. Findings: Referrals Made to Specific Departments at Scenic Bluffs Community Health Centers (2014)

Referrals Made to Depts	Frequency	Percent	Cumulative Percent
Community Wellness	25	24.8	24.8
Dental	16	15.8	40.6
Medical	53	52.5	93.1
Chiropractic	7	6.9	100.0
Total	101	100.0	100.0

Observed reception of greeting. Described in Section II, when opening a brief conversation with the patients, the author first greeted them offering a smile, direct eye contact and a handshake. As shown in Table 3.3, the majority of patients' observed receptions to the greeting by the author were categorized as ambivalent, representing 65.3 percent of the total patient interactions. Of the patients observed, 28.7 percent were categorized as interested, 5 percent were very interested and 1 percent was uninterested in the greeting used by the author. These findings show that patients at SBCHC were generally open to a greeting from an employee of SBCHC in the waiting room.

Table 3.3. Findings: Observed Reception of Greeting at Scenic Bluffs Community Health Center (2014)

Observed Reception of Greeting	Frequency	Percent	Cumulative Percent
Very Interested	5	5.0	5.0
Interested	29	28.7	33.7
Ambivalent	66	65.3	99.0
Uninterested	1	1.0	100.0
Total	101	100.0	100.0

Observed reception of introduction. Table 3.4 illustrates the author's observation of the patients' reception of the standardized introduction whereby the author introduced herself as a student working at SBCHC to improve the accessibility and ease

with which its services can be used by patients and the community. The majority of the patients were interested in the author's introduction. Of the patients observed, 70.3 percent were observed to be interested in the author's introduction, 23.8 were observed to be ambivalent to the author's introduction, and a small 5.9% were very interested. Definitions of the levels of interest are defined in Section II. These findings show that patients at SBCHC were generally open to speaking with a student at SBCHC.

Table 3.4. Findings: Observed Reception of Introduction at Scenic Bluffs Community Health Center (2014)

Observed Reception of Introduction	**Frequency**	**Percent**	**Cumulative Percent**
Very Interested	6	5.9	5.9
Interested	71	70.3	76.2
Ambivalent	24	23.8	100.0
Uninterested	0	0	100.0
Total	101	100.0	100.0

Observed reception of permission request. After greeting and introducing herself the patients, the author asked for their permissions to ask a couple of quick questions. Table 3.5 illustrates the author's observation of the patients' receptions to this permission request. The majority of patients were observed to be interested, representing 70.3 percent of the total interactions. A smaller 2.8 percent were observed to be ambivalent to completing the permission statement, but still assenting, and 5 percent were observed to be very interested in the author's request for permission. These findings show that after being greeted by, and introduced to, a student at SBCHC, most patients will assent to being asked a couple of quick questions so that their insights can be heard and reactions observed.

Table 3.5. Findings: Observed Reception of Permission Request at Scenic Bluffs Community Health Center (2014)

Observed Reception of Permission Request	Frequency	Percent	Cumulative Percent
Very Interested	5	5.0	5.0
Interested	71	70.3	75.2
Ambivalent	25	24.8	100.0
Uninterested	0	0	100.0
Total	101	100.0	100.0

Description of Findings from the Pilot: Specific Language and Prompts

Questions about services used and observed reception. During each patient interaction, the author chose from one of seven opening questions addressing which services the patients used and didn't use at SBCHC. The author allowed the flow of conversation to be the deciding factor regarding which question about services she asked each patient. The question used most frequently to open a discussion leading to intra-organizational referrals was, "Are you familiar with all of the services that are offered at Scenic Bluffs?" This question was used 39 of 101 times and was used most often in the first two days of the pilot. The second most frequently used question was, "Did you know about all of the health and community events we've created for our patients this summer?" This question was asked 29 of 101 times and was used more frequently in the last two days of the pilot. Figure 3.1 illustrates the frequency with which each question was used during the pilot of the action plan and the observed reception that it received from the patients. Of the total patients observed, 76.2 percent were observed to receive the question they were asked about services used at SBCHC with interest, 14.9 percent were ambivalent, 5 percent were very interested, and 4 percent were uninterested in the question about services. These findings tend to indicate that simple, broad conversation

starters provide an easy way to transition to a more focused conversation about other opportunities for patients' health care at SBCHC.

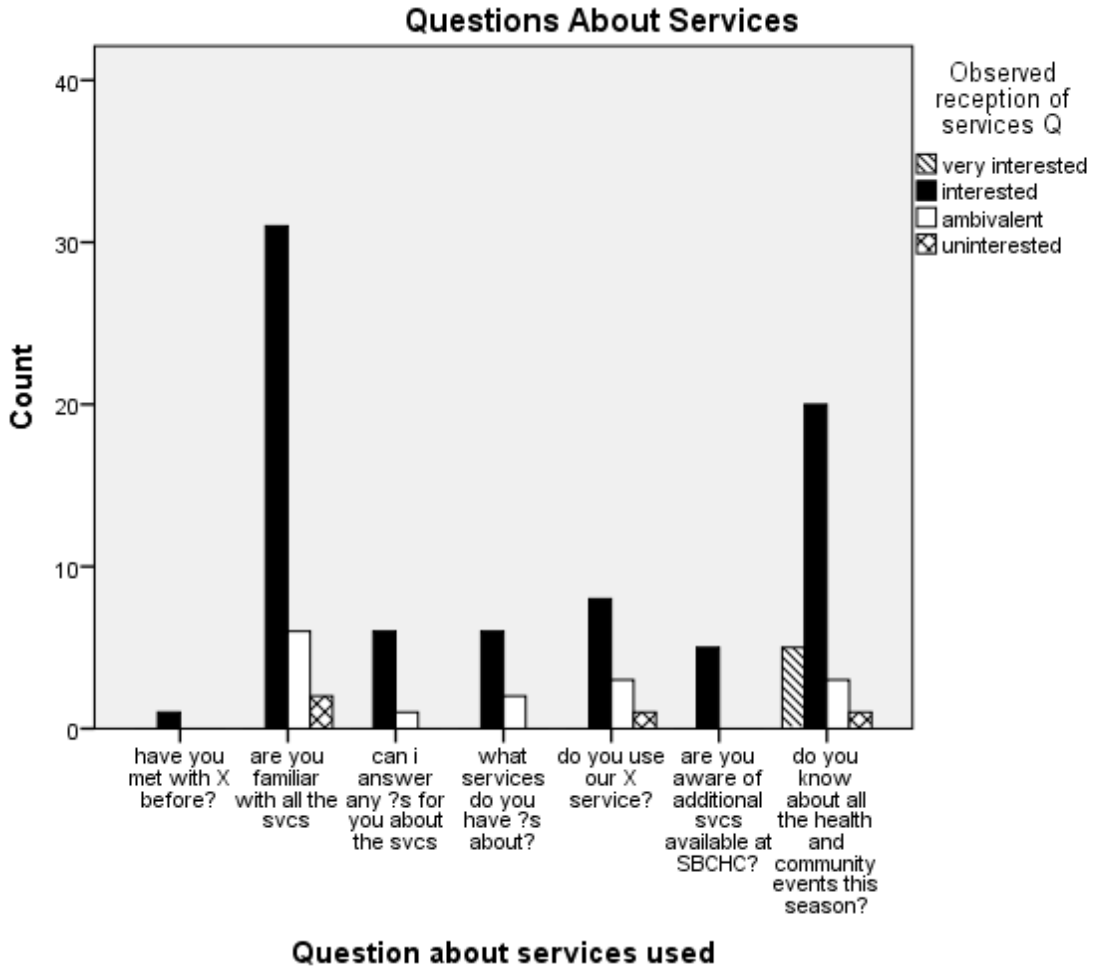

Figure 3.1. Findings: Questions about Services Used at Scenic Bluffs Community Health Center (2014).

Prompts used and observed reception. After the author asked the patients about services at SBCHC, she used up to four prompts in order to make references to other opportunities for patients at SBCHC. These prompts represented opportunities for the patients to access additional services at SBCHC and were either directly the intra-organizational referral or led to the referral itself. Each of the prompts was chosen by the author as an appropriate opportunity for each individual patient. For example, if the

patient was in the clinic with her three children for their dental visit, the author may have chosen to mention the *July: Kids' Health Month*. Alternatively, if the patient mentioned in conversation living in Viroqua, the author may have chosen to discuss the expansion of the dental department into the Vernon Memorial Hospital which was scheduled to take place before fall, 2014. At least one prompt was used with every patient interaction and 17.8 of the interactions received mention of at least four additional opportunities or prompts. As illustrated in Figures 3.2, 3.3, 3.4 and 3.5, the most frequently used prompt was community wellness, followed by the Viroqua dental expansion, sports physicals and kids' health month, and the August 2014 Annual Health Fair. Figures 3.2-3.5 also illustrate the strong interest in the opportunity as observed by the author. Only 3 percent of patients were observed to be uninterested in the additional opportunities available to them for services at SBCHC. These findings show that prompts that are individually tailored to a person's experience result in a greater likelihood of the patient receiving the suggestion to engage further with opportunities for health care at SBCHC with greater interest.

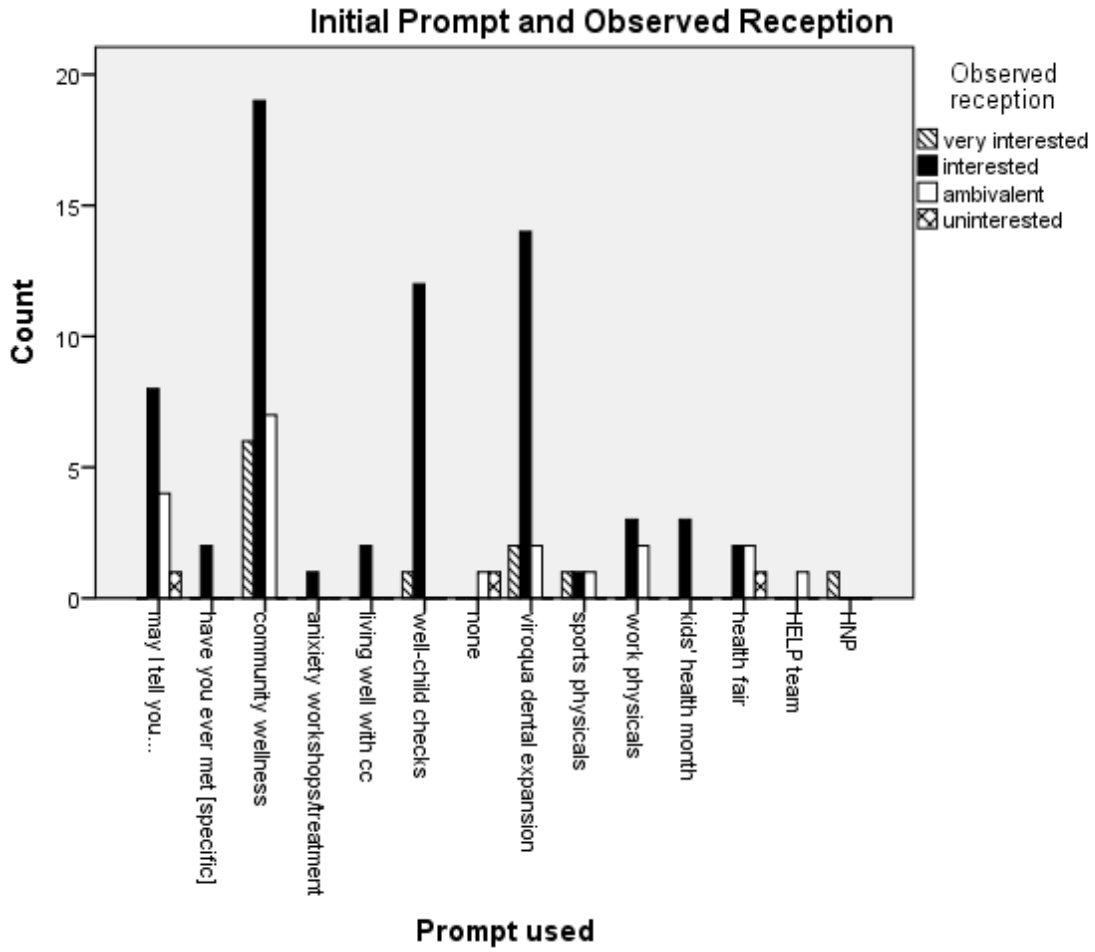

Figure 3.2. Findings: Initial Prompt and Observed Reception at Scenic Bluffs Community Health Center (2014). (For review, specific prompts are available in Appendix O).

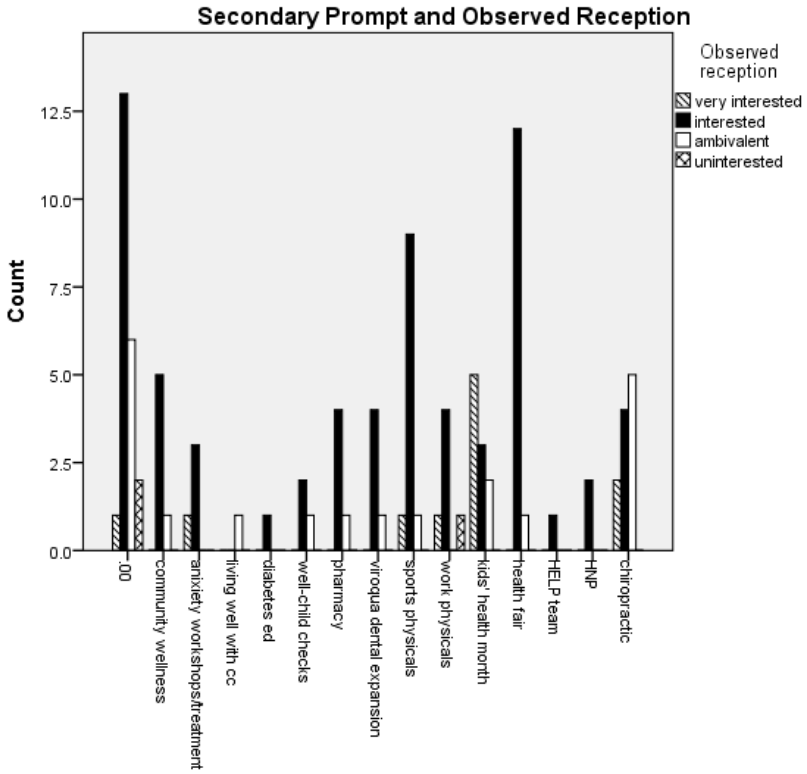

Figure 3.3. Findings: Secondary Prompt and Observed Reception at Scenic Bluffs Community Health Center (2014).

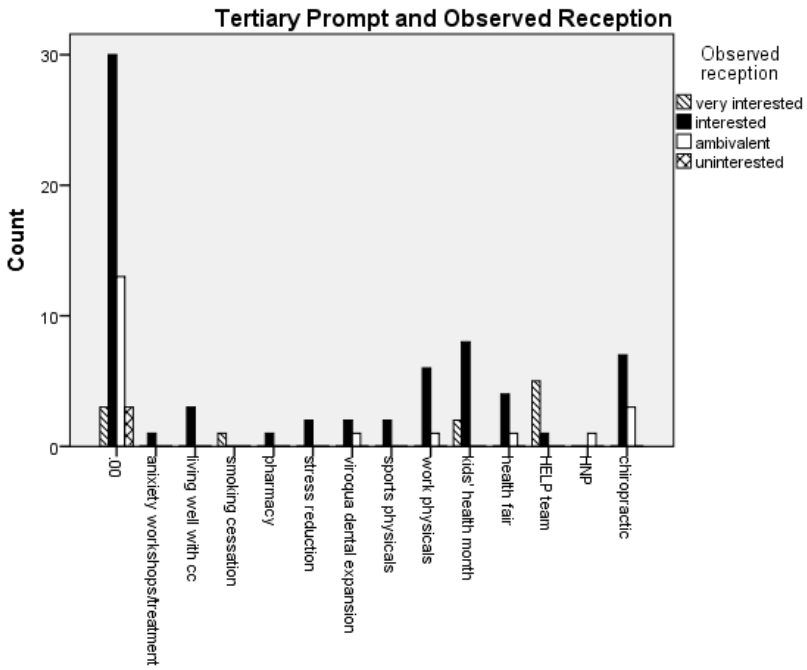

Figure 3.4. Findings: Tertiary Prompt and Observed Reception at Scenic Bluffs Community Health Center (2014).

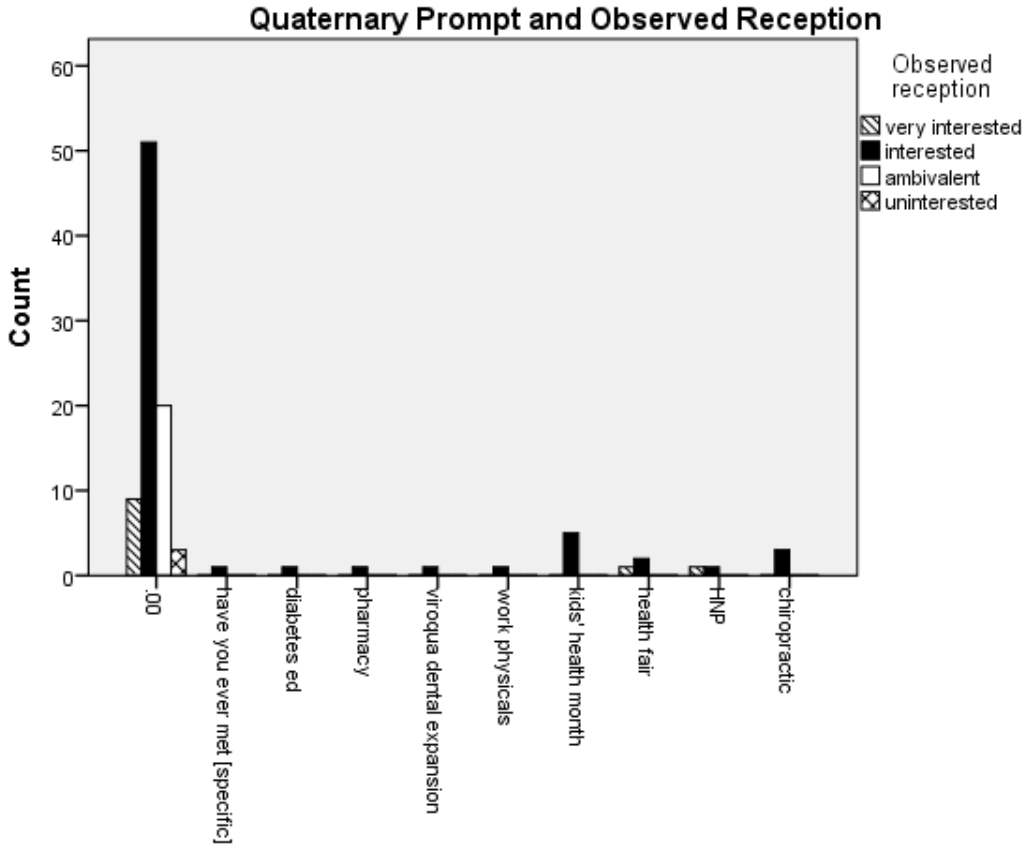

Figure 3.5. Findings: Quaternary Prompt and Observed Reception at Scenic Bluffs Community Health Center (2014).

Results from telephone calls. Though not used in the data analysis because of the perceived difficulty in observing body language and reactions over the telephone, the phone call component of the pilot gave the author the opportunity to attempt to make intra-organizational referrals over the telephone during regularly scheduled new dental patient calls. During the pilot, five new dental patients were scheduled for the phone calls. All of the new patients were children so the author addressed the parents of the new patients during the calls. Of the five calls that were made, three messages were left on voicemails and two conversations took place with parents. Whether speaking directly to a parent or leaving a message, the author spoke about the *July: Kids' Health Month*

activities and specials which were not a part of the normal phone script during her phone calls. The author also included the promotional materials for the *July: Kids' Health Month* in the packet of forms sent to the new dental patients' parents.

Even when leaving a message, the author was able to make a referral to another program within SBCHC. The three times the author addressed voicemails, she left a message similar to, "Hi, this is Kate calling from Scenic Bluffs Community Health Centers. [Child name] has a dentist appointment on [date] and since we haven't seen him/her before, I am calling to verify some information and speak with you about services we offer all our patients. I also wanted to let you know about our *July: Kids' Health Month* specials which take place this July. Please expect a packet in the mail with forms to fill out before your appointment and some informational materials. Please call 608-654-5100 with any questions. Thank you." Making a small change to the telephone script whereby the caller from SBCHC referenced another opportunity for the patient to receive excellent care or participate in a health center promotion was an easy way to make an intra-organizational referral over the telephone. Sending the promotional materials with the packet further reinforced the opportunity for the patients.

Study: Analyze the Effect of the Action Plan

The analysis of the pilot protocol and development of the toolkit is described in Section III in alignment with the S or "study" component of the PDSA cycle. The S stage has two steps. During the first step which is to reflect on the analysis, the findings were summarized described and analyzed further in alignment with the purpose statement. The second step was to document lessons learned, knowledge gained and surprising results that emerged. An additional phase was added to the PDSA S or "study" stage by the

author wherein she describes the development of the web-based toolkit based on phases one and two of the "study" phase of the PDSA cycle.

Phase One: Reflect on the Analysis in Alignment with the Purpose Statement

Demographics. The purpose of this project was to develop the foundation for a new, systematic method for improving intra-organizational referrals at Scenic Bluffs Community Health Centers. The findings from the protocols helped the author to develop a toolkit for improving intra-organizational referrals on which to base this foundation. The findings presented representing demographic data provided the information needed to describe the protocol, the observations of the people spoken with, how many people spoken with and their observed ages and genders. These descriptive findings were of value because age and gender were often important when the author was considering which additional opportunity or prompt to share with the patient, even though no specific demographic goals were set for the action plan implementation.

Ease of use and situation. The section on findings that illustrated the ease of use and situations provided insight into how long patient interactions designed to result in intra-organizational referrals actually took as described in the section on duration. This section provided data as to what times of the day were the most successful in making intra-organizational referrals and connecting with people, what departments the patients already were seeing, whether or not referrals were made and to whom, and also observed reception data of greeting, introduction and permission request. The findings derived from this section allowed the author to focus in on specific times throughout the day, and also provided insight into how length of conversation was reflected in the success or failure of an intra-organizational referral attempt. The author used the findings from this

section to describe ideal situations in which to make intra-organizational referrals and ideal durations of conversations based on intra-organizational referrals. Also, to highlight that the individualization of specific prompts used for each patient is important for making successful intra-organizational referrals.

Specific language and prompts. The conclusions based on the section on findings regarding specific language and prompts allowed the author to make conclusions which led to recommendations being drawn for specific cues to action and word tracks. The findings showed which specific conversation starters worked to engage patients in discussion about intra-organizational referrals. Further, the results of testing specific language and prompts or opportunities and comparing them against situations was important for the author to experience so that she could make informed conclusions and recommendations for the toolkit outlining best practices. The findings provided the author a basis for making conclusions, and subsequently recommendations, such as the recommendation to define anew what an intra-organizational referral is, and the development of a toolkit for improving intra-organizational referrals at SBCHC. Simple, broad conversation starters provided an easy way to transition to more individually-focused conversations about prompts or other opportunities for patients' health care at SBCHC.

Phase Two: Document Problems, Observations, and Lessons Learned

The findings described in Section III reflect the experience of the author during the pilot protocol of the action plan to test specific language and word tracks for improving intra-organizational referrals at SBCHC. Several notable observations that were not highlighted in the data from the findings were made by the author. Pride and

familiarity were two important predictors of intra-organizational referral making success that were represented by specific interactions that stuck out in the author's mind.

Pride. During a specific interaction, after the author had provided a prompt or an opportunity for one particular patient to access additional services at SBCHC, the patient commented to the author that he felt that he was now part of a "health club." During this interaction, the author provided the patient with brief information on community wellness activities and also health fair opportunities that the patient didn't know about. The author observed the patient's perception of the breadth of health care opportunities available at SBCHC improved because of the brief conversation and that the patient was proud to have chosen to be connected with the organization and the people at SBCHC. This demonstrated to the author a strong motivator for making the intra-organizational referrals: instilling pride in services was an ancillary result of providing information on additional opportunities for health care and wellness services.

Familiarity. As a result of the needs and capacity assessment and pre-pilot protocol, designed to test and evaluate the process of the action plan, the patients and staff at SBCHC became more familiar with the author who facilitated these events. This was an important consideration to the success of intra-organizational referrals because patients who had spoken briefly with the author during the pre-pilot were observed to be forthcoming and interested in providing information during the pilot. The author observed that patients she had seen or spoken with previously at the clinic not only received her greeting, introduction, and permission request with more familiarity and openness as observed by their reception of her introduction, but were also more likely to

engage further in conversation about the prompts (opportunities) mentioned during the brief conversation.

Phase Three: Development of Product

Using the findings described in phases one and two of the "study" stage of the PDSA cycle, the author developed an idea for a web-based toolkit to be housed on the SBCHC website with the purpose to provide ongoing access for SBCHC, as well as other health centers and organizations to access the training and tips that were developed. This toolkit is available at www.scenicbluffs.org and is also included in Appendix R. The piloted action plan designed to test out specific language provided the author with data on piloted word tracks, cues, conversation starters, general language and situations that were conducive to conversations about additional opportunities for patients at SBCHC and to making intra-organizational referrals in the best interest of the individual patients. The author used these findings and conclusions as the systematically-derived basis for developing a toolkit for improving intra-organizational referrals to share with the staff to be used as the foundation for the new, systematic method for improving intra-organizational referrals and interprofessional communication at SBCHC.

The web-based toolkit was organized into sections: Introduction and Foundational Materials, Training Resources, and Evaluation. The introduction and foundational materials, designed as the landing page for the web-based project define what an intra-organizational referral is within the context of a PCMH, demonstrate the importance of having a systematic method for improving and promoting intra-organizational referral within a PCMH and state the goals of the toolkit, briefly referencing literature on the subject. On this page, a brief but important discussion about needs and capacity

assessments is included. The introduction and foundational materials set the stage for improving organizational strategy by first asking users to define what an intra-organizational referral is, what success in making intra-organizational referrals at specific health care organizations looks like, and to define and communicate what is expected of specific staff members for making intra-organizational referrals.

Moving away from the landing page, the second section titled Training Resources provides training tools and challenges designed to help people learn how to open conversations about additional health center opportunities for patients and how to make intra-organizational referrals. Within the Training Resources section, the author provides links to resources that will help staff *identify* opportunities for making intra-organizational referrals, *discuss* scenarios, questions and common concerns, and *practice* using skills. Within the Training Resources, the author developed resources titled Conversations Starters to practice, Cues to Action to identify, Role Plays to practice, and Scenarios to discuss. Each of these resources was developed using insights gained from the pilot.

The third section of the web-based toolkit provides an evaluation of the content and sequence of the information provided. Because of the dynamic nature of health care quality improvement, this toolkit has the potential to be revised, updated and changed to match the way it is being used. Guided by the information provided by staff at SBCHC and other organizations who complete this evaluation, the author will revise and improve upon this first iteration of the Building a Strategic Foundation for Improving Intra-Organizational Referrals and Interprofessional Collaboration Toolkit. The internet-based format allows for updates, revisions and additions to be made to the toolkit based on how

it is being used in the field. This toolkit is available at www.scenicbluffs.org and is also included in Appendix R for review.

SECTION IV

CONCLUSIONS, RECOMMENDATIONS AND DISCUSSION

Section IV includes the conclusions, recommendations, and discussion. The conclusions, or categorized groupings of findings, are listed and discussed for sharing insights with others in the field. With the recommendations, the PDSA cycle concludes with the A or "act" stage whereby the author makes a recommendation for the action plan used for this protocol. The recommendations continue in alignment with each conclusion, discussing how this project could be used by others in the field and include considerations for implementation of the toolkit and resources. The discussion includes personal and professional viewpoints of the author and what was derived from the project and its related activities as a health educator.

Conclusions

Conclusion #1: Definition. Success for a foundation for improving intra-organizational referrals will be directed by an organization's definition of intra-organizational referral. Successful intra-organizational referrals do not have to be made by a provider and do not have to exclusively be based on need or diagnosis; they can be made to improve patient interaction with the opportunities available to them for their health care at a PCMH. Successful intra-organizational referrals can be very brief and require little more than a few minutes, knowledge of available opportunities within one's health center, and the ability to open a conversation and follow with a focused, individualized recommendation for patient engagement. From the author's vantage point,

making intra-organizational referrals is easier when the referrer is engaged, knowledgeable and proud of the organization.

Conclusion #2: Demographics and completion rate. Across gender, age, time of day, and date, the pilot implementation aimed at increasing intra-organizational referrals at SBCHC was successful. The implementation of the pilot protocol resulted in intra-organizational referrals being made for 98 of 101 patient interactions, a completion rate of 97 percent. Although only one appointment was actually set as a direct result of the brief conversations had by the author with the patients, the author's observation of the receptivity of patients was almost consistently classified as "interested." Both male and female patients from a range of ages at Scenic Bluffs Community Health Centers showed interest in hearing about other opportunities for health care available to them through their local PCMH. Additionally, the author observed that throughout the implementation of the pilot, more staff members at SBCHC showed interest in what she was doing and she began to hear the word "intra-organizational" around the building. So, not only did the pilot promote services within the SBCHC patient community, but it also promoted intra-organizational referrals and interprofessional communication foci within the SBCHC staff.

Conclusion #3: Ease of use and situation. Because the definition for intra-organizational referrals included referrals made to any service, department, provider, community event or activity put on by SBCHC and SBCHC staff members, whether or not an appointment was made, not exclusive to billable services, but also including referrals to enriching or prevention services, it was easy for the author to identify opportunities to make intra-organizational referrals in brief patient interactions. The

duration of the client interactions leading to intra-organizational referrals was short: the average time spent with each patient interaction was two minutes or less. It was clear from the study that conversations lasting three minutes or less resulted in completed intra-organizational referrals. This provides important insight into the low-effort and time commitment by staff that is needed to promote intra-organizational referrals within an organization.

The findings further show that patients at SBCHC are generally interested and open to talking with SBCHC staff about additional opportunities for their health care and that using a brief greeting, introduction and request for permission results in opportunities to gain patient feedback and insights. These findings also show that broad-based intra-organizational referrals may result in the lower likelihood of patients immediately making additional appointments for additional services. The author was successful in speaking with 60 percent of the average number of patients seen at SBCHC in a week and providing them with an informed referral to other services within the organization.

Conclusion #4: Specific language and prompts. General, broad-based conversation starters followed by focused, individualized, prompts usually result in positive patient interactions when making intra-organizational referrals. The general conversation starters provided the author a more efficient way to transition to a more focused conversation about other opportunities for patients' health care. This study generally found that when a simple, direct conversation starter is used with a patient consisting of two to three questions, followed by a focused and individualized prompt or referral to other opportunities within the health center, intra-organizational referrals were usually met with high observed interest by the patients. In the study, two broad questions

about services were used that resulted in observed interest by the patients. Narrowing the focus of the prompt or referral to the individual's perceived needs as was done by the author of this study, provided patients with opportunities for additional knowledge of community events, services and departmental offering that they hadn't known before the brief conversations that took place, if remembered from the conversations.

Conclusion #5: Pride and familiarity. Finally, during this study, the author observed that familiarity with the person making the intra-organizational referral and pride in the health center were two important factors regarding patient engagement and interest. When the author was recognized by the patient, her questions were more openly welcome and patients engaged further in the conversations as illustrated by examples of patients with whom the author had interacted or seen during the pre-pilot. Additionally, when the author perceived that the patients took pride and were happy with their decision to associate with SBCHC, engagement was also enriched for both the patient and for the author. The author observed excitement in the conversations and reception of the patients who exhibited pride during the brief conversations.

The author realizes that her innate positive attitude, excitement, and passion had an influence during these conversations with patients affecting pride and engagement. The author, as the instrument of assessment, observing and categorizing reactions, body language and verbal cues also influenced the positive engagement with the patients and staff members. The author realizes that she was a highly positive influence in this study.

Act: Act Upon What Has Been Learned

Recommendations for Model Implementation

To complete the PDSA cycle, the final stage is the A or "act" stage in which one of three options is chosen using the information from the findings and conclusions examined during the S or "study" phase. Option one is to adopt or standardize the action plan that was tested. Option two is to adapt or to modify and try again, going back to the D or "do" phase and following through with evaluation of modifications and analysis of new results. Option three is to abandon or to throw away the idea and start again at the P or "plan" phase of the PDSA cycle. The ACT phase represents the circularity of the PDSA cycle whereby a user may go all the way back to the beginning of the cycle to try implementing a new action plan or they may close the circle choosing to adopt the tested action plan. With the assistance of the toolkit derived from the PDSA cycle aimed at developing a systematic foundation for improving intra-organizational referrals at SBCHC, the author recommends adoption of the change.

Recommendation #1: Definition. Based on the conclusions drawn, it is recommended by the author that organizations first define intra-organizational referrals within parameters specific to individual organizations. Related to the success of this action plan guided by the PDSA framework, the broad definition of intra-organizational referral not only provided increased opportunities for making referrals within the SBCHC organization, but it also promoted the idea of interprofessional collaboration as something that doesn't have to be entirely need-based or medical diagnosis-based. Need-based referrals are an important daily activity of health care providers who have been trained to identify health issues within and outside their individual scopes of practice. Broadening

the definition to include referrals to enriching, prevention-based services has the potential to improve staff members' ability throughout the organization to make intra-organizational referrals. When all staff members are trained to, and expected to, make intra-organizational referrals because the definition includes not only referrals for immediate health needs as identified by a health care provider, but also referrals for the improvement and enrichment of the patient experience within the health center by engaging more fully with the patient-centered health care available to them, the foundation for this organizational strategy could be established.

Recommendation #2: Demographics and success. Intra-organizational referrals can be made at any time of the day, any day of the week, by motivated staff members. Intra-organizational referrals can also be made to any gender and any adult patient. It is important to the success of an intra-organizational referral foundation that demographics are used as descriptors and not as delimiters when making referrals. Recognizing the breadth of opportunities for making these referrals, unbound by race, sex, age, or first-impression will add to the success of intra-organizational referral making.

Recommendation #3: Ease of use and situation. Intra-organizational referrals can be brief, relatively easy to make and can be made anywhere. It is recommended that they are not made more complicated than necessary. A brief interaction, sharing with patients the opportunities available to them to benefit their health through a health center or health organization is an easy way to provide a personal touch, and most people are open to having a quick conversation with a representative of a health center.

Recommendation #4: Specific language and prompts. It is recommended to try to open conversations with greetings, introductions and permission requests and then to

move the conversation forward with a broad, open-ended question about the patient's experiences with or knowledge of the opportunities for health care provided by the organization. It is recommended to make the referral by providing a suggestion about an opportunity for care the patient may not be using already that is tailored to that patient using the brief observations made early in the conversation. For example, if the patient is surrounded by children, mention special events or promotions aimed at enriching the health and wellness of children put on by your health center or partners, such as local anti-smoking or physical fitness coalitions or larger organizations.

Recommendation #5: Pride and familiarity. It is recommended that if a person is proud of what the health center does for its patients and community and staff let it show in normal conversation, patients have a better opportunity to gain that excitement. It is recommended to let pride of what you stand for as a PCMH show. This can be done by engaging in activities within the health center and also within the greater community as a representative of the organization. If people recognize staff as positive, helpful partners in their health and wellness, they may be more likely to give staff a chance to promote the opportunities provided by the PCMH.

Recommendation #6: Customize the toolkit. The web-based toolkit developed is a guide for improving organizational strategy for intra-organizational referral making. Following the steps outlined in the toolkit, and using the information you found in your needs and capacity assessment, it is recommended to first define in specific terms what intra-organizational referrals means to your organization. Based on this definition, describe what success in making intra-organizational referrals looks like. Success may look like EMR-linked referrals to specific departments based on needs that can be

measured on a daily or weekly basis, based on billable primary care services. For example, a patient comes in to see a physician for a strep throat culture and the physician notices an obvious oral health issue such as a cavity and refers the patient to the dental team using the electronic medical record (EMR). Another example could be having staff members walking through the waiting room stop to welcome and address patients and tell them about specific events going on at a health center or in specific departments at a health center, focusing on the enriching, preventive services.

Finally, it is recommended to establish and communicate clear expectations to staff members held responsible for making intra-organizational referrals. The tools available in the toolkit are designed to assist in training the staff on how to make and identify opportunities for intra-organizational referrals in a health center. Every health center is different because the patients and staff members are different. When an organization has defined what an intra-organizational referral is, what success making intra-organizational referrals looks like, and how clear expectations for making intra-organizational referrals can be set and communicated, a strong foundation will be set for improving this organizational strategy. It is recommended to try using a few of the resources provided in the SBCHC toolkit for improving intra-organizational referrals in a PCMH to see how they can be put to practice to improve referrals and interprofessional communication within your organization. Importantly, it is recommended that results be shared so that others may benefit from the experiences of similar organizations.

Discussion

Throughout the development of this graduate project, the author was intent on following a natural, organic process that evolved out of preceptorship-related duties from

the identification of a need, with the goal of creating something to address that need. It was very important to her that the project was not simply a means to an end, but rather a process that could be used by health professionals to practically and professionally address an area for health care quality improvement at Scenic Bluffs Community Health Center and with further research, potentially other health centers recognized at Patient-Centered Medical Homes across the country. By focusing her skills and proficiencies and listening to what the organization needed as determined by the staff, executive director, and Board of Directors, the author was able to follow a systematic process derived from and guided by her Master of Public Health-Community Health Education experience. This project represents a cumulative, capstone experience that fulfilled the greatest expectations of the author.

Emerging early in the process as an important consideration in the development of a foundation for improving intra-organizational referrals, interprofessional collaboration became a concept that gained much depth and breadth for the author. Working as an administrative health professional and health educator in a small, rural community health center gave the author a clear, distinct idea of what interprofessional collaboration looks, sounds, and feels like. Interprofessional collaboration was not an intended consequence, however, it was crucial to the success of the development of this graduate project, and this became clear to the author early in the process. Without the collaboration and partnership of professionals outside of the field of public health and community health education, this project would not have been possible. Interprofessional collaboration and intra-organizational communication were the most important factors leading to the success of the development of a foundation for improving intra-organizational referrals

due to the nature of the Patient-Centered Medical Home. Doctors, health educators, chiropractors, dentists, registration professionals, hygienists, medical assistants and administrative professionals work together toward the goals of providing patient-focused health care of the highest quality at Scenic Bluffs Community Health Center every day and without the systematic sharing of information and knowledge across professions facilitated by the Executive Director and leaders within the organization, without refined interprofessional collaboration, this goal would not be attainable. Interprofessional collaboration keeps the patient as the center and the focus of the care provided.

Throughout the development of this project at Scenic Bluffs, the author had the opportunity to take on the role of facilitator of interprofessional collaboration and intra-organizational communication. Her training as a health educator provided her with the flexibility and versatility to meet the challenges of the experience. When appropriate, the author took on leadership roles, guiding discussions, providing education to the Board of Directors and staff, and facilitating important conversations with key members of the staff from every department. Other times, as appropriate, the author took the opportunity to sit back and observe, to listen openly, and to provide support for conversations and ideas had by others. She utilized professional salesmanship and teaching skills on a daily basis and found that her preparation as a Master of Public Health-Community Health Education candidate provided her with unique insight that made the facilitation of interprofessional collaboration a challenge she was well prepared for. It is the nature of the health educator to interact with not only patients from all different backgrounds, educational experiences, but also to interact with health care professionals from many different professional backgrounds. With a growing awareness of the importance of the

integration and partnership of medicine and public health fields as outlined by the Institute of Medicine's *Primary Care and Public Health: Exploring Integration to Improve Population Health* (2012), the author's experience provided her with unique insight into how health educators can play important roles in the facilitation of new, important partnerships between primary care and public health professionals. Guided by her experiences, the author views the role of the health educator in the primary care setting as one most appropriate for facilitating important partnerships between primary care professionals within an organization or health center. The author feels that the role of health educator could appropriately be responsible in a health center setting for patient experiences and health outcomes resulting from facilitated collaborations between primary care professionals and public health professionals. Because of flexible and versatile professional development, the health educator can do much for improving the continuity of care for patients within health centers.

Through her experiences in developing the foundations for improving intra-organizational referrals at SBCHC, the author gained a solid understanding of the importance of interprofessional collaboration and intra-organizational communication within a primary care health center. Redefining intra-organizational referrals outside of the specifically health-need based referral system opens the door for improved continuity of care for patients and improved job satisfaction for health center professionals. The author observed increases of several factors in the staff members at Scenic Bluffs Community Health Centers throughout the development of her graduate project because of the significant focus on transparency and clear communication. Those factors developed within the author, as well, and included increased proficiency for

interprofessional collaboration, increased understanding of patient-centered care and continuity of care, and pride. This project provided the author with the ideal opportunity to dedicate herself to addressing a real need in the organization, and at its conclusion, the satisfaction of a well-received, systematic, and clearly-defined process.

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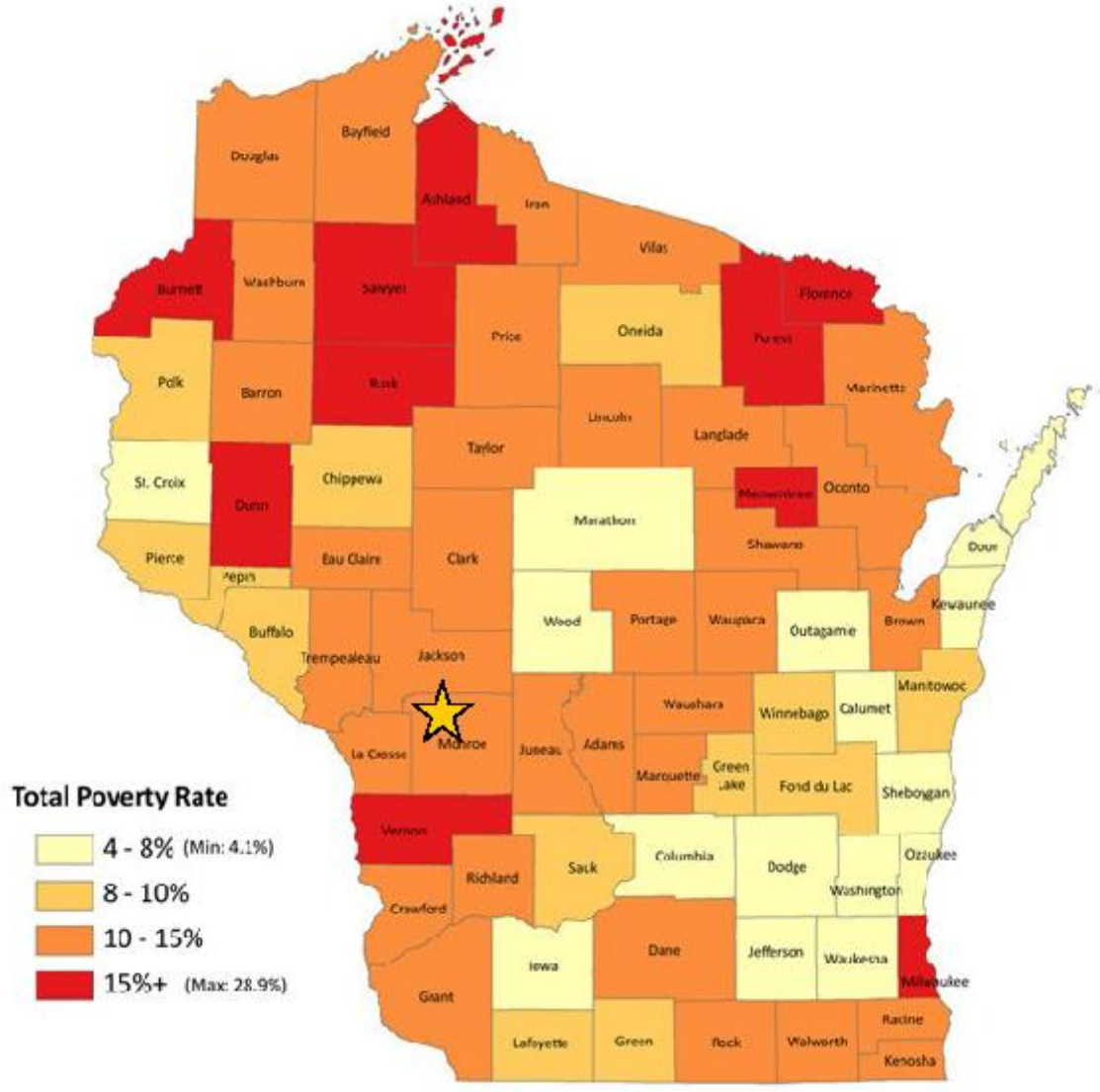
APPENDIX A

SBCHC SERVICE AREA MAP

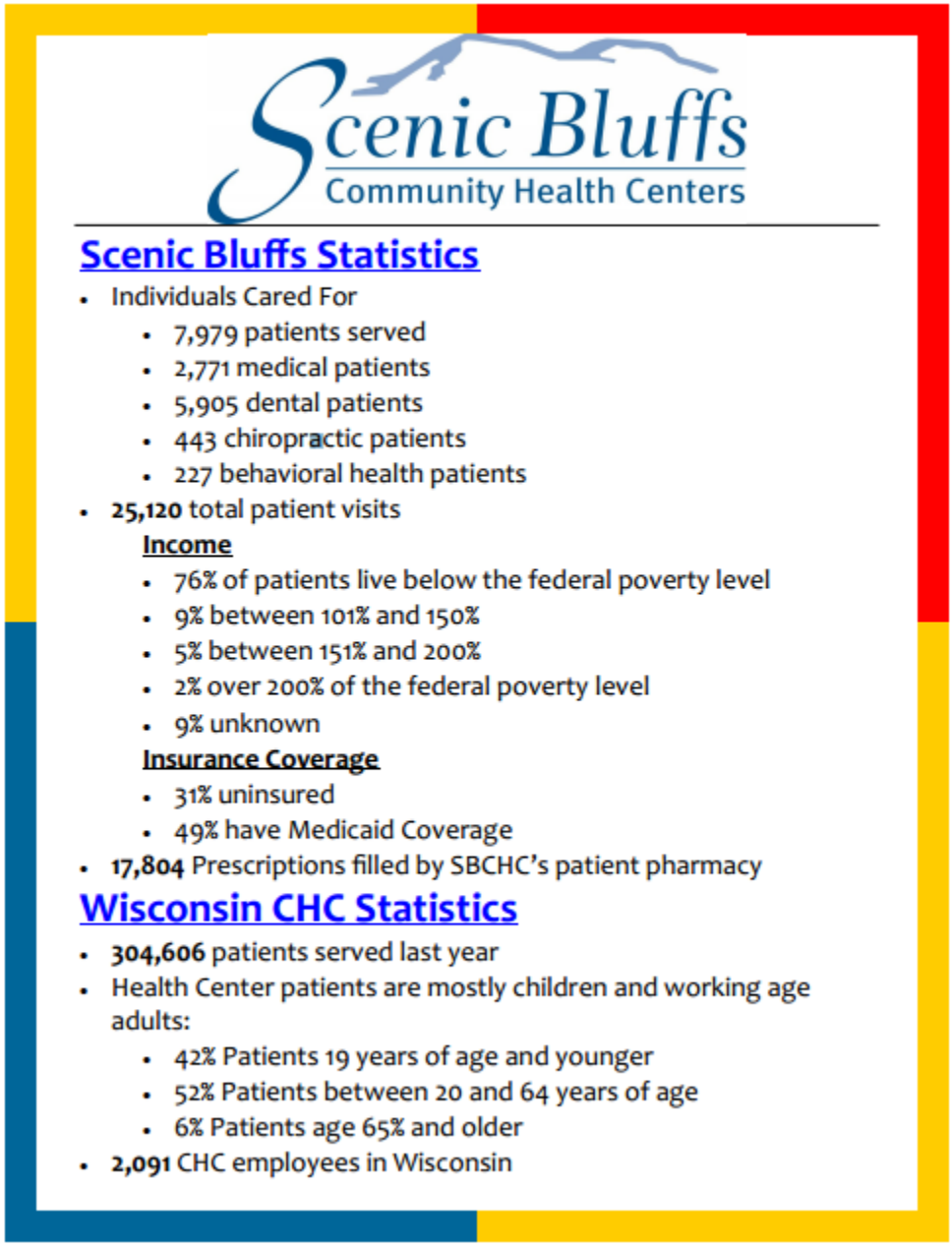
Appendix A:
Total Poverty Rates for Wisconsin Counties, 2005–09 and Location of Scenic Bluffs Community Health Center



Source: Map provided by Applied Population Laboratory, Department of Community and Environmental Sociology, University of Wisconsin–Madison, U.S. Census Bureau, 2005–2009 American Community Surveys. Retrieved from http://www.irp.wisc.edu/faqs/faq4.htm

APPENDIX B

SBCHC FACT SHEET


Scenic Bluffs
Community Health Centers
Scenic Bluffs Statistics
Individuals Cared For
7,979 patients served
2,771 medical patients
5,905 dental patients
443 chiropractic patients
227 behavioral health patients
25,120 total patient visits
Income
76% of patients live below the federal poverty level
9% between 101% and 150%
5% between 151% and 200%
2% over 200% of the federal poverty level
9% unknown
Insurance Coverage
31% uninsured
49% have Medicaid Coverage
17,804 Prescriptions filled by SBCHC's patient pharmacy
Wisconsin CHC Statistics
304,606 patients served last year
Health Center patients are mostly children and working age adults:
42% Patients 19 years of age and younger
52% Patients between 20 and 64 years of age
6% Patients age 65% and older
2,091 CHC employees in Wisconsin

APPENDIX C

SBCHC 2013 SUMMARY OF STATISTICS

Scenic Bluffs
COMMUNITY HEALTH CENTERS

1994-2014: 20 Years of Brining Healthcare to You

To provide accessible, patient centered primary healthcare focusing on disease prevention and education to improve the health and well-being of our communities.

Patient Care

- In 2013, Scenic Bluffs Community Health Centers
  - Served 8664 patients
  - Provided 25,991 appointments to patients-
    - Medical 36%
    - Dental 73%
    - Chiropractic 5%
    - Behavioral Health 3%
- Our 2013 patients included:
  - 20.7% - under age of 19
  - 3.3% - non-white
  - 87.3% - living below 200% of the federal poverty level
  - 71% living below 100% of the federal poverty level
  - 32.6% - uninsured
  - 6.3% - best served in another language (primarily Spanish)
  - 46% - Medicaid coverage
  - 7.8% - Amish
  - 18.1% -private insurance

Recognitions/Grants

- Patient Centered Medical Home
  - Highest Level 3 Recognition
- United Way Agency Partnership
- Outreach and Enrollment Grant to educate and assist patients through healthcare reform.

Economic Impact of Scenic Bluffs in our Communities

- Economic impact of $5.3 million to local economy
- Over $1.4 million in sliding fee scale discounts given in 2013
- $5.6 million annual operational budget
- Employ 62 people (full-time equivalent jobs)
- Operate 2 sites
  - Cashton: medical, dental, pharmacy, chiropractic, and behavioral health
  - Norwalk: medical, and chiropractic

Very Satisfied Patients
(October 2013 Patient Satisfaction Survey)

- 95.7% say their provider gives them good advice and treatment.
- 98.9% say they would recommend Scenic Bluffs to their family and friends.
- 99.5% of Scenic Bluffs patients say their provider considers their personal family beliefs in relation to care decisions.

MEDICAL • DENTAL • BEHAVIORAL HEALTH • PHARMACY • CHIROPRACTIC

Norwalk Location
200 West North Street
Norwalk, WI 54648

Our Mission
To provide accessible, patient centered primary health care focusing on disease prevention and education to improve the health and well-being of our communities.

Cashton Location
238 Front St,
Cashton, WI 54619

Community Outreach and Impact in 2013

- Staff attended 177 Community Outreach Events in 2013
- Provided Outreach and Enrollment services in accordance with the new Affordable Care Act.
  - 605 people assisted
  - 168 people received an eligibility determination
  - 51 people enrolled in a plan
- In 2013, taught 27 CPR/First Aid classes
  - 105 students
- Scenic Bluffs Walkers (2012-2013 program)
  - 559 people registered for winter walking program in Cashton and Norwalk-Ontario-Wilton [N.O.W.] Schools and Communities
- Hosted Hemophilia Education Day
  - Over 100 participants
- Hosted 2 Session of Living Well With Chronic Conditions Course
- 5 Classes of Question, Persuade, Refer Suicide Gatekeeper Class
  - 54 people trained
- Senior Exercise Classes - chair exercise program for elderly community members held twice a week
  - Averaged 6 participants each day
- Hosted 3rd Annual Dandelion Dash with Wellness Celebration
  - 117 Registrants
- Offer community wellness and nursing services in collaboration with Public Schools (Cashton, Westby and N.O.W.)
  - Family Activity Nights
  - Cooking Classes
  - Monthly Kids Health Newsletter
  - Fitness Classes offered in Cashton & Norwalk
  - Open Gym and Cardio Lab
  - Adult Dodgeball Tournament
- Partnered with N.O.W. and Cashton schools to teach once a month in afterschool program
- Hosted the Gundersen Lutheran Mobile Mammography on 3 occasions
- Hosted two onsite Drug-Take-Back Dates to allow for safe and anonymous drug disposal
- Partnered with Lugar De Reunion in Sparta to provide CPR and 1st Aid Programs as well as Affordable Care Act Outreach and Enrollment.
- Provided dental sealants to 2nd and 7th graders from Cashton, N.O.W., Kickapoo, La Farge, and Sparta Public Schools.
  - 124 students examined
  - 267 free sealants were placed
- Participate in health fairs at Ft. McCoy, Diary Breakfasts, Organic Valley, Viterbo, Head Start, Logistics Health and various schools in region.
- Attended Advocacy Events in Madison and Washington D.C. to build relations with funding officials
- National Health Centers Week Celebration
  - First Aid Mini-Camp for Kids
  - Staff Appreciation
  - Patient Appreciation
  - CHC Awareness Campaign
  - Free Health Fair
    - Free cancer screenings: skin, prostate, colon, breast, oral
    - 81 people participated in services
- Targeted health activities
  - Children's Health Month
  - Heart Health Month
  - Dental Month
    - 435 total students reached
  - Flu vaccine education
  - Monthly health education focus in waiting rooms, advertising and mailings

24 Hour Answering Services:

608-654-5100. 608-823-7853
608-785-2550

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APPENDIX D

BUDGET

Intra-Organizational Referrals Budget

Items	Cost Per	# Requested	Percent	Amount Requested	In-Kind Donations	Total Budget
Categories						
Transportation						
62.8 miles per day, two days per week= 125.6 miles per week Route calculated: https://goo.gl/maps/D5Rw4	$0.56 per mile	31 weeks			$2,180.42	$2,180.42
Presentation Materials						
Professionally printed poster board- DigiCopy, La Crosse	$78.00	1		$78.00		$78.00
Professionally printed, bound report, black and white- DigiCopy, LaX	$16.00	3		$48.00		$48.00
Professionally printed tool kits for Cashton and Norwalk locations: 16 color pages spiral bound on index stock with plastic cover	$9.15	10		$91.50		$91.50
Printing						
Printing costs for report drafts, pre-pilot and pilot data collection forms 400 pages times $0.06 per pge	$0.06	400			$24.00	$24.00
Total Budget	$103.21		0	$217.50	$2,204.42	$2,421.92

APPENDIX E

SBCHC PDSA CYCLE WORKSHEET

Scenic Bluffs
COMMUNITY HEALTH CENTERS

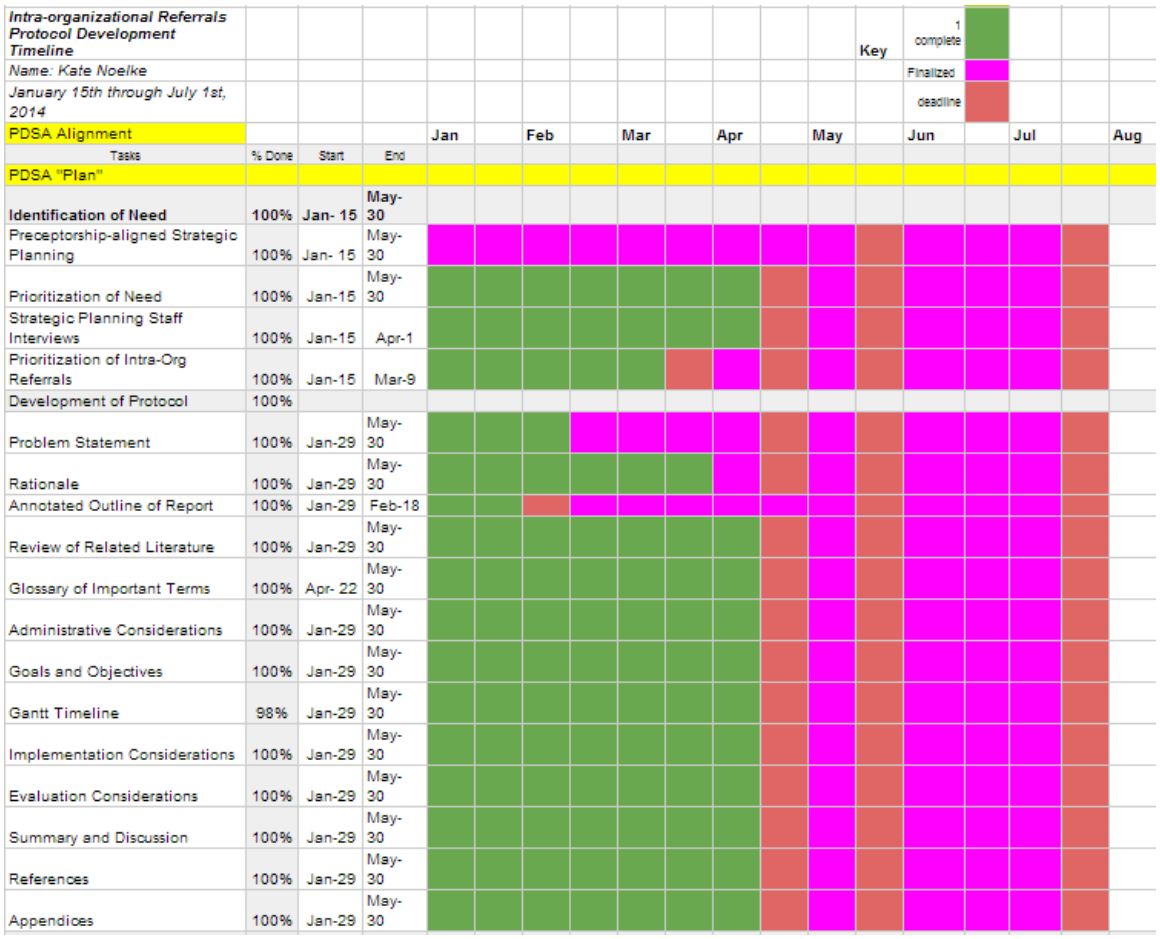
Model for Improvement

PDSA CYCLE WORKSHEET – The Plan-Do-Study-Act (PDSA) cycle is shorthand for testing a change — by planning it, trying it, observing the results, and acting on what is learned.

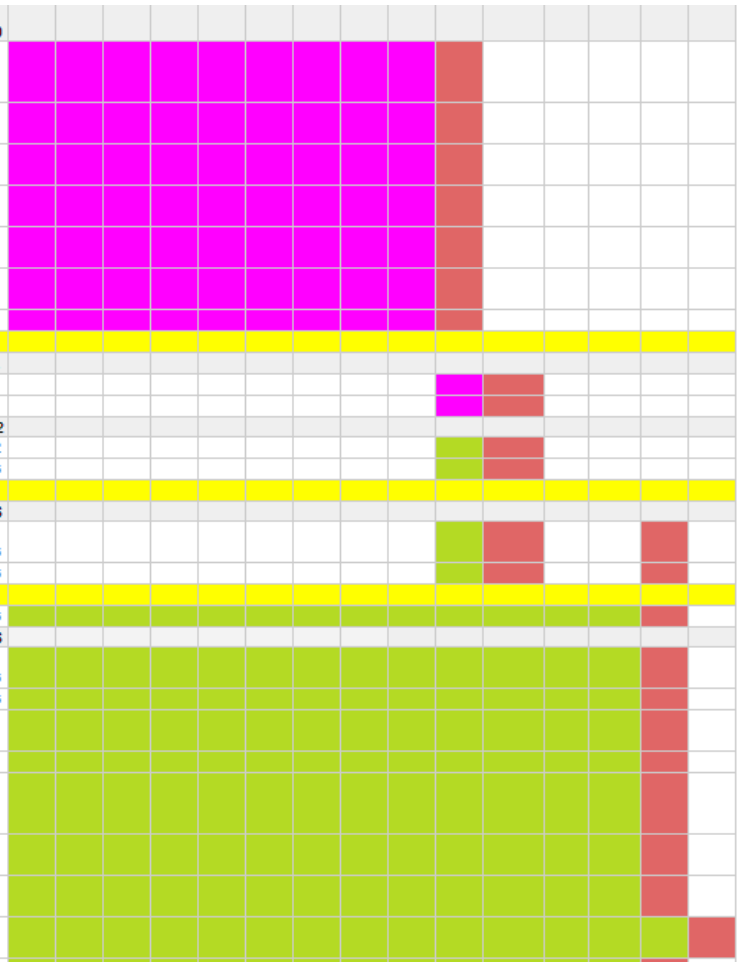
What are we trying to accomplish? (overall goal)
How will we know if a change is an improvement? (measurement)
What changes can we make that will lead to improvement? (brainstorm ideas)
Design a P-D-S-A Cycle **PLAN:** What are you going to do and when will you do it? (Choose one of the ideas above)
DO: Detail timeline and specific steps for action.
STUDY: Were we successful? What happened? What did we learn?
ACT: Can we make other changes to improve? Is this issue resolved? Do we need to review again to make sure things are still working? *2014-1*

APPENDIX F

GANTT CHART TIMELINE


Intra-organizational Referrals Protocol Development Timeline
Name: Kate Noelke
January 15th through July 1st, 2014
PDSA Alignment
Key
1 complete
Finalized
deadline
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Tasks
% Done
Start
End
PDSA "Plan"
Identification of Need 100% Jan- 15 May-30
Preceptorship-aligned Strategic Planning 100% Jan- 15 May-30
Prioritization of Need 100% Jan-15 May-30
Strategic Planning Staff Interviews 100% Jan-15 Apr-1
Prioritization of Intra-Org Referrals 100% Jan-15 Mar-9
Development of Protocol 100%
Problem Statement 100% Jan-29 May-30
Rationale 100% Jan-29 May-30
Annotated Outline of Report 100% Jan-29 Feb-18
Review of Related Literature 100% Jan-29 May-30
Glossary of Important Terms 100% Apr- 22 May-30
Administrative Considerations 100% Jan-29 May-30
Goals and Objectives 100% Jan-29 May-30
Gantt Timeline 98% Jan-29 May-30
Implementation Considerations 100% Jan-29 May-30
Evaluation Considerations 100% Jan-29 May-30
Summary and Discussion 100% Jan-29 May-30
References 100% Jan-29 May-30
Appendices 100% Jan-29 May-30

Needs and Capacity Assessment	100%	**Mar-9**	**May-30**
Focus group interviews to establish recommendations for strategy	100%	Apr-22	May-30
Data analysis and compilation	100%	May- 1	May-15
Review alignment with related literature	100%	May-15	May-29
Prioritization of strategies to try in pilot	100%	May-25	May-29
Development of pre-pilot	100%	May-25	May-29
Development of ore-pilot materials	100%	May-25	May-29
Development of pilot	100%	Jun-3	Jun- 5
PDSA "Do"			
Pre-Pilot	100%	**Jun- 3**	**Jun- 4**
Pre-pilot implementation	100%	Jun-3	Jun-4
Evaluation of pre-pilot	100%	Jun- 3	Jun- 4
Pilot	0%	**Jun- 9**	**Jun- 12**
Pilot implementation	0%	Jun- 9	Jun- 12
Process evaluation	0%	Jun- 12	Jun- 16
PDSA "Study"			
Evaluation	0%	**Jun- 12**	**Jun- 16**
Process evaluation (begins above)	0%	Jun- 12	Jun- 16
Outcome evaluation	0%	Jun- 12	Jun- 16
PDSA "Act"			
Development of Toolkit	0%	Jun- 12	Jun- 16
Reporting of Findings	0%	**Jun- 12**	**Jun- 16**
Data analysis and compilation of findings	0%	Jun- 12	Jun- 16
Completion of protocol	0%	Jun- 12	Jun- 16
Production of protocol summary/manuscript	0%		Jul- 1
Printing of Tool Kit			Jul- 1
Reporting of findings to executive director and PCMH leader	0%		Jul- 1
Reporting of findings to key collaborators	0%		Jul- 1
Reporting of findings to board of directors	0%		Jul- 10
Reporting of findings via Employee Newsletter	0%		Aug- 1



APPENDIX G

QUALITATIVE INTERVIEW QUESTIONS FOR STRATEGIC PLANNING

Qualitative Interview Questions for Strategic Planning

Mari Freiberg

1/3/14

General Strategic Planning Questions for Staff

1. In three years, if we're at our best, what do we look like? What are our systems like? Are there new things? What's bigger and better? What's gone?
2. What would you do differently if you HAD to get 10 times better/bigger in the next 12 months?
3. What do we stand for as an organization that makes us special? - STRENGTHS
4. What benefits are people seeing from us when they come to us? Who else is poised to deliver those benefits to them?
5. Instead of asking "what keeps you up at night", let me ask….What gets you up in the morning?
6. What can we do to dramatically speed up every element of the patient care/projects we're working on right now?
7. How can we ensure that use of technology translates into positive outcomes for staff and patients?
8. How do we get from where we are today to where we want to be in the future?
9. What are your hopes for learning about things as fast as the world is changing?
10. What partnerships or strategic alliance might help us to achieve our vision? - OPPORTUNITIES
11. What will create impossible-to-ignore buzz daily about what you're doing and accomplishing?

Marketing specific questions

1. What are our organization's passion and purpose and how we are effectively and innovatively marketing them?
2. How do we craft a social media approach that still works hard f or us if Facebook Twitter, or some other high-profile social marketing network went away next year?

3. What will it take to dramatically improve the clarity of our marketing message by reducing the number of DIFFERENT messages we blast into the universe?
4. How can we do something so big and innovative that our current patients will have to follow up on care with us?
5. What could we put in place, or get trained in, or do better, to help our customers and the possibility of strong word of mouth referrals?

HR specific questions

1. What are we doing on a regular basis to strengthen leadership at all levels of the organization to sustain a high performing Scenic Bluffs?
2. We want to retain and engage our employees. In three years, what does it look like when we say we have created a vibrant work environment that is safe, healthy, fair and rewarding?
3. How do we want to see one another interact with patients to assure they have a great experience?
4. What can we do in the coming three years to assure we are seen as helpful, not rigid and assure patients and community members have good experiences with all our staff?

Health Education/outreach Questions

1. Give me your vision. What does it look like if Scenic Bluffs is the center of community health?
2. What communities/populations do you think we should focus on to assure everyone is benefitting from our Health Center services?
3. What patient and community health issues are we addressing well and what can we do more of?
4. What community and patient health issues should we focus on more in the next three years?
5. What do we need to learn or skills do we need to develop, or expertise should we tap, to positively impact even more people in our service area?

Technology questions

1. How can we ensure that use of technology translates into positive outcomes for the staff and patients?
2. What do you like/not like about current information and technology systems?
3. What problems or concerns do you have that you would like IT staff and technology systems to help you with?
4. Over the next 3 years, how do you think information and technology systems will change your profession?
5. Do you have any creative ideas for using computers, phones, or information systems to help patients? If so, please describe

Administrative staff

1. What are the three key priorities/projects you will work on in the next year?
2. What are the roadblocks I need to eliminate to bring my professional development desires to reality?
3. What behaviors do we need to foster in staff, or trainings should we have, so patients can know each of us values and appreciates them?
4. What is our unique niche in health care? What makes us special?
5. Pie in the sky…..What could Scenic Bluffs do, or be, that is so big and grandiose that others will have to follow us?

APPENDIX H

MASTER CODEX OF STRATEGIC PLANNING RESPONSES

The following findings were collected during the strategic planning interviews which took place as a component of the author's preceptorship-related responsibilities. This document represents the qualitative interview and focus group responses categorized by key term or issue by the author and the Executive Director of Scenic Bluffs Community Health Centers.

All Departments- Draft- Jan/Feb Qualitative Interviews- Complete Document

1- To develop an organizational culture that demonstrates respect in all interactions with a team of employees engaged in the Health Center mission, working together to provide excellent services that exceeds expectations.
2- To continuously grow while protecting the long-term financial and operational health of Scenic Bluffs through responsible stewardship of resources, capital, and business investments.
3- To consistently deliver high quality, culturally appropriate, evidence-based medical, dental, pharmacy, mental health, chiropractic and other care that is financially and geographically accessible for all community members.
4- To promote measureable health improvements and to take action on unique community health priorities for residents of our service area through effective partnerships, educational activities and services.

Goal: EXPANSION/RETENTION OF STAFF
Objectives: Hire more to cover work load, Fill in gaps of offerings in medical home model, Keep staff we have now: appreciation and training/engagement

Hire more:
-If we were able to offer specialty care on site, as well (oral surgeon, OB/GYN, etc…) we would be really
-Child Psychologist
-PCMH Coordinator
-Bi-Lingual Health Educator
-Male Provider
-Increase the number of providers/assistants to accommodate the current demand and potential growth
-Have an assistant for hygiene
-More hygienists
-More staff: dentists, assistants, hygiene
-Right staff in the right positions
-Staff that understands and promotes our mission and vision
-Dental schedulers with dental experience for pt triage.
-If we had 10 times more employees, we'd completely restructure the HR department (which is currently Amy supervising Danielle) to include multiple people with clear, distinct responsibilities while still working as a cohesive team aware of all responsibilities taking place within the department.
-Grow the HELP team (RPs' comments)
-Take coding and billing responsibilities off clinical staff- build staffing and expertise in billing/coding.
-More Spanish language speakers for help with phones, community outreach and education/HELP
-We have expanded and have more doctors, dentists and hygienists.
-Need more hygienists: they are the bread and butter of this organization and need more chairs for them to do cleanings: take some room from medical to get cash NOW instead of booking out months into the future.
-We have brought on an eye doctor (for eye injuries as well as annual exams).
- Additional RP Personnel: a person to be in charge of verification of insurances and to catch/collect all extra calls so we can reduce missed calls and voicemails.
-Additional RP Personnel to be in charge of Healthy Neighbor Plan specifically.
-Additional person/area for Check-out only in a completely separate area in which if a person doesn't get their next appointment set with the assistants, this person can do it or if a person needs referrals to other departments or other services, this person can set those appointments; will have to know all the insurance program rules.
-In 3 years, we have more dentists/hygienists to really take advantage of this need at the clinic/for the patients.
- Hire more staff immediately and as commensurate with expansion of services/patient base.
-Hire a billing person who has a private space in which to privately talk to people about insurance, payment, etc… it is NOT private in the front hallway.
-Hire more RPs to ensure coverage at all times of the phone, the people coming in and outgoing call pads.
-There is more work than people to do it so some of it just doesn't get done.
-Need adequate staffing: be prepared for high phone traffic and not complicate lives for sick and vacation time.
-Adequate staffing
-We are currently incapable of handing the demands of current patient load; turning people away who are finding somewhere else to go… gotta fix this!

- Checking in/Checking out specific areas/personnel with privacy. In one area, a person could focus on intake, insurance, etc. and at the check out area, the person could focus on taking payment, setting up next appointment, referrals to other departments. This also would be more effective for collection of payments (Norwalk, too.)
-Better/more appropriate staffing: For example, when a RP has no experience in dental clinic/practice, it's hard to know what procedures can be double-booked and this may result in poorer scheduling and patient care. If we do better screening and more interviews for better qualified candidates for RP positions with medical/dental center experience, we'll get people with backgrounds that are much more helpful to the everyday needs of the job. Or if we took the time and resources necessary to adequately train people, this issued would be lessened as well.
-If we get bigger, we need more duty-specific facilities help to manage the work and do the work of cleaning, facilities, equipment.
-With 10 times growth, more open to adding administrative staff members
-With 10 times growth, administrative staff restructured- it is pretty silo'ed right now.
-Enough dentists are hired and retained to expand to Norwalk

Fill in gaps of offerings in medical home model:

-Hire dental specialists
-Hire an eye doctor (expand on availability of collaborative services under one roof)
-Provide transportation services to patients
- Provide alternate service/benefits that would result in referrals (oral surgeon)- fill a niche?
-Offer DBT (therapy) (medical)
-Add full-medical including eye doctor and ultrasounds
-Get an on-site lab for dental and save the money it costs to send out dentures, etc. get them faster and improve customer satisfaction.

Keep staff we have now: appreciation and training/engagement

-Administer internal employee succe4ssion plan
-More staff ownership/engagement in QUI projects
-Anniversary through employee engagement
-Talk with people one-on-one about ways to advance strategic priorities and how to meet them
-I want to increase positivity and engagement and to feel supported in my goal
-Want more feeling like I accomplished something/doing work that satisfies me.
-Want more Recognition and celebration of success of all types within the Health Center.
-Learn how to use Twitter and social media
-Teach how to make a good, supported improvement suggestion
-Foster more ownership and pride in what we do here
- Foster true patient centeredness – staff instinctively evaluating all they do and routinely suggesting improvements that benefit care of patients and the patient experience
-Foster realization that problems don't require blame
-Foster teamwork in a selfless way – people seeing the big picture and stepping up to help despite the extra work.
-Foster more happiness with the job – if staff are happy and feel values, this reflects in patient care
-Foster more pride in working at a CHC
-Foster more enjoyment with the jobs
-Promote positive, can-do attitudes
-Organization, management and communication on IT issues with staff and in front of patients
- More active staff Technology group
-Assuring good responsiveness from IT support staff
- SBCHC website education/training
- Employee portal on website education/training
- EHS training
- Patient portal training/education
- Ongoing IT training plan – not just when new staff are hired or when new systems are instituted but regular routine opportunities for training in all technology areas
- Make sure all staff are comfortable with the IT equipment we have
-Behavioral Health Training: RAD, VA services
-Training for scheduling – make it more intense/focused so patient flow is more manageable
-Up-to-date technology and training
-We could work more like a team and not so much silos
-Departments need to work more closely
-Improve the connection to Health Education: uniting thread of resources throughout SBCHC.
-How make integration of health education smoother?

-Educate full staff into classes happening in the community- get the staff to refer to these opportunities routinely (Clinical Assistants, etc).
-Assist providers @SBCHC in more fall-prevention work with aging population: we have a grant for this (Sarah and Anne) will research how to effectively develop a focused plan of action.
-MAKE US ALL A TEAM! Things go on one way in one hallway and a different way in another hallway- "I didn't know you guys did that here" is heard from employees under the same roof as the health educators- she asks, How can we teach the public about what we can do if we can't even teach our own employees?
-Improve employee education and referrals and team attitude to improve Patient Centered Medical Home
-Do employee training on social/health disparities
-Continue to improve and focus on employee wellness programs-keep this growing and going strong.
-We improve upon working together for the patients within and among all departments.
-We increase employee involvement and participation across the board. People really want to be here to help versus to do their job, get paid and get home.
-We are comprised of HAPPY employees, who have good energy, who share positive interactions as they pass in the hallways such as, "good morning, hello!" instead of looking at the floor as they pass.
-We have good engagement with collaborative nature of PCMH and with daily tasks and goals within all departments
-We improve on the engagement and inclusion of health center employee activities.
-Training: continue to attend professional development trainings and expand and diversify who attends to beyond the management level teams to foster leadership in all levels of employees.
-After trainings, make better attempts, change expectations to share the knowledge gained at professional development trainings upon return.
-Include/develop emails about trainings, share HR magazines, share articles and activities to engage leadership at all levels (even outside of managers).
-Positivity (good energy, positive outlook, smile and eye contact)
- Can-do attitudes.
-With this improved engagement, we are developing/hosting new things to bring staff together and also to bring the community in!
-We should fully embrace and promote the concept of a federally recognized Patient Centered Health Home (PCHH)to be fully understood by community and staff
-We need to make the correlation of the information tied to our primary health services (medical, dental, chiropractic, behavioral health & pharmacy) even more convenient: emails, updates with community events and schedules.
-Continue to attend conferences for professional development.
-Stay on the forefront of how marketing messages are reaching people in communities across the country.
- Marketing can help train staff
-Continue to go to department meeting to help staff members learn what the SBCHC website has to offer and where information is located on the site. Alana is the expert on the site, she can ease the time requirement needed for staff to be familiar with the site by sharing her expertise.
-Promote the PCMH model: the patient comes 1st. Need to do staff training on this as well. The concept will trickle down and around if staff members are held to the expectation that this PCMH model is our culture and our main goal is to fulfil the health and wellness needs of the people in our communities.
-Training: More emergency scenario training
-Put in place a training program for new hires.
-Hire people with the correct background/training.
-Ongoing training for staff.
-Focus on what staff does well and recognize them for a job well done.
-Better trained staff so we're all on the same page: Continuity of Care.
-Take coding and billing responsibilities off clinical staff- build staffing and expertise in billing/coding.
-Keep our friendly, caring staff: patients like familiar faces
-Refresher "medical lingo" course
-Refresher computer course including systems like EHS
-Spanish language skills for Marina and Ashley
-Refresher course of interviewing/MI techniques
-Cross-job train with people ; learn the tasks of other SBCHC clinic staff so we can better understand their roles and also help fill in when needed.
-PAP education (prescription assistance programs) have/are changing
-Continuing education for CACs will have to be a component as well
-Adequate pay/competitive pay.

-Pay staff (RPs and providers) to stay here at SBCHC: be competitive to increase longevity because it means a lot to our patients.
-Make sure new people aren't brought in doing same jobs and making more money than people who have been here and stuck with SBCHC.
-More sincere, personal employee appreciation: positive recognition to boost employee morale.
-Job security: we have it and feel irreplaceable and appreciated.
-STAFF APPRECIATION: Staff need to know they are appreciated and also to be heard. Feel like the extra effort of considering ways to improve things at SBCHC is valued instead of a hassle to listen to… Staff comments need to be addressed and acknowledged; maybe even tried out? Otherwise, why should staff continue to engage/or try to change/improve when nothing ever happens?
-Change the general feeling among staff and providers that we are replaceable
-TRAINING: RPs have to know a whole world worth of stuff: insurance, resources, HNP, billing, referrals: specialized training into specific areas of work would be very helpful. A little knowledge of everything is good, but specific knowledge of things is very, very helpful when you're wearing many hats in a job. We need some specialized training.
-RPs could use MI training along with assistants
-Training: For example, it would be ideal to get organized training by skilled trainers in an environment that is set aside specifically for the tax and isn't completely overwhelming instead of just being thrown into the job. When questions come up in these on-the-job training situations, there is no time to ask and no one to fully address concerns/learning opportunities.
-Train and Cross-train employees in departments so we can continue to help each other out!
-Specific training in dental for RPs to help with scheduling, etc.; specific training to fix things that other people already learned to deal with and then never wrote down when they left to take a new position within or outside of the company.
-If we get bigger, we need more duty-specific facilities help to manage the work and do the work of cleaning, facilities, equipment.
-More recognition of efforts with stories and testimonials, including behind-the-scenes achievements.
-Show appreciation for what everyone does.
-Reciprocate!
-Continue to answer "why?" to our staff, patients and community members in terms of why we do what we do with policies, procedures, goals, services, objectives.
-Strengthen leadership by setting clear expectation and exceeding them.
-Strengthen independence of staff by having resources established to go to with questions/concerns
-Continue to improve communication with transparency and information sharing.

Goal: EXPANSION OF FACILITY
Objectives: Privacy, Accessibility, Equipment and Technology
-Trevor would like more space including another treatment room for physiological therapeutics for acute patients, i.e. where someone could sit for 20-30 minutes with ice/heat therapies and maybe a traction table. Multiple patients would have the potential to be served at the same time with this resource.
-Bigger, better staff areas: break room and changing rooms
- More space (20x) and specifically more chairs for hygienists
-Revamp of building is complete (remodel) within 3 years.
-Get an on-site lab for dental and save the money it costs to send out dentures, etc. get them faster and improve customer satisfaction.
-In 3 years, the expansion of the Cashton facility will be done.
-In 3 years, we will have evaluated the Cashton expansion and will be using evaluation data in the decision process regarding moving forward with and planning the Norwalk expansion.
-In 3 years, both facilities will be inviting and relaxing inside and out- the internal and external patient experience will include the WOW factor: Wow appearance, WOW RPs, WOW Help team, WOW care I received. Patients will have the "St. Jude experience:" they will say, "If I have to do this, if I have to go through this, I want to do it here and go through it with these folks."
-Create wow with visual representation of SBCHC: people have to see it to believe it.
-With expansion, allow more room for greater inventory of drugs on site in pharmacy.
-Medical renovation will be done in Cashton and work fully aiding to the full-integrated medical team
Privacy:
- Printers: get one for each department so many people aren't walking in and out of the registration area= reduce distraction, noise, interrupting RPs jobs, population of area where "cash register" (computer with drawer with money and credit card payments, etc) are kept. Black and white would be fine.

-Cubicle walls/partitions between check-in/check-out/registration stations
-Buzzers for patients (improve comfort and privacy)
-More confidential check-in/insurance areas: Plexiglass dividers/separators between RPs: receive complaints because patients have heard specific sensitive information about other patients in waiting area/pharmacy area.
-A private space set aside to take patients for conversations about billing, insurance, concerns: need privacy and a secure place for these sensitive issues.
-We are patients here, too, and the privacy issue is a concern for us as well.
-Printers in each department to cut down on traffic, distraction, privacy issues and noise.
-Front end remodeled with more privacy and accessibility in mind for our clients: we take SS#s, credit card numbers, insurance verification and other sensitive information and Privacy is a concern of our clients.
-Remodel includes new check-in stations with MORE PRIVACY and additional front desk STAFFERS for busy times and phone coverage.
-Make processes/facilities/environment conducive to the fact the patients standing in front of us are the #1 priority and deserve privacy and respect.
-Get billing/insurance away from the front desk
- Create a private space in which to privately talk to people about insurance, payment, etc… it is NOT private in the front hallway.
-Checking in/Checking out specific areas with privacy. IN one area, a person could focus on intake, insurance, etc. and at the check out area, the person could focus on taking payment, setting up next appointment, referrals to other departments. This also would be more effective for collection of payments (Norwalk, too.)

Accessibility
-Accessibility: bigger/better ops, more room for handicap and doors for privacy
-Accessibility: bigger doorways and operatories for wheel chair access
-Dental clinic floor plan and equipment would need to improve: not necessarily more extravagant stuff but better basics, i.e. chairs, design
-Handicap accessible ops: we are not capable of doing wheelchair patients easily.
-Self check-in system with signature pads
-Drop-Off Front Entrance with Canopy/Covered area for weather protection for handicap patients
-Heating system out in the front (it is very cold)
-Improve accessibility: widen doors (only one electronically opens) for wheelchair access

Equipment:
-Up-to-date dental equipment
-New, larger chairs for large patients and wheel chair accessible equipment
-Up-to-date technology and training
-Improve by updating equipment & supplies that we use for patient care.
-Offer DBT (therapy)

Technology:
-Complete ICD-10 (may be delayed a year) but within 3 years
-Continue to work on improving pricing transparency for patients
-Continue to improve understandability of finance/billing for patients and staff
    a-staff can better explain/understand reimbursement from insurance,
    b-staff can better use insurance websites to identify individuals' plans and how much is left on their deductibles so patients fully understand out-of-pocket expenses associated with care received.
-Improve technology communication and training and ease of use with systems in place.
-MediaDent implementation and transition goes smoothly
-Have a busy medical practice, a community kitchen and a fitness center
- IT Hardware updating – 3 year plan, education, do we have replacement plans for all the equipment we should?
-External pictures and interoral pictures
-Headphones with the wireless phones
-Individual music in ops for patients
-Videos for patients in the dental chairs
-Provider FOB for unlocking computers
-Electronic signature pads for patients

-Auto reminders for standard appointments
-Back up for printer cartridges
-Better translation lines for interpreting
-Hardware updating – 3 year plan, education, do we have replacement plans for all the equipment we should?
-ISP speed and bandwidth
-Trevor hopes that long before three years, the EHS (EHR?) system for chiropractic notes will be streamlined and updated. He is currently writing the notes and scanning them in to utilize a digital system, however he hopes that work with a representative will yield a revised and updated electronic template. He anticipates working with the EHS specialist from WIPCA but thinks she's on maternity leave. Regardless, he expects to utilize typed, electronic chiropractic notes sooner than three years from the current time.
-COMPUTER/SOFTWARE SYSTEMS (EHS, Dentrics/MediaDent) should be compatible between all the departments (esp. dental and medical). Healthy Neighbor II takes is not compatible and sometimes patients decide to leave without paying their bill because of the delay. HNIII works okay. This addresses technology, accessibility and convenience: we want our patients to find it easy to come here and pay their bill before they walk out the door.
-Computer/EHS systems need to talk to each other and information should move seamlessly through the systems instead of separately.
-Processes are less complicated as a result of the streamlined computer systems.
- Technology: computer systems (EHS, Dentrics/MediaDent) should be compatible between all the departments (esp. dental and medical). Healthy Neighbor II takes is not compatible and sometimes patients decide to leave without paying their bill because of the delay. HNIII works okay. This addresses technology, accessibility and convenience: we want our patients to find it easy to come here and pay their bill before they walk out the door.
-With expansion, allow more room for greater inventory of drugs on site in pharmacy.

Goal: SATELLITE FACILITIES IMPROVEMENT
-Smooth opening of Viroqua
-Pilot behavioral health services in Norwalk
-Move the chiropractic offices to a bigger city to ensure that the services are more accessible and more convenient while maintaining price-point competitiveness.
-Vernon Memorial is also an important alliance. Trevor wonders with the possible expansion of dental into that facility if there might be the potential to expand chiropractic into that area as well (to offer services in Viroqua).
-Dental runs smoothly in both Viroqua and Norwalk
-PRIVACY: Checking in/Checking out specific areas with privacy. IN one area, a person could focus on intake, insurance, etc. and at the check out area, the person could focus on taking payment, setting up next appointment, referrals to other departments. This also would be more effective for collection of payments (Norwalk, too.)
-In 3 years, we will have evaluated the Cashton expansion and will be using evaluation data in the decision process regarding moving forward with and planning the Norwalk expansion.
-In 3 years, both facilities will be inviting and relaxing inside and out- the internal and external patient experience will include the WOW factor: Wow appearance, WOW RPs, WOW Help team, WOW care I received. Patients will have the "St. Jude experience:" they will say, "If I have to do this, if I have to go through this, I want to do it here and go through it with these folks."
-Create wow with visual representation of SBCHC: people have to see it to believe it.
-Enough dentists are hired and retained to expand to Norwalk
-Viroqua expansion is off the ground and possibly expanding

Goal: IMPROVED COMMUNICATION/REFERRALS
Objectives: Phone system, Marketing, Intra-organizational Referrals and Community Outreach
-Clearer communication from IT staff in emails is a goal.
-Assuring good responsiveness from IT support staff
-Keep employees and staff members informed on decision making, procedures and policies- good communication is key.
Phone system:
-Chiropractic has had clients choose to go to other local chiropractors because their phone calls have not been answered or messages not returned. He hopes to have a phone system that rings to a human being who can answer questions instead of to a voice message system.
-Improve the phone system. It does NOT work. Stop being so rigid about it.
-PHONE SYSTEM: At the front desk, the phones are very disturbing. The phone rings when the RPs are trying to take credit card numbers over the phone to settle bills, it rings in the middle of customer service face-to-face

conversations with patients, it is forwarded here when the phone person has to do her other tasks and adds to the already full bill including Healthy Neighbor Plan coordination. Telephone tree is supposed to be a back-up but instead becomes used frequently. People leave scenic bluffs because their calls are not answered or not returned.
-PHONE SYSTEM: 100 messages per day in dental, need some help here.
-What is gone: we no longer call people for appointment reminders, we have an automated system for appointment reminders.
-PHONE SYSTEM: sucks. People have to be transferred a bunch of times, leave message and don't get return calls: it's a deterrent to coming here and it degrades the patient experience.
-We incorporate a better PHONE SYSTEM because currently, if our phones are down, our systems are down. Calls come to the front desk. We incorporate a cue for telephone system where people wait to speak to a human person.
-Goal: voicemail turnaround/reply within 4 hours of left message or AT LEAST with in one business day.
-#284 for Medical is very helpful: we need this connection with all departments.
- We lose patients when phone calls are not answered. If we address this issue, we can improve the ease and convenience with which our patients have access to our services and further, we can retain our current clients and receive better referrals. (The Amish sometimes are using a neighbor's phone to call so they don't leave messages and we miss them sometimes).
-Continue to work on improving pricing/billing transparency for patients
-Continue to improve understandability of finance/billing for patients and staff
    a-staff can better explain/understand reimbursement from insurance,
    b-staff can better use insurance websites to identify individuals' plans and how much is left on their deductibles so patients fully understand out-of-pocket expenses associated with care received.
-Improve technology communication and training and ease of use with systems in place.

Marketing:

-Promote as the center of all things health and wellness
- Enhanced Marketing plan- specific action steps for mental health services
-Review existing marketing materials for behavioral health. What do we already have? VA/American Legion Mailing? Other local clinics?
- Strengthening our referral base is the way to grow Behavioral Health practice.
- Targeted service area is a 15 mile radius of Cashton
-Clearly communicate the VALUE of the patient centered medical home: increase promotion of all the services available under one roof and of the collaborative efforts of the medical personnel across departments for the improved patient outcomes and service.
-More marketing, but how? How do we become the choice for health care? How get more word of mouth for chiropractic? Trevor acknowledges the need for appropriate, effective and cost-effective marketing of the businesses, its services and the BENEFITS it offers its clients.
-Differentiating self and services/benefits by offering different services, different benefits OR offering the same services/benefits as competitors and offering them WAY better.
-Maybe personal testimonials via print, radio, television advertising?
-Bumper stickers? (dental)
-Continue to promote CPR/1st Aid
-Promote CPR/1st Aid classes with specific organizations in the community
-Market more creatively/more targeted marketing/promotion of classes to daycare providers, girl scout leaders, SPANISH SPEAKERS (Asa is already very busy)- Harmony Valley Farms, places with large Hispanic populations: research and explore how to do this and how to fill the need we uncover.
-Within three years, we should be recognized in our communities for what we actually are.
-Concept of a Community Health Center should be understood by community.
-All departments should be known to the community including behavioral health, chiropractic, and health education.
- We should make extra effort to make ourselves known in outlying communities including Crawford County and Viroqua.
-We should continue to strive to maximize efficient marketing efforts and value.
-Evaluate current methods of communication for cost effectiveness
-Reduce printing and mailing costs (not as much bang for the buck) while considering effective solutions for harder to reach populations such as the elderly and the Amish.
-Much more online presence
-PSAs

-Social media: give the patients/communities/potential clients social media marketing campaigns that establish SBCHC as THE HEALTH EXPERT! Give them social marketing that brings them to interact with us as their resource, their resident expert on all health information.
-Idea: Send home care packages that make our patients want to tell everyone about us and that bring us back.
-To get more word-of-mouth referrals, we could have patients to testimonials in articles/ads in local newspaper.
-Improve getting out better advertising: newspapers, tv ads?
-Educating on what community based health center model actually is- NOT A NURSING HOME!!
-Advertising: better, but not sure how. Radio=great improvement on previous attempts.
-Improve phone system and/or add personnel to handle phone traffic
-COMMUNICATION: Some signs, handouts, mailings don't look professional; they look cheap. We have to look the part to get the patients we want and to compete: Need clean carpets, good upkeep of buildings. Sub-par communication and facilities invokes mistrust. We've got to walk the walk and talk the talk of high quality patient care in all our facilities.
-Signage designating "Registration," "Check Out," "Dental appointments"
-Get the word out about the breadth of knowledge, experience and capabilities we have available here for medical care at Scenic Bluffs- we are about more than just low-income accessibility, we're also about the highest quality care!
-Market to the community the full breadth of the services we provide, our target population and the high quality of services.
-Come up with a special, "Get to know us" campaign.
-Establish an advertising budget for pharmacy to help increase client base. If we can get people in to use pharmacy services, people will automatically use other services as they have to be patients here to use pharmacy and it is NOT an exclusive relationship!
-Get word out to the community about pharmacy services.

Intra-organizational Referrals:

-More staff ownership/engagement in QUI projects
-Talk with people one-on-one about ways to advance strategic priorities and how to meet them.
- More cohesive staff that works together service our mission (work environment)
-Foster more ownership and pride in what we do here
-Foster true patient centeredness – staff instinctively evaluating all they do and routinely suggesting improvements that benefit care of patients and the patient experience
-Foster teamwork in a selfless way – people seeing the big picture and stepping up to help despite the extra work.
-Foster more pride in working at a CHC
-Want Patient Centered Health Home in inherent in every procedure, process and interaction with patients
-Coordinated care – all departments working seamlessly for the best patient experience
-WE should be the place with the healthiest patients and staff
-WE should be the health center of choice for local residents – even those who are insured
-WE should be a place people come because of our service, not because we are the only ones that take their insurance
-WE should be a place patients WANT care.
- More active staff technology group
- Assuring good responsiveness from IT support staff
- Can we use all provider meetings differently to increase integration with other departments?
-Focus on integration of behavioral health with other departments: especially chronic disease, group visits for diabetics and building off of first aid for anxiety workshops.
-Strengthening our referral base is the way to grow Behavioral Health practice.
-Improved ancillary services and in-house referrals/collaborations.
-Chiropractic would like the X-Rays and good communication with the medical department to continue and greatly values the ability of medical and chiropractic departments to communicate well, collaborate, squeeze in patients, work together on insurance issues and work together on X-rays. He hopes to continue the relationships in this fashion.
-Tap into individual professional strengths in clinical care and channel specific patients to them. This could also generate more $$.
-Good communication between all personnel in all departments in the clinic
-Greater opportunity for in-house professional consultations, discussions and treatment planning
-We could work more like a team and not so much silos
-Departments need to work more closely
-Improve the connection to Health Education: uniting thread of resources throughout SBCHC.

-Try to integrate health education into other departments and work alongside each other (for example: whole person approach to physicals which is working well where Anne meets with annual physical patients).
-Make collaboration at regular appointments with health educator REGULAR and not spotty. Can help strengthen intra-organizational communication.
-Different departments have the attitude of "this is our patient"- we need to share the patients and further enrich the experience of our patients at a Patient Centered Medical Home
-Educate full staff into classes happening in the community- get the staff to refer to these opportunities routinely (Clinical Assistants, etc).
-Assist providers @SBCHC in more fall-prevention work with aging population: we have a grant for this (Sarah and Anne) will research how to effectively develop a focused plan of action.
-MAKE US ALL A TEAM! Things go on one way in one hallway and a different way in another hallway- "I didn't know you guys did that here" is heard from employees under the same roof as the health educators- she asks, How can we teach the public about what we can do if we can't even teach our own employees?
-Improve employee education and referrals and team attitude to improve Patient Centered Medical Home
-We improve upon working together for the patients within and among all departments.
- All employees are a resource and act as one: we can't do everything here at Scenic Bluffs (in terms of services), but we CAN establish ourselves as the health home of the greater community by exploring what our patients options are with them and by making good, solid referrals.
-We need to make the correlation of this information tied to our primary health services (medical, dental, chiropractic, behavioral health & pharmacy) even more convenient: emails, updates with community events and schedules.
-Improve communication and access pathways.
-We can do more of: mental health referrals, eliminate patients that are only seeking narcotics
-Help with phobias- need to really know what Docs/departments are dealing with/doing so we can look more competent. Learn more about other niches within SBCHC so we can help them and make better referrals.
-Know who to ask about weird questions they get: understand roles/tasks/focuses within SBCHC better in order to improve referrals.
-We could improve interdepartmental communication and communication within our team
-We can sign them up for insurance and refer them for all needs to SBCHC and to other resources for non-health stuff (can always improve/focus on this…)
-We need to HYPE up SBCHC… hear, "I didn't know that (service was) available, and I work here!!!"
-Lets ask the patients- get a survey going to improve processes, to include the following questions, "Did you feel your patient information is kept confidential?" Rate your satisfaction with the services you received today. Do you have a primary dentists/doc/mental health/chiropractor?"
-Improve proactive behaviors/streamline: Example: If a patient is in the system as "self-pay," which means they are not on HNP, have the HELP team or an insurance/billing specialist call them ahead of time.
- We need to HYPE up SBCHC… hear, "I didn't know that (service was available) and I work here!!!"
-Improve proactive behaviors/streamline: Example: If a patient is in the system as "self-pay," which means they are not on HNP, have the HELP team or an insurance/billing specialist call them ahead of time.
-BOARD OF DIRECTORS ENGAGEMENT/INTERACTIVITY: The board should know the employees, should know the every day happenings here, should engage with the staff and providers. They should interact to see how things are going on a regular basis and not just with admin/managers. Maybe have rotating involvement of employee at board meetings?
-Pharmacy can help get more folks in the community in for services by spreading the world that no one is excluded, we give 1st rate medical care, by welcoming patients.
-In order to have a prescription filled at SBCHC, you must see a provider here- however, that provider does not have to be your only provider! This is hard to communicate, especially to the elderly. In order to provide the continuing, excellence of care that is the goal of SBCHC, our providers need to know the medical histories and experiences of our patients in chiropractic, behavioral, medical, dental and pharmacy: this is a core goal of the patient centered medical home model.
-Our small size allows improved face-to-face communication.
-Providers and pharmacists truly know each other as well as sharing a roof, this greatly improves communication and the PCMH experience.
-Pharmacy experiences no disconnect with the providers: there is no reason not to know them.

Community Outreach:
-Every patient receives oral health education and values oral health as a part of their whole wellness.
-Host more open houses and/or health fairs
-Continue to expand education work in community and under the roof/roofs of SBCHC

-Health Ed continue to support and collaborate with school nurses and their roles in the community
- Increase number of people trained in CPR/1st Aid in the community
-With improved employee engagement, we are developing/hosting new things to bring staff together and also to bring the community in!
-Concept of a Community Health Center should be understood by community.
-All departments should be known to the community including behavioral health, chiropractic, and health education.
- We should make extra effort to make ourselves known in outlying communities including Crawford County and Viroqua
-We should fully embrace and promote the concept of a federally recognized Patient Centered Health Home (PCHH)to be fully understood by community and staff
-Be the expert HUB of health and wellness for our communities.
-Make information available of health educators' events through email/facebook/website so that information can be garnered about community health and wellness efforts without having to navigate the phone system. CONVENIENCE and ACCESS to INFORMATION
-Patients/Community Members should not have to work hard to use our services.
-Improve communication and access pathways.
-Educate the community on who we are (not a nursing home), i.e. what services we provide.
-Recruit a great storyteller to convey the grassroots history of the health center in a way people can't help but share (with others)
-Speak well of ALL staff with patients and members of the community. Have pride in working here: brag us up!
-Improve/make bigger the health fair and health days.
-Join a collaborative of other health centers that face the same issues.
-Patient education on how our appointments work.
-We have improved on our patient education, but still could be doing more.
-We can do better at helping patients with no or little insurance get signed up for what is available.
-We should do more with alcohol abuse.
-We should try to involve other communities that SBCHC is becoming involved in and the other school districts: Brookwood for one.
-We can do better in healthy living and drug use
-Youth and drug use
-We need a connection with the school community and exercise lab
-It is HARD not to see the outreach efforts and HELP team at SBCHC: not only as community health main place, but as a community resource to be used by schools, businesses, and other organizations.
- A healthy community: we are addressing the pockets of people who are sick/unwell and unable to gain health education, health access and empowerment.
-SBCHC is a beehive! We are a busy hub of activity and action in the community, our HELP team is collecting and organizing things at the hub, going out collecting things, bringing back information, sending out information, collaborating!
-Tackle these issues with more vigor:
-Obesity
-AODA: drugs and alcohol
-drunk driving
-Mental health
-Pediatric mental health
-Ongoing affordable health care
-Affordable dental care outreach
-Low-income housing (shelters only in La Crosse)
-Domestic violence (nearest shelter = Viroqua, task force in Sparta)
-Sex trafficking
-Teen pregnancies are down- lets keep that trend going!
-Lets host some job fairs and bring in professionals from the surrounding community!
- More public interaction (presentations/coalitions)
-Improve communication within and outside of SBCHC
-More outreach to legal community and domestic abuse community (behavioral health)
-Build children's services: Have quarterly meetings with school personnel on services and student needs in - Cashton/NOW/Westby
-Be the expert HUB of health and wellness for our communities.

-Make information available of health educators' events through email/facebook/website so that information can be garnered about community health and wellness efforts without having to navigate the phone system. CONVENIENCE and ACCESS to INFORMATION
-Promote the PCMH model: the patient comes 1st. Need to do staff training on this as well. The concept will trickle down and around if staff members are held to the expectation that this PCMH model is our culture and our main goal is to fulfil the health and wellness needs of the people in our communities.
-Pharmacy can help get more folks in the community in for services by spreading the world that no one is excluded, we give 1st rate medical care, by welcoming patients.
-In order to have a prescription filled at SBCHC, you must see a provider here- however, that provider does not have to be your only provider! This is hard to communicate, especially to the elderly. In order to provide the continuing, excellence of care that is the goal of SBCHC, our providers need to know the medical histories and experiences of our patients in chiropractic, behavioral, medical, dental and pharmacy: this is a core goal of the patient centered medical home model.

Goal: IMPROVED SCHEDULING/WORKLOAD
Objectives: Employee Scheduling, Patient Scheduling, Workload

Employee Scheduling:
- Allow quiet blocks of time to focus on projects
-Better organize to meet regular deadlines
- Schedule focused time away from my desk once a week
-Coordinate dental schedules as not to schedule 3 root canals at a time
-Wish the work load allowed a few "moments to crayon" or catch breath during the day.
-Need for a rejuvenating work-break.
-Scheduling: schedule a block of time for HNP person away from front desk.
-Sometimes things that are lower priorities just don't get done or get pushed back days because the work load is heavy.
-Template scheduling: less complicated, easier for dentists/hygienists to anticipate their days in advance.

Patient Scheduling:
-Scheduling is also an area chiropractic would like to see improvement in. He would like to have a full schedule every day (routinely), where the patients routinely show up on time (which is 20 minutes early).
-Coordinate recalls, checks and dental schedules
-Having a steady flow of patients/schedule- no double booking
-Patients show up on time (which means 15 minutes early)
-No no-shows
-All appointments start on time and end on time
-No errors with scheduling
-Schedules full of patients of record with treatments plans coming on schedule for routine dentistry
-Enough time for patient care that we don't run behind schedule
-Enough time scheduled for task at hand
-Equipment available when needed
-The day is scheduled productively
-All patients show up and are early for their appointments
-Decrease the wait for hygiene appointments to no greater than 2 weeks.
-Different way of scheduling

Workload:
-A perfect day would have less than 2,000 hygiene checks.
-Improved time management in dental
-Everyone gets to work on time in dental
-Scheduling: schedule all our own appointments in dental- HELP team could learn how to do that.
-Improve the outreach days scheduling- it's hard having an outreach day and coming straight back to the office- little time to decompress, make necessary notes. Running around, it gets crazy out there and we begin anew as soon as we're done.

Goal: MAKE OUR SERVICES MORE CONVENIENT

Objectives: Intake process,
-Easy to understand pricing
-Understandable billing
- Expand to include evening hours for behavioral health.
-Concern is that the convenience factor is lower compared to other practitioners and people see value in convenience. Patients must pass through several layers of intake in order to get back to see him. Chiropractic would like to streamline the process of intake and he hopes for a less complex, more unified and simpler intake process that could benefit all the departments at Scenic Bluffs.
-Trevor would like to see uniformity of patient intake- same assistant/intake personnel, same simplified/unified intake process and personnel for medical and chiropractic patients- also dental patients if it can happen that way for dental, too.
-Trevor's biggest concern is with the flow of patient intake. His concern is that the convenience factor is lower compared to other practitioners and people see value in convenience. Patients must pass through several layers of intake in order to get back to see him. He would like to streamline the process of intake and he hopes for a less complex, more unified and simpler intake process that could benefit all the departments at Scenic Bluffs.
-Use Health Promotion Items including a First Aid Kit with our information all over it so returning to us is EASY/CONVENIENT.
-Make information available of health educators' events through email/facebook/website so that information can be garnered about community health and wellness efforts without having to navigate the phone system. CONVENIENCE and ACCESS to INFORMATION
-Patients/Community Members should not have to work hard to use our services.
-Improve communication and access pathways.
-Be more accessible: we are busy! When in clinics, at desk at appointments and when in community always engaged= not really available for walk-in help
-Spanish speaker available at the front desk for interpreting, phone calls, and/or patient education at all times to answer the greater Spanish speaking patient flow.
-More HELP/outreach team people available for new patient education and insurance plan/healthy neighbor plan education on-site; also education on medication programs/patient assistant program (know these guys are busy… want more help ON-SITE!)
-Upgrade patient portal on website to include online bill pay.
-Convenience to pay: bill not done when they have to leave=mailing costs, lost revenue when people decide to go elsewhere.
- We lose patients when phone calls are not answered. If we address this issue, we can improve the ease and convenience with which our patients have access to our services and further, we can retain our current clients and receive better referrals. (The Amish sometimes are using a neighbor's phone to call so they don't leave messages and we miss them sometimes.)
-Automation of check-in
-Online check-in
-It is not all or nothing here in terms of medical care and pharmaceutical accessibility.
-Get word out to the community about pharmacy services.

Goal: MISCELLANEOUS… "Within the next 3 years…"
Objectives: Process Improvement, Resource utilization,
-VMH project – work on using the Gannt chart to complete the project
-Going to lunch and being able to warm food and find a seat without worry
-More microwaves
-Bigger/better lunch room with more places to sit
-We have a nicer break room with more space, microwaves.
-We need forms updated!! (Spanish ones). Can we ask nicely that the Spanish speakers get together for a 30-45 minute meeting and hash out the details?
Process Improvement:
-Expand AODA services
-Legal aspects of HR
-Organization checklists for everything and revamping manual
-Improve document and processes for UDS data
-Finish change of scopes
-Process improvement committee has taken more of a role in looking at how we do processes and things to try
-Dental referral follow-up

- Fundraising work plan
- Loading insurance fee schedules into EHS
- Better organize to meet regular deadlines
- Could improve by addressing lack of time/education – time spent on "other" things
- Maintaining paperwork organization
- Get my office in better order
- Not checking email all the time
-WE should be the place with the healthiest patients and staff
-WE should be the health center of choice for local residents – even those who are insured
-WE should be a place people come because of our service, not because we are the only ones that take their insurance
-WE should be a place patients WANT care
- Clear written plan for IT requirements
- Patient portal and Mediadent – any changes possible with that?
- Written IT information on who, what, and when to contact. For example, when should we call ABC versus using in house staff?
- Patient phone tree – works but it could be better, make it understandable, all calls are answered within clinic hours (phone forwards and programs)
- IT Hardware updating – 3 year plan, education, do we have replacement plans for all the equipment we should?
-Stricter guidelines for patients to show up on time in dental
-Standardize notes in dental
-Screen patients with real pain versus people with a chipped tooth, etc.
-Getting an X-ray perfect the first time
-Lab work is accomplished as expected
-Use Professional Pros/Pres Lab (sp?- not sure about second word)
-Making sure everything is in working order
-All technology works correctly
-Docs do exams quickly and are prompt
-Procedures go as planned
-Technology works perfectly
-Staff gets to work on time
-Have contracts for referrals
-Call referrals and set up appointments or Doc that was referred can call to follow-up on referral
-Invite patients to bring their families & friends to clinic
-Document follow-up calls to surgery patients
-Every 100th patient gets $10 off
-When patients tell us how grateful they are, tell them to let everyone know
-Referral follow-up procedures
-Ask for the referrals
-Have signage asking for interdepartmental/intra-Scenic Bluffs referrals promoting in-house referrals/collaborations
-Quality over quantity of care
-Be more empathetic
-Stop being a cookie cutter clinic in dental
-Send Christmas cards in dental
-Practice having patience with patients in dental
-Know and DO our mission every day
-Do all we can to resolve a problem while the patient is on-site in dental
-Health Education Dept may be under utilized in daily appointments, etc.
-Try to integrate health education into other departments and work alongside each other (for example: whole person approach to physicals which is working well where Anne meets with annual physical patients).
-Make collaboration at regular appointments with health educator REGULAR and not spotty.
-Continue and improve referral process from Behavioral Health- process is there, just doesn't work/isn't used.
-Look at Senior Exercise class for updates/revamp/reorg- Give it a fresh look! Redo, rename- Freshen this up with another
-Consider/Research barriers to special populations: Amish- and explore opportunities to expand education i.e. Dental Awareness, CPR/1st Aid, etc.
-Do more to address holistic health: i.e. stress reduction, living well classes, continue with Living a Healthy Life with Chronic Disease, mindfulness

-We have completed the revamp of records retention: make sure we are better organized and only have what we need.
-We adapt to new laws, legislation that arises in regards to HR and records retention.
-We need to keep a person in the health center promotion department dedicated to the purpose of social marketing. This person should be abreast of current trends in marketing and social media and should be educated as to how to put trends to use for SBCHC.
-Improve EMR system to better delivery of care and more efficient care.
-Be more efficient so we can see more patients.
-Continue with ways to give patients a great experience when they are here. Gather ideas from staff and patients.
-Set guidelines and follow through with them.
-Join a collaborative of other health centers that face the same issues.
-We are focusing on groups of people who don't think they need health care and people whose barriers to seeking health care are strong: mortal fear of doctors and dentists, phobias, men, people who are waiting till the last minute or until its too late to come in. Changing these perceptions and fears by having conversations and encouraging reflection upon the positive experience they had with our providers.
-New focuses in greater community:
-Framing all interactions with cultural competency including how we do dental, billing, etc.
-We are focusing not only on lower income people but also on higher income people
-Catching people who are down and out, maybe homeless who think they may not qualify for any health insurance coverage or any help and showing them that we can help.
-'No-show" rate decreases
-No Shows: new process to deal with these.
-Prioritize! Processes and procedures should be created, tried and tested/evaluated and changed as necessary by the people who actually do the jobs.
- There is disconnect because people feel they aren't being heard or involved in the development and goal setting for their jobs. People want to share their views from different angles to improve and streamline workload and flow!
-Streamline the processes, write down how the best possible practice looks like and train people/new people on how to do it.
-Find a better way to bill/charge for dentures: currently, like 5 appointments, but only pay on one occasion with all fittings, etc.
Resource Utilization:
-Utilize resources we already have that aren't sufficiently being used currently: space in basement at administrative/medical rooms.
-We have excellent resources in the staff that is here already, has been here for years. We have to tap into that and really explore their ideas for improvement – it will improve morale and engagement. It will improve movement and collaboration and quality of work across departments will improve when staff who do the jobs are invited into conversations about performance improvement and policy.
-Improved facilities task management with spreadsheet including timeline and cyclical considerations for painting, cleaning carpets and regular preventive maintenance allowing ability to answer inquiries/requests with confident, "It's on the list and it will happen at X time."
-Required maintenance on equipment scheduled and done on a regular basis.
-Use established local vendors for plowing/mowing/facilities whenever possible.
-Continue to focus on the whole picture, start to finish, not just the beginning.
-Know who/what we're going to be up against as we move forward in strategic planning for SBCHC.
-Keep realistic view of what is a need for SBCHC and what is a want when considering our long-term views.
-Remember to evaluate and re-evaluate decisions and progress; follow-through of the process of change is important. The final step of change is evaluation and reporting back, only after this occurs is a change truly completed/implemented.
-Know the "big picture" from the "enormous picture": how much can we handle effectively while keeping up with the times/trends- this is a constant challenge!
-The people who work here set us apart. If we treat it [pharmacy] like a business and continue to be personable and provide excellent customer service, people will continue to come.
-Continue to treat everyone well at all levels and to be conscious of every person that walks in the door. People who have a good experience tell 1 person; people who have a bad experience tell 10.
-Educate patients that are already here as to pharmacy services.
-Pharmacy would like to have more patients for the SBCHC, because then they would be busier
-In 3 years, SBCHC pharmacy will be the first choice of all local residents and community members.
-No other pharmacy offers Health Neighbor Plan

-In three years, increase communication and education with the public regarding pharmacy services.
-Keep accounts receivable down.
-In three years, we should work to identify/find a way to identify and assess better care productivity, i.e. not just visits/reimbursements rates but how to help our providers be more efficient so our costs are lower so we can build more support structures with the resulting funds.
-All are comfortable with the technology/systems we have
Resource utilization:
-Improve the connection to Health Education: uniting thread of resources throughout SBCHC.
-We are improving to implement the full potential of our policies and procedures. We also have a system to track, evaluate and follow-up on how this progress is being made. What we need is here, we just need to use it!
-Make sure employees fully understand all the services and opportunities we offer at SBCHC- health center promotion department can help with this with intranet and new website capabilities.
-Make sure we have resources available and the right allies.
-Educate patients that are already here as to pharmacy services.
-Goal: to fill every prescription SBCHC providers write in-house within 3 years.

Goal: STRATEGIC AND IMPORTANT ALLIANCES/COLLABORATIONS
- What's happened to Viterbo University referrals to behavioral health? We need to reach higher education.
- More outreach to legal community and domestic abuse community
-Build children's services: Have quarterly meetings with school personnel on services and student needs in -Cashton/NOW/Westby
-Enhance networking: already work with CenterPoint and Monroe County Mental Health group, need to strengthen work with the schools, La Crosse County, especially to get an update on the intensive case management services. We should look at ways to tap into county contracts.
-Gundersen Health System is a valuable partnership/alliance for Chiropractic. Trevor plans to shadow the two chiropractors on staff at Gundersen in the physical medicine department to observe the strengths of how that office runs/how the chiropractors' days go.
-Vernon Memorial is also an important alliance. Trevor wonders with the possible expansion of dental into that facility if there might be the potential to expand chiropractic into that area as well (to offer services in Viroqua).
-Trevor would like to see further affiliation and partnership with Gundersen Health System, Vernon Memorial and development of partnerships for potential referrals with Mayo Health System.
-Affiliations will lead to/should lead to referral for chiropractic follow-up after hospital appointments= goal.
-Continue partnerships with Behavioral Health and community: Suicide prevention in Schools- Continue and research improvements, updates to QPR program/workshop
-Continue collaborations with Gundersen with Amish
-Continue partnerships/relationship with Viterbo, UW-L, WTC, Vernon County Public Health, Monroe County Public Health
-Continue coalition involvement
-Improve relationships with La Crosse Co and Crawford Co
-Continue to build relationships for referrals and with organizations that serve the same patients that we do
-Goal: Strategically analyze and understand referrals that come from professionals/partners (example: local lawyers are sending referrals to AODA in behavioral health). How do we effectively communicate and promote our services to these types of professional partners? Who has a large number of Spanish speakers that we could market our health education program to? Who are the community members/partners/organizations that we could increase this type of professional referral with?
-We should try to involve other communities that SBCHC is becoming involved in and the other school districts: Brookwood for one.
-*** Link with Smart Bus to deliver patients out here!!! (Only goes to Organic Valley): address transportation.
-Get Organic Valley more involved with SBCHC: build on partnerships!
-Important to keep alliances with both Mayo Health System and Gundersen Health System: these alliances are both a strength and also a threat to employee turnover.
-Important to keep relationships strong with local organizations as business partners, avenues for promotion, communication and marketing of SBCHC services.
-Keep up great work with state-level alliances- Mari's continuous involvement and ability to talk-the-talk and walk-the-walk are great strengths
-In order to have a prescription filled at SBCHC, you must see a provider here- however, that provider does not have to be your only provider! This is hard to communicate, especially to the elderly. In order to provide the continuing, excellence of care that is the goal of SBCHC, our providers need to know the medical histories and experiences of our

patients in chiropractic, behavioral, medical, dental and pharmacy: this is a core goal of the patient centered medical home model.
-We collaborate!
-We have great relationships with our referral partners (Mayo and Gundersen Health Systems), as such, we can refer you to the best of either.
-In terms of alliances/referrals, SBCHC is not affiliated with either Mayo or Gundersen, we are partners, coordinators, and collaborators. We can refer to the BEST option at either health system for specialty care.
-A beneficial relationship to continue is with the other WI Health Centers: this growing cohesion and solid core group of clinics may offer avenues for advancement such as shared staffing allowing investment in specialty providers.

Goal: CONTINUE AWESOMENESS
Objectives: What we do well/What BENEFITS we offer
-Our mission – we provide care to those who would not otherwise receive it, usually for financial reasons
-Several things under one roof
-Care we are able to provide to patients regardless of financial status
-Health education/wellness things we promote and help with
-Provide total care. Help patients achieve the care they need including assistance with payment and other
-Patient centeredness
-Familiar/comfortable
-Small town friendly with big city quality
-Individual attention to the patient – they are a person and not a number
-Provide more than just specific health care
-Personalized care – patients are not a number here but a name
-Primary care focus – PCMH and holistic health care
-We serve the rural populations
-We are affordable.
-Most of the people that work here are truly compassionate, caring, and kind: they really care about the service they provide and patients are #1 priority with standard of care a close second. (Dr. Lyons called out here for being incredibly empathetic and patient-centered.)
-Patients aren't treated like a number or an illness- they are treated as our patients and they are called by their names.
-Rapport is built with patients who truly appreciate and rely on seeing the same faces when they come to this clinic. (They're already anxious about coming to the doctor/clinic- a familiar face sets them at ease.)
-We do a LOT of education (anxiety workshops, CPR, senior fitness, pain management (with HELP Team, sarah and anne).
-We have in-house pharmacy
-HNP/affordability
-Flexibility in billing department
-Location: being here in the rural community and serving this population
-Alana is awesome and marketing is much better.
-We're out in the community more now than in the last 5 years
-We are in the community.
-We are affordable and flexible.
-What makes us special is knowing the names of our patients, having time and education/training to make a good referral within the clinic and without and having access to resources like Spanish speakers/translators and HELP team: we are losing this because of the expanded work load.
-We are also special for keeping quite a few good people for many, many years, even if providers come and go, there are some very familiar faces to our patients and that is important and meaningful.
-WE have a fabulous mission that we are satisfying by helping people.
-Health care is dynamic, demands change. We can do that if we work together!
-We have excellent resources in the staff that is here already, has been here for years. We have to tap into that and really explore their ideas for improvement – it will improve morale and engagement. It will improve movement and collaboration and quality of work across departments will improve when staffers who do the jobs are invited into conversations about performance improvement and policy.
-Continue with Veterans Administration Services in Behavioral Health
-Evidenced-based research is very important. Continue to base policies, programs, medical/dental practice on up-to-date, empirical data.
-In Chiro, honesty and realistic expectations for chiropractic care

-Integrity to the work and the industry
-Convenience of collaboration of all the medical professionals under one roof: close knit relationship with medical department yielding collaborative care for patients.
-Referrals back and forth between departments are a big deal.
-Biggest benefit patients receive is collaboration between medical professionals on their behalf and multiple factions of health care in one place. All the services are in one place!
-Excellent chiropractic care with the patients' best health as focus.
-Resources for whole wellness and health education (i.e. smoking cessation) under one roof.
-In house connections- ancillary services.
-Best benefit: Doctor/Patient relationship offered by a skilled physician (himself) in a nurturing and honest environment and excellent adjustments. He also offers empathy, which is unique in his field.
-Money/insurance (how people pay) is not a factor in the care that the patient needs or the services they receive.
-We are good at making the patient comfortable and confident in care received.
-We have a great vision and mission and our staff members support it.
-We have busy, hard working, productive, supportive staff
-Patients are grateful for what we do
-Working hard
-Friendly staff
-Great team work with super friendly, understanding, helpful, respectful assistants...oh wait, I got that!
Integrity
-We don't sell something that is not needed, i.e. dental crowns (dental selling)
-No dental selling
-Small town clinic
-Friendly staff
-Personalized care: our patients are people, not numbers or diseases/conditions.
-We have a lot of experience in helping people in difficult situations.
-We care about our patients
-Continue excellent customer service
-We make sure our patients are given the right care.
-We are strictly here for the patients. We aren't in it for the $. We don't push services.
-Friendly and knowledgeable staff
-Family atmosphere
-Provide care to/take care of the poor and uninsured.
-Scenic Bluffs accepts all patients.
-We provide the highest quality of care for all patients regardless of payment methods.
Price Point/Fee Scale/Payment Methods
-Sliding fee scale
-Take all or no insurances
-We will see Badgercarepts when no one else will
-We serve patients other places won't due to insurance or lack of.
-We have HNP and everyone can use it.
-Take state aid
-Accept Forward Health
-Sliding fee scale
-Patients get incredible price break making us more accessible.
In-House Collaborations
-Availability of collateral health care services in house.
-We have numerous services under one roof
-We provide medical, behavioral health, pharmacy, chiropractic and dental care
-Several departments in the clinic to refer to
-Small clinic/facility with many departments for whole health care
-Medical, Chiropractic, Behavioral Health and Dental
-*We are accessible.*
-We have a stable
-We accept multiple forms of insurance/payment so people can afford to come here
-Convenient
-Local
-Continue with Health Education being the referral/expert on lifestyle stuff

-Continue Classes in the community
-Continue collaboration between Sarah and Anne in Health Ed
-Continue Hemophilia Day project- keep involved
-Great staff
-Great mission
-Great outreach opportunities
-Community involvement and longevity
-We are all under one roof.
-We are IN the community- our clients don't have to drive 40 minutes to get here.
-Affordability: even if our patients have to spend gas money or cab money to get here, they can still afford it.
-We have the potential ability to address overall health of patients with interdepartmental collaborations.
-Promotion of Community Wellness is effective. This includes fitness classes, family events, senior exercise, CPR classes. This is evident from the growth the classes have experienced over the last 12-24 months. This is also evident from the number of people inquiring about the community wellness services/classes.
-I believe the med staff is already very helpful t patients- the only bad experiences I've seen are from VERY difficult patients.
-We address DM, CVD and WCC15 well
-Primary care for patients
-Good immunization rates
-Available care: open schedules
-We do immunizations well
-We have HELP team that help patients in clinic as well as community services available
End medical
-We are continuing to focus on religious sects that are hard to reach (amish)
-Continuing to focus on low-income who can/may benefit from Healthy Neighbor Plan
-Make clear that ANYONE is welcome, any race, sect, color, religion, creed
-Badgercare/Insurance
-Helping people communicate with the marketplace
-Getting people signed up for the marketplace, badgercare, and HNP
-Hemophilia Day
-Chronic health programs
-HNP
-Involvement in schools is getting better
-Bilingual capabilities (ASA) is a HUGE plus on this team.
-Linkage: we are great resources for referral of other services to help our clients
-Being out where the people are.
-OUTREACH
- We return phone calls really well, good turnaround
-WE do great referrals amongst each other and also to other CACs and resources in the community
-High quality of Care at SBCHC
-Great resources available: Great Rivers 211 we use a lot
-Great relationships in the community: schools, agencies, hospitals
-We are wanted and needed in the communities we serve.
-Keep the momentum moving forward with HELP team momentum!
-Sliding fee scale makes us special.
-Our ability to help patients, especially children who wouldn't be able to access or afford medical, dental and behavioral help makes us special.
-PCMH model and committed experience to it makes us special.
-Diversity of who we serve makes us special.
-The genuine caring of the staff makes us special.
-All of the services we have under one roof makes us special, including Xray, lab access and pharmacy.
-Keep respecting each other and our community members/patients.
-Our board is supportive, effective and is made of great communicators who are open to discussion, this is a strength.
-Our ability to empathize make us special.
-We collaborate!
-We know enough to know what we don't know.
-We have great relationships with our referral partners (Mayo and Gundersen Health Systems), as such, we can refer you to the best of either.

-The MUA is important, but it doesn't preclude us from serving younger people who can afford services or who have private or employer-sponsored health insurance.
-The personalized service our patients receive in all cooperating departments makes us special.
-The face-to-face communication between pharmacy and the medical/behavioral/dental/chiropractic staff makes us special. Because of the ability to walk over and speak with providers, pharmacy has fewer misunderstandings and mistakes; patients get improved continuity of care, pharmacy is quicker and more efficient.
-We know our clients and our clients know us: trust is built by our consistency and commitment to the communities we serve.
-The staff in the pharmacy and other departments are here for the RIGHT reasons and go above and beyond the normal expectations by helping people, making solid referrals, referring people to the HELP team, working well together as a team in pharmacy and using the first names of our patients.
-All departments work well together and this makes us special.
-Pharmacy services are the highest quality including access to medications, staff, customer service and the sliding fee scale applies.
-The door to pharmacy is open to the staff at SBCHC for relationship building and clear communication; this atmosphere is supported and maintained by Jeff, Bob, Joyce and Georgia.
-Pharmacy works as a team and is reliable.
-Pharmacy services, affordability, accessibility and quality of care are good for the whole of SBCHC!
-Pharmacy will continue to collaborate with the HELP team because patient education and clean language is so important.
-Pharmacy will continue to make solid referrals within the building and to partners.
-Legally, everyone who uses the pharmacy must be a patient of our clinic. This is an expectation we achieve and continue to promote.
-Our staff/providers TRULY care for our patients whether they're insured or not/regardless of how they pay.
-We help our patients down the path to wellness by providing the highest quality care and also the highest quality referrals to other services/programs that may assist in non-health related areas of their lives and reduce thereby improving their social determinants of health.
-We not only offer the full range of care under one roof, we also PROVIDE it.

APPENDIX I

STRATEGIC INTERVIEW DATA SUMMARY

Strategic Planning Staff Goals & Considerations– 2014

1. To develop an organizational culture that demonstrates respect in all interactions with a team of employees engaged in the Health Center mission, working together to provide excellent services that exceeds expectations.

- Enrich focus on promotion of Patient Centered Medical Home and Community Health Center
- Improve staff development and engagement
  - Continued QI
    - Continued education for staff
    - Focus on problem solving skills
    - More emergency scenario training
- Continue growth of employee wellness programs
- Increase focus on continuity of care
- Improve intra-organizational referrals
- Continue focus on holistic health
- Integrate health education into all departments
- Expand of Facility
  - Privacy
  - Accessibility
  - Equipment
  - Technology
  - Space
- Improve Communication
  - Phone System
  - Marketing
  - More Intra-organizational referrals
  - IT communications and systems

Key Strengths:

- We provide the highest quality of patient-centered care.
- We are familiar and comfortable, offering a dedicated, reliable team of providers and support.
- Our mission is truly awesome and we strive to achieve it every day.
- We know are patients and speak their languages, literally.

2. To continuously grow while protecting the long-term financial and operational health of Scenic Bluffs through responsible stewardship of resources, capital, and business investments.

- Improve Convenience
  - Easy to understand pricing
  - Easy to understand billing
  - Expand to include evening hours
  - Streamline patient intake
  - Make patient intake uniform across departments
- Improve processes such as dental referral follow-up to result in increased business
- Provide transportation services or options to patients (SmartBus)

Key Strengths:

- We provide excellent care at a price our patients can afford with many flexible payment and health insurance options including the Healthy Neighbor Plan.
- We are always looking for ways to improve our business and care.
- We provide the highest quality of care to our patients regardless of their religion, creed, race, color, ability to pay or status.
- We provide a lot of education around accessing health care and insurance.

3. To consistently deliver high quality, culturally appropriate, evidence-based medical, dental, pharmacy, mental health, chiropractic and other care that is financially and geographically accessible for all community members.

- Add key staff and specialist providers to enrich PCMH
  - Oral Surgeon
  - OB/GYN
  - Eye Doctor
  - Child Psychologist
  - Additional Bi-Lingual Health Educator
  - Male physician
  - Additional Hygienists
  - Additional Dentists
  - Additional Dental Assistants
  - Additional, well-experienced RP personnel
- Enrich satellite location services
  - Expand Behavioral Health services to Norwalk
  - Expand services in Viroqua
- Expand AODA services
- Provide additional therapies for more inclusive experience
  - DBT (medical)
  - Physiological therapies (ice/heat therapies-chiro)

Key Strengths:

- We meet the needs of the patients where they are, providing personalized rural care to the communities we serve.
- We continue to expand outreach services and education.
- We continue to expand satellite location services.
- We offer holistic, patient-centered care under one roof for the whole person and the whole family.

4. To promote measureable health improvements and to take action on unique community health priorities for residents of our service area through effective partnerships, educational activities and services.

- Build and improve strategic alliances and collaborations in the communities we serve
- Improve and expand community outreach
  - Sparta
  - Crawford County
  - Viroqua
- Build a healthier community by addressing focus on health and prevention in:
  - Obesity
  - Chronic Disease
  - AODA: drugs and alcohol
  - Drunk Driving
  - Mental Health
  - Pediatric mental health
  - Ongoing affordable health care

Key Strengths:

- We know the names of our patients, we offer training, education and health promotion and are able to make great referrals for care.
- Health care is dynamic and demands change with the changing needs of the population. When we work together, we provide that dynamic care.
- We understand the needs of the communities we serve and work to meet them with primary and preventive care.
- Personalized care and availability of community programs and outreach keeps us in touch with our patients and communities.

APPENDIX J

FOCUS GROUP AND INTERVIEW QUESTIONS (NEEDS AND CAPACITY ASSESSMENT)

Medical Department/Dental Department Date

_____

Focus Group/Interview

A Systematic Approach for Improving Intra-organizational Referrals- Focus Group/Interview Questions

Literature suggests that a systematic approach to intra-organizational referrals improves program consistency, sustainability and may lead to improved interprofessional collaboration. Through the strategic interview process at SBCHC lasting January 15th through April 1st, 2014, it was identified by staff members in every department at every level that improving the protocol for intra-organizational referrals will also build improved communication between departments and further the goal to maintain status as a level-3 PCMH. A systematic pilot protocol and referral recommendations are being developed to improve this process within SBCHC. The pilot will begin with 2 -4 individuals from the medical and dental departments and will be evaluated and assessed for broader health center implementation. **Your input is needed and your opinions and ideas are essential to the formation and sustainability of this systematic plan.**

Current Strategies:

1. What strategies that are currently used at SBCHC work to promote intra-organizational referrals?
2. To what extent do you think these strategies are working?
3. To what extent do you think these existing strategies are providing a systematic, consistent and sustainable intra-organizational referral program?

New Strategies:

4. What are other ways in which SBCHC can provide a systematic, consistent and sustainable intra-organizational referral program?
5. In what other ways can individuals in the medical/dental departments be prompted to provide referrals to the medical/dental departments or other departments at SBCHC?

Prompts/In-take forms:

6. If SBCHC were to amend the intake/health history forms used in each department to include specific questions to prompt or guide referrals, what would you like the questions to ask? [For example: Do you have a primary medical provider? OR Please circle all of the services you receive at Scenic Bluffs Community Health Centers (list of depts), OR SBCHC offers medical, behavioral health, pharmacy, dental and chiropractic services. Please circle the services you would like more information on today.]
7. What specific recommendations would you make for consideration when amending health history/in-take forms to achieve uniformity between departments?
8. What specific recommendations would you make for consideration when amending health history/in-take forms to prompt staff to provide patients with a referral to another department/professional at SBCHC?

Referral Training:

9. If SBCHC were to offer a brief referral training program, what specific components of making a referral to your department would you want to have covered in this training?
10. What specific recommendations would you make for inclusion in referral training for SBCHC staff members?

Referral Forms:

11. Specific to referrals TO your department, what information is important for you to know when initiating contact with referred patients?
12. What specific recommendations would you make for inclusion in referral forms between departments at SBCHC?

General/Other:

13. What other ways can you think of to improve intra-organization referrals between departments at SBCHC (YOUR clinic, YOUR communities, what would work here?)?

APPENDIX K

NEEDS AND CAPACITY ASSESSMENT SUMMARIES

Tuesday, April 22nd, 2014
Dental Focus Group- SBCHC
3:20pm-3:50pm
Kate Noelke- Author, Interviewer, Preceptee
Colleen Daines- Dental Department Manager
Tricia Van Beek- Registered Dental Hygienist
Terri White- Dental Assistant

Current Strategies/Assets/Capacity:

14. What strategies that are currently used at SBCHC work <u>well</u>to promote intra-organizational referrals?
15. To what extent do you think these existing strategies are providing a systematic, consistent and sustainable intra-organizational referral program?

New Strategies/Needs:

16. What are other strategies by which SBCHC staff can implement a systematic, consistent and sustainable intra-organizational referral program?
17. In what other ways can individuals in the medical/dental departments be prompted or reminded to provide referrals to the medical/dental departments or other departments at SBCHC?

NEED-DRIVEN REFERRALS THROUGH INCLUSION IN REGULAR EXAMS

- Strep throat: a medical provider sees an obviously crummy tooth during a throat exam/strep test. - In order to provide need-driven intra-organizational referrals, there should be quick oral exams with primary care medical exams. This will require some simple training and open communication between medical and dental. This happens in the dental department when oral exams include neck and mouth cancer screenings, for example.

WELL CHILD VISITS TO INCLUDE DENTAL

- Get dental before the kids are hurting. The children often come into the dentist for the first time to have dental work done on a tooth or area of the mouth that is giving them pain. Dental would like to have an opportunity in well-child visits to see the children and invite them to sit in the chair. If they are introduced to dental and a dental office before they have to come in for work, anxiety is reduced.
- Link well child checks with a stop in dental (give a toothbrush) or a full screening in dental (managed appointment setting) and a meeting with a health educator/care coordinator

WOMEN'S HEALTH/PREGNANCY REFERRALS FOR CLEANING

Prompts/In-take forms/Health history forms:

18. If SBCHC were to amend the intake/health history forms used in each department to include two specific questions to prompt or guide referrals, do you think this would help/prompt staff members to make intra-organizational referrals? (Are you aware that SBCHC supports collaborative care between our medical, dental, behavioral health, chiropractic and pharmacy professionals under one roof with the goal of improving your health? Would you like to learn more about collaborative care available to you from our medical, dental, behavioral health, chiropractic or pharmacy departments?)
19. What specific recommendations would you make for consideration when amending health history/in-take forms to achieve uniformity between departments?

EMR/EHR

HEALTH HISTORY FORMS: Dental staff only sees the intake/health history form if they have to look up HIPAA or a child's consent to treat; otherwise dental assistants and hygienists don't see these intake/health history forms.

Referral Training:

20. If SBCHC were to offer a brief referral training program, what specific components of making a referral to your department would you want to have covered in this training?

21. What specific recommendations would you make for inclusion in referral training for SBCHC staff members?

REALISTIC EXPECTATIONS FOR APPOINTMENT TIME and DURATION: It's important during the referral to set realistic expectation for the appointment in the new department- sometimes we may be able to fit the person right in and sometimes there may be a wait. Staff should have an idea of the work load of the departments- this can be accomplished by interprofessional case/care conferencing. Also new adult patients that come to dental need a comprehensive medical exam with a dentist; the dentist can't just go in an fix a cavity.

INTERPROFESSIONAL CASE/CARE CONFERENCES: weekly meetings to discuss referrals, loads, specific problems dealing with, specific cases if needed between providers of different departments.

KEY VERBAL/PHYSICAL/BEHAVIORAL TRIGGERS: Staff need training to recognize things that may indicate a referral may be appropriate for example, if a patient is continuously late, no-shows, signs of depression: maybe refer to another department to HELP them: get them through. Needs to keep on…

- When a patient starts discussing the "stress in my life" and they begin to tell you everything, may be appropriate referral to Behavioral health: down-and-out, stressed, saying things about stuff like that
- Or refer to the HELP team when verbalizing concerns with insurance issues or healthy neighbor plan issues or problems and community resources (Also- Health Education!!)

HOW TO DO WARM-HAND OFFS: How to walk someone over to Health Education for smoking cessation

HOW TO USE EHR/HEALTH HISTORY FORM: When someone indicates they smoke or have other issues in EHR/health history forms, bring up these issues and ask if they want to talk to someone (Anne/HELP, etc); does MediaDent have a program for internal referrals that talks to EHS? Can dental make referrals to the medical through the CHART or EHS/EMR technology???

Referral Forms:

22. Specific to referrals TO your department, what information is important for you to know when initiating contact with referred patients?
23. What specific recommendations would you make for inclusion in referral forms between departments at SBCHC?

- DATE
- TIME
- PAIN SCALE- How much pain or discomfort is the patient experiencing?
- SPECIFIC REASON FOR REFERRAL WITH DESCRIPTION OF PROBLEM/ISSUE/CONCERN/REASON- medical terminology isn't necessary here, but a good, thorough description of the rationale behind the referral is needed so the provider the referral is being made to understands/gets a summary of the problem/reason for referral and has a foundation from which to start a conversation with a patient.
- APPOINTMENT SET? Or should this happen with the first contact from the department of referral?
- CURRENT HEALTH STATUS NOTES: pregnancy, diabetic, hemophilia?
- REFERRALs in EMR/EHR?

General/Other:

24. What other ways can you think of to improve intra-organization referrals between departments at SBCHC (YOUR clinic, YOUR communities, what would work here?)?
25. In what ways do intra-organizational referrals help address the needs of our special populations (Spanish speaking, Amish, mental health) well? How could we do this better?

WARM HAND-OFF: Arrange to have a hygienist or assistant come over to medical (in Cashton) to complete the referral when the patient is in the building BEFORE THEY LEAVE. OR walk them over to the dental area to have them speak with someone from that department before they leave. Big benefit here is that they are with someone they trust (referrer) when they are meeting a new face at SBCHC.

PATIENT-CENTERED: The message of referrals is patient-centered, not to increase your case/work-load or add more to your already busy day, but to IMPROVE CARE for the patient.
ATTITUDES: When negative attitudes are what referrals are greeted with, referrals are less likely to be made in the future. We need to remember that patient-centeredness of the effort.
BULLETIN BOARDS/SIGNAGE: Have some signage that shows all the services and also provides some education for the services for the patients.
EDUCATION TO THE PATIENTS: on all the services provided.

Wednesday, May 14th, 2014
Medical Focus Group- SBCHC
12:30pm-1:00pm
Kate Noelke- Author, Interviewer, Preceptee
Jenny Nottestad- Manager Clinical/Medical Assistants
Jamie Mlsna- Clinical/Medical Assistant
DevorahYahne- Laboratory Professional (teleconferenced in)

Current Strategies/Assets/Capacity:

1. What strategies that are currently used at SBCHC work wellto promote intra-organizational referrals?
2. To what extent do you think these existing strategies are providing a systematic, consistent and sustainable intra-organizational referral program?

New Strategies/Needs:

3. What are other strategies by which SBCHC staff can implement a systematic, consistent and sustainable intra-organizational referral program?
4. In what other ways can individuals in the medical/dental departments be prompted or reminded to provide referrals to the medical/dental departments or other departments at SBCHC?

NEED-DRIVEN REFERRALS THROUGH INCLUSION IN REGULAR EXAMS
- Strep throat: a medical provider sees an obviously crummy tooth during a throat exam/strep test. - In order to provide need-driven intra-organizational referrals, there should be quick oral exams with primary care medical exams. This will require some simple training and open communication between medical and dental. This happens in the dental department when oral exams include neck and mouth cancer screenings, for example.
WELL CHILD VISITS TO INCLUDE DENTAL
- Get dental before the kids are hurting. The children often come into the dentist for the first time to have dental work done on a tooth or area of the mouth that is giving them pain. Dental would like to have an opportunity in well-child visits to see the children and invite them to sit in the chair. If they are introduced to dental and a dental office before they have to come in for work, anxiety is reduced.
- Link well child checks with a stop in dental (give a toothbrush) or a full screening in dental (managed appointment setting) and a meeting with a health educator/care coordinator
WOMEN'S HEALTH/PREGNANCY REFERRALS FOR CLEANING

Prompts/In-take forms/Health history forms:

5. If SBCHC were to amend the intake/health history forms used in each department to include two specific questions to prompt or guide referrals, do you think this would help/prompt staff members to make intra-organizational referrals? (Are you aware that SBCHC supports collaborative care between our medical, dental, behavioral health, chiropractic and pharmacy professionals under one roof with the goal of improving your health? Would you like to learn more about collaborative care available to you from our medical, dental, behavioral health, chiropractic or pharmacy departments?)

6. What specific recommendations would you make for consideration when amending health history/in-take forms to achieve uniformity between departments?

Referral Training:

7. If SBCHC were to offer a brief referral training program, what specific components of making a referral to your department would you want to have covered in this training?
8. What specific recommendations would you make for inclusion in referral training for SBCHC staff members?

Referral Forms:

9. Specific to referrals TO your department, what information is important for you to know when initiating contact with referred patients?
10. What specific recommendations would you make for inclusion in referral forms between departments at SBCHC?

General/Other:

11. What other ways can you think of to improve intra-organization referrals between departments at SBCHC (YOUR clinic, YOUR communities, what would work here?)?
12. In what ways do intra-organizational referrals help address the needs of our special populations (Spanish speaking, Amish, mental health) well? How could we do this better?

Thursday, May 15th, 2014

Registration Professional Focus Group- SBCHC

2:30pm- 3:30pm, Norwalk
Kate Noelke- Author, Interviewer, Preceptee
Barb Mlsna- Administrative Registration Professional Manager
Sara Havlik- Registration Professional

Current Strategies/Assets/Capacity:

26. What strategies that are currently used at SBCHC work <u>well</u>to promote intra-organizational referrals?
27. To what extent do you think these existing strategies are providing a systematic, consistent and sustainable intra-organizational referral program?

New Strategies/Needs:

28. What are other strategies by which SBCHC staff can implement a systematic, consistent and sustainable intra-organizational referral program?
29. In what other ways can individuals in the medical/dental departments be prompted or reminded to provide referrals to the medical/dental departments or other departments at SBCHC?

NEED-DRIVEN REFERRALS THROUGH INCLUSION IN REGULAR EXAMS

- Strep throat: a medical provider sees an obviously crummy tooth during a throat exam/strep test. - In order to provide need-driven intra-organizational referrals, there should be quick oral exams with primary care medical exams. This will require some simple training and open communication between medical and dental. This happens in the dental department when oral exams include neck and mouth cancer screenings, for example.

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- Get dental before the kids are hurting. The children often come into the dentist for the first time to have dental work done on a tooth or area of the mouth that is giving them pain. Dental would like to have an opportunity in well-child visits to see the children and invite them to sit in the chair. If they are introduced to dental and a dental office before they have to come in for work, anxiety is reduced.

- Link well child checks with a stop in dental (give a toothbrush) or a full screening in dental (managed appointment setting) and a meeting with a health educator/care coordinator

WOMEN'S HEALTH/PREGNANCY REFERRALS FOR CLEANING

Prompts/In-take forms/Health history forms:

30. If SBCHC were to amend the intake/health history forms used in each department to include two specific questions to prompt or guide referrals, do you think this would help/prompt staff members to make intra-organizational referrals? (Are you aware that SBCHC supports collaborative care between our medical, dental, behavioral health, chiropractic and pharmacy professionals under one roof with the goal of improving your health? Would you like to learn more about collaborative care available to you from our medical, dental, behavioral health, chiropractic or pharmacy departments?)
31. What specific recommendations would you make for consideration when amending health history/in-take forms to achieve uniformity between departments?

EMR/EHR

HEALTH HISTORY FORMS: Dental staff only sees the intake/health history form if they have to look up HIPAA or a child's consent to treat; otherwise dental assistants and hygienists don't see these intake/health history forms.

Referral Training:

32. If SBCHC were to offer a brief referral training program, what specific components of making a referral to your department would you want to have covered in this training?
33. What specific recommendations would you make for inclusion in referral training for SBCHC staff members?

REALISTIC EXPECTATIONS FOR APPOINTMENT TIME and DURATION: It's important during the referral to set realistic expectation for the appointment in the new department- sometimes we may be able to fit the person right in and sometimes there may be a wait. Staff should have an idea of the work load of the departments- this can be accomplished by interprofessional case/care conferencing. Also new adult patients that come to dental need a comprehensive medical exam with a dentist; the dentist can't just go in an fix a cavity.

INTERPROFESSIONAL CASE/CARE CONFERENCES: weekly meetings to discuss referrals, loads, specific problems dealing with, specific cases if needed between providers of different departments.

KEY VERBAL/PHYSICAL/BEHAVIORAL TRIGGERS: Staff need training to recognize things that may indicate a referral may be appropriate for example, if a patient is continuously late, no-shows, signs of depression: maybe refer to another department to HELP them: get them through. Needs to keep on…

- When a patient starts discussing the "stress in my life" and they begin to tell you everything, may be appropriate referral to Behavioral health: down-and-out, stressed, saying things about stuff like that
- Or refer to the HELP team when verbalizing concerns with insurance issues or healthy neighbor plan issues or problems and community resources (Also- Health Education!!)

HOW TO DO WARM-HAND OFFS: How to walk someone over to Health Education for smoking cessation

HOW TO USE EHR/HEALTH HISTORY FORM: When someone indicates they smoke or have other issues in EHR/health history forms, bring up these issues and ask if they want to talk to someone (Anne/HELP, etc); does MediaDent have a program for internal referrals that talks to EHS? Can dental make referrals to the medical through the CHART or EHS/EMR technology???

Referral Forms:

34. Specific to referrals TO your department, what information is important for you to know when initiating contact with referred patients?
35. What specific recommendations would you make for inclusion in referral forms between departments at SBCHC?

- DATE
- TIME

- PAIN SCALE- How much pain or discomfort is the patient experiencing?
- SPECIFIC REASON FOR REFERRAL WITH DESCRIPTION OF PROBLEM/ISSUE/CONCERN/REASON- medical terminology isn't necessary here, but a good, thorough description of the rationale behind the referral is needed so the provider the referral is being made to understands/gets a summary of the problem/reason for referral and has a foundation from which to start a conversation with a patient.
- APPOINTMENT SET? Or should this happen with the first contact from the department of referral?
- CURRENT HEALTH STATUS NOTES: pregnancy, diabetic, hemophilia?
- REFERRALs in EMR/EHR?

General/Other:

36. What other ways can you think of to improve intra-organization referrals between departments at SBCHC (YOUR clinic, YOUR communities, what would work here?)?
37. In what ways do intra-organizational referrals help address the needs of our special populations (Spanish speaking, Amish, mental health) well? How could we do this better?

WARM HAND-OFF: Arrange to have a hygienist or assistant come over to medical (in Cashton) to complete the referral when the patient is in the building BEFORE THEY LEAVE. OR walk them over to the dental area to have them speak with someone from that department before they leave. Big benefit here is that they are with someone they trust (referrer) when they are meeting a new face at SBCHC.
PATIENT-CENTERED: The message of referrals is patient-centered, not to increase your case/work-load or add more to your already busy day, but to IMPROVE CARE for the patient.
ATTITUDES: When negative attitudes are what referrals are greeted with, referrals are less likely to be made in the future. We need to remember that patient-centeredness of the effort.
BULLETIN BOARDS/SIGNAGE: Have some signage that shows all the services and also provides some education for the services for the patients.
EDUCATION TO THE PATIENTS: on all the services provided.

Wednesday, May 21st, 2014

Impromptu/Unscheduled Focus Group- SBCHC

12:30pm-1:00pm during all-staff in-service lunch
Kate Noelke- Author, Interviewer, Preceptee
Colleen Daines- Dental Department Manager
Terri Komay- Registered Dental Hygienist
Sherry Harris- Family Nurse Practitioner

Current Strategies/Assets/Capacity:

38. What strategies that are currently used at SBCHC work <u>well</u>to promote intra-organizational referrals?
39. To what extent do you think these existing strategies are providing a systematic, consistent and sustainable intra-organizational referral program?

New Strategies/Needs:

40. What are other strategies by which SBCHC staff can implement a systematic, consistent and sustainable intra-organizational referral program?
41. In what other ways can individuals in the medical/dental departments be prompted or reminded to provide referrals to the medical/dental departments or other departments at SBCHC?

NEED-DRIVEN REFERRALS THROUGH INCLUSION IN REGULAR EXAMS
- Strep throat: a medical provider sees an obviously crummy tooth during a throat exam/strep test. - In order to provide need-driven intra-organizational referrals, there should be quick oral exams with primary care medical exams. This will require some

simple training and open communication between medical and dental. This happens in the dental department when oral exams include neck and mouth cancer screenings, for example.

WELL CHILD VISITS TO INCLUDE DENTAL

- Get dental before the kids are hurting. The children often come into the dentist for the first time to have dental work done on a tooth or area of the mouth that is giving them pain. Dental would like to have an opportunity in well-child visits to see the children and invite them to sit in the chair. If they are introduced to dental and a dental office before they have to come in for work, anxiety is reduced.
- Link well child checks with a stop in dental (give a toothbrush) or a full screening in dental (managed appointment setting) and a meeting with a health educator/care coordinator

WOMEN'S HEALTH/PREGNANCY REFERRALS FOR CLEANING

Prompts/In-take forms/Health history forms:

42. If SBCHC were to amend the intake/health history forms used in each department to include two specific questions to prompt or guide referrals, do you think this would help/prompt staff members to make intra-organizational referrals? (Are you aware that SBCHC supports collaborative care between our medical, dental, behavioral health, chiropractic and pharmacy professionals under one roof with the goal of improving your health? Would you like to learn more about collaborative care available to you from our medical, dental, behavioral health, chiropractic or pharmacy departments?)
43. What specific recommendations would you make for consideration when amending health history/in-take forms to achieve uniformity between departments?

EMR/EHR

HEALTH HISTORY FORMS: Dental staff only sees the intake/health history form if they have to look up HIPAA or a child's consent to treat; otherwise dental assistants and hygienists don't see these intake/health history forms.

Referral Training:

44. If SBCHC were to offer a brief referral training program, what specific components of making a referral to your department would you want to have covered in this training?
45. What specific recommendations would you make for inclusion in referral training for SBCHC staff members?

REALISTIC EXPECTATIONS FOR APPOINTMENT TIME and DURATION: It's important during the referral to set realistic expectation for the appointment in the new department- sometimes we may be able to fit the person right in and sometimes there may be a wait. Staff should have an idea of the work load of the departments- this can be accomplished by interprofessional case/care conferencing. Also new adult patients that come to dental need a comprehensive medical exam with a dentist; the dentist can't just go in an fix a cavity.

INTERPROFESSIONAL CASE/CARE CONFERENCES: weekly meetings to discuss referrals, loads, specific problems dealing with, specific cases if needed between providers of different departments.

KEY VERBAL/PHYSICAL/BEHAVIORAL TRIGGERS: Staff need training to recognize things that may indicate a referral may be appropriate for example, if a patient is continuously late, no-shows, signs of depression: maybe refer to another department to HELP them: get them through. Needs to keep on…

- When a patient starts discussing the "stress in my life" and they begin to tell you everything, may be appropriate referral to Behavioral health: down-and-out, stressed, saying things about stuff like that
- Or refer to the HELP team when verbalizing concerns with insurance issues or healthy neighbor plan issues or problems and community resources (Also- Health Education!!)

HOW TO DO WARM-HAND OFFS: How to walk someone over to Health Education for smoking cessation

HOW TO USE EHR/HEALTH HISTORY FORM: When someone indicates they smoke or have other issues in EHR/health history forms, bring up these issues and ask if they want to talk to someone

(Anne/HELP, etc); does MediaDent have a program for internal referrals that talks to EHS? Can dental make referrals to the medical through the CHART or EHS/EMR technology???

Referral Forms:

46. Specific to referrals TO your department, what information is important for you to know when initiating contact with referred patients?
47. What specific recommendations would you make for inclusion in referral forms between departments at SBCHC?

- DATE
- TIME
- PAIN SCALE- How much pain or discomfort is the patient experiencing?
- SPECIFIC REASON FOR REFERRAL WITH DESCRIPTION OF PROBLEM/ISSUE/CONCERN/REASON- medical terminology isn't necessary here, but a good, thorough description of the rationale behind the referral is needed so the provider the referral is being made to understands/gets a summary of the problem/reason for referral and has a foundation from which to start a conversation with a patient.
- APPOINTMENT SET? Or should this happen with the first contact from the department of referral?
- CURRENT HEALTH STATUS NOTES: pregnancy, diabetic, hemophilia?
- REFERRALs in EMR/EHR?

General/Other:

48. What other ways can you think of to improve intra-organization referrals between departments at SBCHC (YOUR clinic, YOUR communities, what would work here?)?
49. In what ways do intra-organizational referrals help address the needs of our special populations (Spanish speaking, Amish, mental health) well? How could we do this better?

WARM HAND-OFF: Arrange to have a hygienist or assistant come over to medical (in Cashton) to complete the referral when the patient is in the building BEFORE THEY LEAVE. OR walk them over to the dental area to have them speak with someone from that department before they leave. Big benefit here is that they are with someone they trust (referrer) when they are meeting a new face at SBCHC.

PATIENT-CENTERED: The message of referrals is patient-centered, not to increase your case/work-load or add more to your already busy day, but to IMPROVE CARE for the patient.

ATTITUDES: When negative attitudes are what referrals are greeted with, referrals are less likely to be made in the future. We need to remember that patient-centeredness of the effort.

BULLETIN BOARDS/SIGNAGE: Have some signage that shows all the services and also provides some education for the services for the patients.

EDUCATION TO THE PATIENTS: on all the services provided.

Tuesday, May 27th, 2014

Key Informant Interview- SBCHC

12:30pm-1:00pm

Kate Noelke- Author, Interviewer, Preceptee

Terri Komay- Registered Dental Hygienist

Current Strategies/Assets/Capacity:

50. What strategies that are currently used at SBCHC work <u>well</u>to promote intra-organizational referrals?
51. To what extent do you think these existing strategies are providing a systematic, consistent and sustainable intra-organizational referral program?

New Strategies/Needs:

52. What are other strategies by which SBCHC staff can implement a systematic, consistent and sustainable intra-organizational referral program?

53. In what other ways can individuals in the medical/dental departments be prompted or reminded to provide referrals to the medical/dental departments or other departments at SBCHC?

NEED-DRIVEN REFERRALS THROUGH INCLUSION IN REGULAR EXAMS

- Strep throat: a medical provider sees an obviously crummy tooth during a throat exam/strep test. - In order to provide need-driven intra-organizational referrals, there should be quick oral exams with primary care medical exams. This will require some simple training and open communication between medical and dental. This happens in the dental department when oral exams include neck and mouth cancer screenings, for example.

WELL CHILD VISITS TO INCLUDE DENTAL

- Get dental before the kids are hurting. The children often come into the dentist for the first time to have dental work done on a tooth or area of the mouth that is giving them pain. Dental would like to have an opportunity in well-child visits to see the children and invite them to sit in the chair. If they are introduced to dental and a dental office before they have to come in for work, anxiety is reduced.
- Link well child checks with a stop in dental (give a toothbrush) or a full screening in dental (managed appointment setting) and a meeting with a health educator/care coordinator

WOMEN'S HEALTH/PREGNANCY REFERRALS FOR CLEANING

Prompts/In-take forms/Health history forms:

54. If SBCHC were to amend the intake/health history forms used in each department to include two specific questions to prompt or guide referrals, do you think this would help/prompt staff members to make intra-organizational referrals? (Are you aware that SBCHC supports collaborative care between our medical, dental, behavioral health, chiropractic and pharmacy professionals under one roof with the goal of improving your health? Would you like to learn more about collaborative care available to you from our medical, dental, behavioral health, chiropractic or pharmacy departments?)
55. What specific recommendations would you make for consideration when amending health history/in-take forms to achieve uniformity between departments?

EMR/EHR

HEALTH HISTORY FORMS: Dental staff only sees the intake/health history form if they have to look up HIPAA or a child's consent to treat; otherwise dental assistants and hygienists don't see these intake/health history forms.

Referral Training:

56. If SBCHC were to offer a brief referral training program, what specific components of making a referral to your department would you want to have covered in this training?
57. What specific recommendations would you make for inclusion in referral training for SBCHC staff members?

REALISTIC EXPECTATIONS FOR APPOINTMENT TIME and DURATION: It's important during the referral to set realistic expectation for the appointment in the new department- sometimes we may be able to fit the person right in and sometimes there may be a wait. Staff should have an idea of the work load of the departments- this can be accomplished by interprofessional case/care conferencing. Also new adult patients that come to dental need a comprehensive medical exam with a dentist; the dentist can't just go in an fix a cavity.

INTERPROFESSIONAL CASE/CARE CONFERENCES: weekly meetings to discuss referrals, loads, specific problems dealing with, specific cases if needed between providers of different departments.

KEY VERBAL/PHYSICAL/BEHAVIORAL TRIGGERS: Staff need training to recognize things that may indicate a referral may be appropriate for example, if a patient is continuously late, no-shows, signs of depression: maybe refer to another department to HELP them: get them through. Needs to keep on…

- When a patient starts discussing the "stress in my life" and they begin to tell you everything, may be appropriate referral to Behavioral health: down-and-out, stressed, saying things about stuff like that
- Or refer to the HELP team when verbalizing concerns with insurance issues or healthy neighbor plan issues or problems and community resources (Also- Health Education!!)

HOW TO DO WARM-HAND OFFS: How to walk someone over to Health Education for smoking cessation

HOW TO USE EHR/HEALTH HISTORY FORM: When someone indicates they smoke or have other issues in EHR/health history forms, bring up these issues and ask if they want to talk to someone (Anne/HELP, etc); does MediaDent have a program for internal referrals that talks to EHS? Can dental make referrals to the medical through the CHART or EHS/EMR technology???

Referral Forms:

58. Specific to referrals TO your department, what information is important for you to know when initiating contact with referred patients?
59. What specific recommendations would you make for inclusion in referral forms between departments at SBCHC?

- DATE
- TIME
- PAIN SCALE- How much pain or discomfort is the patient experiencing?
- SPECIFIC REASON FOR REFERRAL WITH DESCRIPTION OF PROBLEM/ISSUE/CONCERN/REASON- medical terminology isn't necessary here, but a good, thorough description of the rationale behind the referral is needed so the provider the referral is being made to understands/gets a summary of the problem/reason for referral and has a foundation from which to start a conversation with a patient.
- APPOINTMENT SET? Or should this happen with the first contact from the department of referral?
- CURRENT HEALTH STATUS NOTES: pregnancy, diabetic, hemophilia?
- REFERRALs in EMR/EHR?

General/Other:

60. What other ways can you think of to improve intra-organization referrals between departments at SBCHC (YOUR clinic, YOUR communities, what would work here?)?
61. In what ways do intra-organizational referrals help address the needs of our special populations (Spanish speaking, Amish, mental health) well? How could we do this better?

WARM HAND-OFF: Arrange to have a hygienist or assistant come over to medical (in Cashton) to complete the referral when the patient is in the building BEFORE THEY LEAVE. OR walk them over to the dental area to have them speak with someone from that department before they leave. Big benefit here is that they are with someone they trust (referrer) when they are meeting a new face at SBCHC.

PATIENT-CENTERED: The message of referrals is patient-centered, not to increase your case/work-load or add more to your already busy day, but to IMPROVE CARE for the patient.

ATTITUDES: When negative attitudes are what referrals are greeted with, referrals are less likely to be made in the future. We need to remember that patient-centeredness of the effort.

BULLETIN BOARDS/SIGNAGE: Have some signage that shows all the services and also provides some education for the services for the patients.

EDUCATION TO THE PATIENTS: on all the services provided.

Tuesday, May 27th, 2014

Key Informant Interview- SBCHC

12:30pm-1:00pm

Kate Noelke- Author, Interviewer, Preceptee

Dr. Trevor Lyons- Chiropractor

Current Strategies/Assets/Capacity:

62. What strategies that are currently used at SBCHC work wellto promote intra-organizational referrals?
63. To what extent do you think these existing strategies are providing a systematic, consistent and sustainable intra-organizational referral program?

New Strategies/Needs:

64. What are other strategies by which SBCHC staff can implement a systematic, consistent and sustainable intra-organizational referral program?
65. In what other ways can individuals in the medical/dental departments be prompted or reminded to provide referrals to the medical/dental departments or other departments at SBCHC?

NEED-DRIVEN REFERRALS THROUGH INCLUSION IN REGULAR EXAMS

- Strep throat: a medical provider sees an obviously crummy tooth during a throat exam/strep test. - In order to provide need-driven intra-organizational referrals, there should be quick oral exams with primary care medical exams. This will require some simple training and open communication between medical and dental. This happens in the dental department when oral exams include neck and mouth cancer screenings, for example.

WELL CHILD VISITS TO INCLUDE DENTAL

- Get dental before the kids are hurting. The children often come into the dentist for the first time to have dental work done on a tooth or area of the mouth that is giving them pain. Dental would like to have an opportunity in well-child visits to see the children and invite them to sit in the chair. If they are introduced to dental and a dental office before they have to come in for work, anxiety is reduced.
- Link well child checks with a stop in dental (give a toothbrush) or a full screening in dental (managed appointment setting) and a meeting with a health educator/care coordinator

WOMEN'S HEALTH/PREGNANCY REFERRALS FOR CLEANING

Prompts/In-take forms/Health history forms:

66. If SBCHC were to amend the intake/health history forms used in each department to include two specific questions to prompt or guide referrals, do you think this would help/prompt staff members to make intra-organizational referrals? (Are you aware that SBCHC supports collaborative care between our medical, dental, behavioral health, chiropractic and pharmacy professionals under one roof with the goal of improving your health? Would you like to learn more about collaborative care available to you from our medical, dental, behavioral health, chiropractic or pharmacy departments?)
67. What specific recommendations would you make for consideration when amending health history/in-take forms to achieve uniformity between departments?

EMR/EHR

HEALTH HISTORY FORMS: Dental staff only sees the intake/health history form if they have to look up HIPAA or a child's consent to treat; otherwise dental assistants and hygienists don't see these intake/health history forms.

Referral Training:

68. If SBCHC were to offer a brief referral training program, what specific components of making a referral to your department would you want to have covered in this training?
69. What specific recommendations would you make for inclusion in referral training for SBCHC staff members?

REALISTIC EXPECTATIONS FOR APPOINTMENT TIME and DURATION: It's important during the referral to set realistic expectation for the appointment in the new department- sometimes we may be able to fit the person right in and sometimes there may be a wait. Staff should have an idea of the work load of the departments- this can be accomplished by interprofessional case/care conferencing. Also new adult patients that come to dental need a comprehensive medical exam with a dentist; the dentist can't just go in an fix a cavity.

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- When a patient starts discussing the "stress in my life" and they begin to tell you everything, may be appropriate referral to Behavioral health: down-and-out, stressed, saying things about stuff like that
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HOW TO DO WARM-HAND OFFS: How to walk someone over to Health Education for smoking cessation
HOW TO USE EHR/HEALTH HISTORY FORM: When someone indicates they smoke or have other issues in EHR/health history forms, bring up these issues and ask if they want to talk to someone (Anne/HELP, etc); does MediaDent have a program for internal referrals that talks to EHS? Can dental make referrals to the medical through the CHART or EHS/EMR technology???

Referral Forms:

70. Specific to referrals TO your department, what information is important for you to know when initiating contact with referred patients?
71. What specific recommendations would you make for inclusion in referral forms between departments at SBCHC?

- DATE
- TIME
- PAIN SCALE- How much pain or discomfort is the patient experiencing?
- SPECIFIC REASON FOR REFERRAL WITH DESCRIPTION OF PROBLEM/ISSUE/CONCERN/REASON- medical terminology isn't necessary here, but a good, thorough description of the rationale behind the referral is needed so the provider the referral is being made to understands/gets a summary of the problem/reason for referral and has a foundation from which to start a conversation with a patient.
- APPOINTMENT SET? Or should this happen with the first contact from the department of referral?
- CURRENT HEALTH STATUS NOTES: pregnancy, diabetic, hemophilia?
- REFERRALs in EMR/EHR?

General/Other:

72. What other ways can you think of to improve intra-organization referrals between departments at SBCHC (YOUR clinic, YOUR communities, what would work here?)?
73. In what ways do intra-organizational referrals help address the needs of our special populations (Spanish speaking, Amish, mental health) well? How could we do this better?

WARM HAND-OFF: Arrange to have a hygienist or assistant come over to medical (in Cashton) to complete the referral when the patient is in the building BEFORE THEY LEAVE. OR walk them over to the dental area to have them speak with someone from that department before they leave. Big benefit here is that they are with someone they trust (referrer) when they are meeting a new face at SBCHC.
PATIENT-CENTERED: The message of referrals is patient-centered, not to increase your case/work-load or add more to your already busy day, but to IMPROVE CARE for the patient.
ATTITUDES: When negative attitudes are what referrals are greeted with, referrals are less likely to be made in the future. We need to remember that patient-centeredness of the effort.
BULLETIN BOARDS/SIGNAGE: Have some signage that shows all the services and also provides some education for the services for the patients.
EDUCATION TO THE PATIENTS: on all the services provided.

APPENDIX L

2013 SBCHC PATIENTS SEEN IN MULITPLE DEPARTMENTS

In 2013, Scenic Bluffs served 8664 individual patients. This is a summary of those that were seen in multiple departments.

Seen in 2 Departments

Hint: Read the rows of the graph. For example: We saw 223 patients in our BH dept. 12% of these were also seen in Chiro; 47% were also seen in Dental; 58% were also seen in Medical.

Department	2013 Patients	% BH	% Chiro	% Dental	% Medical
BH	223	---	12%	47%	58%
Chiro	463	6%	---	48%	48%
Dental	6314	2%	4%	---	15%
Medical	3102	4%	7%	31%	---

Counts
BH and Chiro: 27
BH and Dental: 106
BH and Medical: 130
Chiro and Dental: 221
Chiro and Medical: 220
Dental and Medical: 971

Seen in 3 Departments

BH/Chiro/Dental = 14 patients
BH/Chiro/Medical = 16 patients
BH/Medical/Dental = 61 patients
Chiro/Medical/Dental = 101 patients

Seen in all 4 Departments

6 patients were seen in all 4 of our departments in 2013.

APPENDIX M

PRE-PILOT TOOL

Greeting.
1:Hello
2: Hi
3: Good morning
4: Good afternoon
5: Other

Introduction: (uniform)
Kate – health educator and intern here- looking into how this community health center is utilized/used by the community and patients so that we can help people better.

Permission: (Closed questions)
1: May I have permission to assist you this morning/afternoon?
2: Is it alright with you if I chat for a minute or two?
3: Is it alright with you if I ask you a couple of quick questions?
4: Do you have a minute to talk with me?
5: Other

Offer assistance:
1:O/C: What can I do for you while you wait? (Prompt: coffee, water, restroom, help with forms?)
2: O: Describe any questions you have about your visit today.
3: O: What can I help you with while you wait?
4: Other- note open or closed

Pick 2 questions
Questions about services:
1: C: Have you met with [PROVIDER NAME] before?
2: O: Describe your relationship with the providers at SBCHC.
3: C: Are you familiar with all the services that are offered at SBCHC?
4: O: Tell me about your experiences at Scenic Bluffs.
5: C: Can I answer any questions for you about the services we offer at Scenic Bluffs?
6: O: What services do you have questions about at Scenic Bluffs?
7: C: Are you familiar with our HELP team?
8: C: Do you use our [SPECIFIC SERVICE]? Example: Do you use the pharmacy here at Scenic Bluffs? Do you use the nurses and doctors at Scenic Bluffs for your medical check-ups?
9: C: Are you aware of additional services available at Scenic Bluffs? (Prompts: Community Wellness, Anxiety workshops/treatment, Living Well with Chronic Conditions, Diabetes Education, Smoking Cessation….) Sara: are there more specific things I should have in my prompts for this?

Follow-Up:
1: May I tell you a little about the services offered here?
2: May I introduce you to one of our HELP team members?
3: Have you ever met one of our [department] staffers?
4: Have you ever met [X first name] from our [DEPARTMENT]?
5: Community Wellness
6: Anxiety Workshops/Treatment
7: Living Well with Chronic Conditions
8: Diabetes Education
9: Smoking Cessation
10: Well-Child Checks/Childhoods Immunizations

Pre-Pilot Evaluation for Patient Interactions Designed to Improve Intra-Organizational Referrals and Support PCMH

Date: _____ Referral made? Y or N #_____

Time: _____ Referral made to _____

In to See [Provider] _____ Notes: _____

_____

_____

_____

_____

_____

Greeting	**Introduction**	**Permission**	**Offer Assistance**	**Questions about Services**		**Prompts**	
1 Hi		1	1	1	6	1	6
2 Hello		2	2	2	7	2	7
3 Good Morning		3	3	3	8	3	8
4 Good Afternoon		4	4	4	9	4	9
5 Other:		5		5	10	5	10
Observed Reception	**Observed Reception**	**Observed Reception**	**Observed Reception**	**Observed Reception**		**Observed Reception**	
Very Interested Interested Ambivalent Uninterested Rejected the Idea	Very Interested Interested Ambivalent Uninterested Rejected the Idea	Very Interested Interested Ambivalent Uninterested Rejected the Idea	Very Interested Interested Ambivalent Uninterested Rejected the Idea	Very Interested Interested Ambivalent Uninterested Rejected the Idea		Very Interested Interested Ambivalent Uninterested Rejected the Idea	

APPENDIX N

PRE-PILOT EVALUATION PERSONAL COMMUNICATION

Pre-Pilot Evaluations Day 1: Personal Communications

Kate--
Below are some notes related to our brief meeting about this we had a few minutes ago.
Looking forward to your findings,
Sara

Sara Martinez, RN, MSN
Scenic Bluffs Community Health
Centers

238 Front St.
Cashton, WI 54619
(608) 654-5100, x229

From: Kate Noelke
Sent: Tuesday, June 03, 2014 11:19 AM
To: Sara Martinez; 'noelke.kate@uwlax.edu'
Cc: Mari Freiberg
Subject: Kate's pre-pilot considerations

Hello Guides and Leaders,

I'm 4 (plus 2 surprise participants) patients into Terri's schedule today and some barriers have been presented in the first few interactions. I have decided to stick with the plan for today so that I am certain whether the barriers are preventing good data from being collected. I am proposing some changes for tomorrow's pre-pilot opportunity and also for the pilot to take place next Monday through Thursday.

To review, I planned to speak with the patients coming into see Terri Komay today. (Dr. Julie and Sherry Harris tomorrow.) There were nine appointments set for Terri today.

The barriers we (me and the RPs) have run into so far include:

1- The patients who come in and check in don't know the name of the specific provider they are going to see. They know they are here to see a doctor, a dentist, etc… There is disconnect in identifying specifically Terri's patients.

2- The RPs are putting forth more effort that I had hoped was necessary to show me the patients who are Terri's today and have to take extra steps to help me identify these folks (walking over to find me= they're awesome and so helpful, but I don't want to cause them extra work). I have decided to check in at the front desk for each

appointment 15 minutes before the scheduled appointment time to reduce their efforts today and it is going well.

3- I'm in the front office that used to be Amy's so I can work between patients and I may be in the way of the HELP team.

4- Language barriers: to be expected (1st three appointments were Hmong speakers).

Moving forward, I have the following requests as a result of pre-pilot evaluation for planning for the Pilot to take place next week 6/9-6/12 (M-R):

1- Instead of delimiting to specific providers, could we delimit to specific 3-hour time slots? For example, during the pilot next week, could I delimit to Monday 7am-9:45am and 1pm-4pm; Tuesday 7am-10am and 10am-1pm; Wednesday 9am-12pm and 1:30-4:30pm; Thursday 8am-11am and 1pm-4pm? In this case, I'd be talking to as many people as I can touch in the waiting room with the most professional manner, of course. Sounds good—and you"ll send a msg out to staff briefly explaining what you're up to, as we talked about.

2- Amy mentioned yesterday that Adam calls all new dental patients before their appointments. Is there any chance I could be a part of that phone call to pilot these questions over the telephone at some point next week as a component of the Pilot study? YES

3- Is there a more appropriate place for me to set up than Amy's old office? This location is ideal as it's close to the in-take area and waiting room, but should I set up work space in the waiting room so I'm out of the HELP team's way? Is it pretty safe to leave computers out in the open in the waiting room? Or do you have any suggestions on where I can work in between patients? Amy's old office is best, as we talked about.

May I have approval to make the delimitation to time-slots instead of providers for tomorrow's iteration of the pre-pilot?

I'll report back after tomorrow with evaluation of both days of the pre-pilot with my perceptions and information gathered.

Best Regards,

Kate

Kate C. Noelke
Masters Candidate- UW-La Crosse
Preceptee- Scenic Bluffs Community Health Centers
knoelke@scenicbluffs.org

APPENDIX O

PILOT TOOL

Greeting.
Hello/Hi/Good Afternoon/Good Morning

Introduction: (uniform)
Kate – health educator and intern here, student at UW-L- looking into how this community health center is utilized/used by the community and patients so that we can help people better.

Permission: (Closed questions/Uniform)
May I have permission to ask you a couple of quick questions?

Pick 2 questions
Questions about services:
1: C: Have you met with [PROVIDER NAME] before?
2: O: Describe your relationship with the providers at SBCHC.
3: C: Are you familiar with all the services that are offered at SBCHC?
4: O: Tell me about your experiences at Scenic Bluffs.
5: C: Can I answer any questions for you about the services we offer at Scenic Bluffs?
6: O: What services do you have questions about at Scenic Bluffs?
7: C: Do you use our [SPECIFIC SERVICE]? Example: Do you use the pharmacy here at Scenic Bluffs? Do you use the nurses and doctors at Scenic Bluffs for your medical check-ups? HELP Team?
8: C: Are you aware of additional services available at Scenic Bluffs? (Prompts: Community Wellness, Anxiety workshops/treatment, Living Well with Chronic Conditions, Diabetes Education, Smoking Cessation….)
9: Other- Are you aware of all the health and community events we've created for our patients this summer?

Prompts:
1: May I tell you a little about the services offered here?
2: Have you ever met one of our [department] staffers?
3: Have you ever met [X first name] from our [DEPARTMENT]?
4: Community Wellness
5: Anxiety Workshops/Treatment
6: Living Well with Chronic Conditions
7: Diabetes Education
8: Smoking Cessation
9: Well-Child Checks/Childhoods Immunizations
10: Pharmacy
11: Stress reduction
12: None used
13: Viroqua Dental Expansion
14: Sports Physicals
15: Work physicals
16: Other: please note

Offer assistance:
O/C: What can I do for you while you wait? (Prompt: coffee, water, restroom, assistance with forms?)
O: Describe any questions you have about your visit today.
O: What can I help you with while you wait?

Pilot Evaluation for Patient Interactions Designed to Improve Intra-Organizational Referrals and Support PCMH 2.0

Date: _____ Time: _____ Duration: _____ Referral made? Y or N #_____

Male or Female Appointment made? Y or N Referral made to _____

Estimated age range 18-29 30-49 50-64 65 & older In to See [Provider] _____

Notes: _____

_____

_____

_____

_____

Greeting	Introduction	Permission	Questions about Services		Prompts			Offer Assistance
			1	6	1	6	11	
			2	7	2	7	12	
			3	8	3	8	13	
			4	9	4	9	14	
			5		5	10	15	
Observed Reception	**Observed Reception**	**Observed Reception**	**Observed Reception**		**Observed Reception**		16	**Observed Reception**
Very Interested Interested Ambivalent Uninterested Rejected the Idea	Very Interested Interested Ambivalent Uninterested Rejected the Idea	Very Interested Interested Ambivalent Uninterested Rejected the Idea	Very Interested Interested Ambivalent Uninterested Rejected the Idea		Very Interested Interested Ambivalent Uninterested Rejected the Idea			Very Interested Interested Ambivalent Uninterested Rejected the Idea

APPENDIX P

HEALTH CENTER PROMOTIONS KIDS' HEALTH MONTH AND HEALTH FAIR


Scenic Bluffs
COMMUNITY HEALTH CENTERS
Get ready for Fall Sports!
July is Kids' Health Month
Sports Physical-$20
Fitted Mouth Guard-$10
New Chiropractic Consultation- $30
Behavioral Health– Dealing with Depression
Cashton: 654-5100 & Norwalk: 823-7853
Cash only offer, insurance will not be billed
WWW.SCENICBLUFFS.ORG


Scenic Bluffs
COMMUNITY HEALTH CENTERS
Health Fair
Cashton Health Center
Tuesday, Aug. 5th
8— 11am
Norwalk Health Center
Thursday, Aug. 7th
8— 11am
No appointments—
All Adults Welcome!
WWW.SCENICBLUFFS.ORG
*FREE Screenings—Breast, colon, skin, and oral cancers
*FREE Chiropractic—Posture Screenings along with information on the Truth about Chiropractic.
*FREE Glucose and Cholesterol Screenings—Free labs, 12 hour fasting is required
*FREE BadgerCare Plus, Prescription Drug Assistance Program and other health benefits information
*FREE Behavioral Health Workshops-
First Aid for Anxiety & Dealing with Depression.

APPENDIX Q

SBCHC NEW DENTAL PATIENTS TELEPHONE SCRIPT

Hi, this is_____ from Scenic Bluffs Community Health Centers. Is [the parent of] _____there? I am calling about your [son/daughter's] upcoming dental appointment _____. Because you are a new patient with us, I am calling to verify some of your information, as well as talk with you about some of the service we offer to all of our patients. So, do you have a few minutes?

Topics to talk about

1. Demographics: using Patient Administration, verify name, DOB, address, guarantor, etc , (insurance, and additional patient data tab). ** For the insurance, just write it down on a piece of paper and then put it into the comments sections in the scheduling side.
2. Text/Email Reminders: We have started a new system that can text or email you the night before to remind you of your appointment. **There is a half-sheet that you can fill out and give to Adriana. (Name, phone #, carrier, any other family members).
3. Patient Portal: We have also just created a patient portal online, where our patients can log in and see any future appointments, their list of medications, and any lab results. We are asking all our patients to sign up for this service. If you don't use it often, that is fine, and we would still like for you to sign up. (In the first page of Patient Administration), you need to click on the tab called Portal Setup->New->and enter in the person's email account. They will then receive an email on how to activate their account and change their password.)
4. Healthy Neighbor Plan: The HNP is a free program that we offer to all of our patients. It is a sliding fee scale that based on your income and family size you can qualify for reduced fees even after your insurance. We have three different levels that you can qualify for and all it takes is to fill out an application and show proof of your income.
5. I will be mailing out some forms that you will need to fill out before you come in for your appointment, as well as the HNP brochure that you can read more about. This does help reduce some of your waiting time at the beginning of your appointment. We do ask that you still get here about 15 minutes before your scheduled appointment.

Thank you very much for taking the time to talk with me today, if you have any questions, please don't hesitate to give me or the dental receptionists a call.

Kate: "Are you familiar with all of the health care, preventive and community wellness services and activities here?"
Kids Health Month, Well-Child Checks, Sports Physicals, August Health Fair…
Provided handout on *July: Kids' Health Month* to be mailed with packet to all 5 phone calls Kate made 6/9/2014.

APPENDIX R

BUILDING A STRATEGIC FOUNDATION FOR IMPROVING INTRA-ORGANIZATIONAL REFERRALS AND INTERPROFESSIONAL COLLABORATION: A TOOLKIT

Building a Strategic Foundation for Improving Intra-Organizational Referrals and Interprofessional Collaboration: A Toolkit

Getting Started

Introduction.

The development of this toolkit emerged out of the strategic planning process facilitated by Scenic Bluffs Community Health Centers in 2014, and evolved into the graduate project of a Master of Public Health candidate during her preceptorship experience. Scenic Bluffs is a federally qualified health center (FQHC) operating under Section 330 of the Public Health Service Act and is also recognized by the National Committee on Quality Assurance (NCQA) as a level-three Patient Centered Medical Home (PCMH). The need for a strategic foundation for improving intra-organizational referrals was identified by the staff members of Scenic Bluffs during focus groups and interviews conducted as components of the strategic planning process, and was further explored through important needs and capacity assessment endeavors. This need was aligned with the goals of the organization, the pursuit of PCMH status and health care quality improvement (QI), and with the interests of the author.

Why Intra-organizational Referrals?

Interprofessional collaboration is an important component of a successful health care home operating as a PCMH and also an area of emerging research in health system quality improvement (Agency for Healthcare Research and Quality (AHRQ), 2013; Buhler, Farrell, Fuentes, Scott, Shaffer, and Von, 2011; Capella, 2013; Goldman &Borkan, 2013; Tailani, Bricker, Adelman, Cronholm, and Gabbay, 2013; Wooten, Harno&Repornen, 2003). NCQA's PCMH standard number two outlines team-based care and specifies that in order to meet this requirement, "the practice must provide continuity of care using culturally and linguistically appropriate, team-based approaches" (NCQA, 2014, p. 37). Other elements of the PCMH model improved by a strategic foundation for improving intra-organizational referrals include the areas of continuity, medical home responsibilities, providing culturally and linguistically appropriate services, and a coordinated practice team (NCQA, 2014).

The NCQA model of PCMH is the most widely used and accepted and has been found to increase quality and reduce costs of primary medical care by a number of research studies (Grumbach& Grundy, 2010; NCQA, 2012; Patient Centered Primary Care Collaborative, 2009; Robert Graham Center, 2007).PCMH aims to make primary care "accessible, continuous, comprehensive, and coordinated" while being delivered in the context of family and community and in doing so, will improve quality, affordability, and patient and caregiver experience as well as health care professional experience" (Peikes, et al., 2012, p.1). It is also widely considered a cost-effective solution for health care (Ewing, 2013) because it emphasizes collaborative care, prevention and continuity of care through close medical provider relationships. It is the management principles of this approach to medicine that have demonstrated lower costs and higher-quality healthcare for patients with chronic disease (Robert Wood Johnson Foundation, 2012). Through improved management principles and strategic, replicable processes, this toolkit was developed to assist in sustaining PCMH recognition and as a measure to improve health care quality and interprofessional collaboration, supporting the goal of the PCMH model.

Goal.

Designed through the collaborative efforts and ingenuity of the staff at Scenic Bluffs Community Health Center, it is a goal that this toolkit be available for reference, download, use, and customization by other organizations and agencies who value the benefit of improved intra-organizational referrals and interprofessional communication. Please contact the author for more information or foundational materials regarding this project in our health center and how you can put it to use in your organization or agency.

Kate C. Noelke, MPH
knoelke@scenicbluffs.org
www.scenicbluffs.org

Bubble

Key Terms:

Intra-organizational: a term for exchange of knowledge, cooperation, collaboration, efforts or communication between different departments or persons within one organization. For example, a referral made from a hygienist in the dental department for a dental patient of SBCHC to a health care practitioner in the behavioral health department of the same organization for counseling treatment is an intra-organizational referral
Interprofessional: a term for exchange of knowledge, cooperation, collaboration, efforts or communication between separate professional groups. For example, communication between a physician and a pharmacist in reference to an individual patient or topic are interprofessional communications.

Bubble

Gaining Deeper Understanding: Needs and Capacity Assessments

It is important to note the role of the needs and capacity assessment when considering implementing small or large-scale change within an organization. Whether taking place during program planning, strategic planning or efforts of regular maintenance and sustainability related to organizational quality improvement, needs and capacity assessments are used to identify and better understand the varied impactors affecting a specific topic or area so that informed decisions can be made about how to address and improve it (Gilmore, 2012). In this case, the author administered focus groups and key informant interviews with the goal of gaining deeper understanding of what strengths and measures were already being practiced at Scenic Bluffs Community Health Centers, what ideas the staff had about how intra-organizational referrals could be improved, and what they perceived as strengths and barriers related to improving intra-organizational referrals. Not only did the needs and capacity assessment lead to a deeper understanding of how intra-organizational referrals were being made and how they could be improved, but it also involved the staff people in the development and guidance of organizational change which had immense positive effects on how the program was received.

Challenge: Do a needs and capacity assessment to gain a deeper understanding of the issue you are planning to improve. Ask questions about need: What could we do better? What are barriers to this change? Ask important questions about capacity: What are we doing well? What works about the way we are doing things now? What resources do we already have that could help us in this effort?

How to Build a Foundation for Improving Intra-Organizational Referrals

Step One: Define what intra-organizational referral is to your organization.

Start fresh. If you do not have a definition: write one out. What are the limitations of your definition? How does it fit within your mission, vision and values? Is your definition clear? If you have a working definition of what an intra-organizational referral is within your organization, review the definition. Consider the implications of broadening or narrowing the scope. How you define intra-organizational referral will guide how you can measure success in your efforts to improve your referral system.

Bubble

Intra-organizational Referral at SBCHC: a referral to any service, department, provider, community event or activity put on by SBCHC and SBCHC staff members, whether or not an appointment was made, not exclusive to billable services such as an appointment with a physician for throat pain, or a chiropractic adjustment, but also including referrals to enriching or prevention services such as community wellness activities, monthly specials, workshops and health fairs.

Step Two: Define what success in making intra-organizational referrals looks like.

How will you measure the success of your intra-organizational referral strategy? Will you measure process (how many intra-organizational referrals are made each week)? Or will you measure outcome (increases in patients seen in multiple departments or community events)? In your definition, did you require intra-organizational referrals be input into the EMR and can you use those software capabilities to track referrals made and outcome measures? Does your organization require you to track referrals made to billable health care services versus enriching, prevention based services? How will you differentiate?

Bubble

Success for SBCHC in Intra-Organizational Referral Making: In 2013, six patients were seen in all four departments (medical, dental, behavioral health and chiropractic) at SBCHC. It is our aim to double that number to twelve patients by the end of the current strategic planning cycle, July 2017.

Step Three: Set clear expectations for staff members regarding intra-organizational referrals. Communicate clear expectations to staff members.

Who is responsible for making intra-organizational referrals? For example, are health care providers the only people on staff who will be held accountable for making referrals to other providers because of their access to the EMR? Or, can everyone on staff be expected to make intra-organizational referrals to billable services as well as enriching, prevention-based services? Set clear expectations: provide an in-person update to clarify the new definition of intra-organizational referral, how success will be measured, and what specifically is expected of each staff member. Support this in-person discussion with a follow-up email bulletin and also write it into the job descriptions of appropriate staff positions. It is important to communicate the new, strategic system, especially to those who will be held accountable for making intra-organizational referrals.

Step Four: Offer training and tools to increase intra-organizational referral making proficiency

Use the toolkit provided for some ideas on how to jumpstart improved intra-organizational referrals in your organization or agency. Use the Training Resources to help your staff *identify* opportunities for making intra-organizational referrals, *discuss* scenarios, questions and common concerns, and *practice* using language and conversation opening skills. Check out the Best Practices for Communication and Promotion to access scripts, templates, tools and resources for patient interaction to use when practicing and making intra-organizational referrals.

Large Side Bubble

Special Consideration: Role of the Electronic Medical Record

A needs and capacity assessment was facilitated during the development of this protocol in order to identify, understand and describe the intra-organizational referral practices in place at Scenic Bluffs. From these focus groups and key informant interviews, the role of the electronic medical record (EMR) emerged as a significant consideration. The EMR, in regards to intra-organizational referrals, was viewed by the health care team at Scenic Bluffs to be a potential asset and also a considerable barrier to intra-organizational referral making practices.

Because different EMR vendors offer different software packages, the EMR has the potential to be an invaluable tool in the making and tracking of referrals between departments. Some EMRs provide easy-to-use intra-organizational referral promoting components whereby referrals can be made with just a few clicks of the mouse. For example, if a health care provider wants to make a referral, he/she can go into the patient's EMR, click under the "referral" heading on the name of another health care provider and select that person's name. Notes can be entered into the EMR to direct the other provider. In this example, intra-organizational referral making can be easily measured, but is also primarily the responsibility of people with access to the EMR.

Some organizations use less sophisticated EMR software, or don't access the EMR at all. The difficulty and tedium associated with entering referrals into the software is a considerable barrier to the making and tracking of intra-organizational referrals using the EMR. It was reported during the needs and capacity assessment that some health care providers associated the capabilities of the EMR directly with the success or failure of intra-organizational referral tracking. Organizations without EMR access or with limited

EMR capabilities can still create a strong foundation for intra-organizational referral making. Without the strong EMR capabilities, the responsibility of intra-organizational referral making can be accepted by all, not just those with access to it. Consider that intra-organizational referrals may be tracked by measuring outcome, such as the number of patients who access services in multiple departments year-over-year, or by the number of participants in community wellness events.

It is important to fully understand the capabilities of your EMR. When defining what an intra-organizational referral is for your organization, what success looks like and outlining expectations, it is important to consider what role the EMR will play in your strategic foundation for intra-organizational referral making. It is also important to think outside of the box and to identify alternative ways to make and to measure intra-organizational referrals.

Training Resources

Objective

Using the training resources, staff will identify opportunities for making intra-organizational referrals, discuss scenarios, questions and common concerns, and practice using language and conversation opening skills.

Training Modules

I: Identify & Discuss - Scenarios

II: Practice & Discuss - Conversation Starters

III: Practice & Discuss - Cues to Action

IV: Practice & Discuss - Role Plays

Bubble to accompany Module III

Special Considerations: Licensed Health Care Providers' Roles

Traditionally, it has fallen to the licensed health care providers such as doctors, nurses, dentists, and hygienists to identify health problems that are best served by another health professional and to make an intra-organizational referral based on this professional identification or diagnosis of a symptom. For example, a family nurse practitioner may notice an obvious dental cavity when he or she is doing an exam for strep throat. A referral is then made to a dentist in this example. During the needs and capacity assessment which took place during the development of this protocol, licensed health care providers provided some important insight guiding when to make that referral to another professional.

Consider the following recommendations from other licensed health care providers.

- The message of referrals is patient-centered, not to increase your case/work-load or add more to your already busy day, but to IMPROVE CARE for the patient.
- Remember that patient-centeredness of the effort: intra-organizational referrals are made to improve the health outcomes of our patients and clients by improving care coordination and health care accessibility.
- Need-driven referrals can be included in regular exams. For example, include a visit to the dental department during well-child visits. Or have the health educator included in annual physical appointments.
- Know your expertise, strengths, weaknesses and limits. Make an effort to get to know the expertise, strengths, weaknesses and limits of your interprofessional

- colleagues. Open conversations like this will make intra-organizational referral making easier and more comfortable for you and your patients.

Intra-organizational Referral Training Module I: Identifying Opportunities - Scenarios

Talk through the following scenarios with your team. Identify potential ways in which you could introduce an intra-organizational referral with this patient. Consider the following questions.

***Challenge: Read through and discuss these scenarios in interprofessional teams.**

1. What is your role in this situation?
2. At what point(s) in this scenario could you introduce yourself and an opportunity at the health center for this patient?
3. Reflect on similar real-life situations. What worked? What didn't?
4. Think outside of the box. How could you introduce this patient to a service of the PCMH you work for in order to improve their health care center experience? What events or activities are coming up that this family/person might be interested in?

Scenario One

June 3rd: A young woman with three children (ages 3, 5 and 9) checks in at the front desk for dental appointments. You aren't sure which dental hygienist she is going to see, but you infer that all three kids have regular dental cleanings scheduled today. They sit down near the corner of the waiting room and begin to play quietly. *Fifteen minutes go by and the first, oldest child goes back for her appointment and the mom and the two younger children stay in the waiting area. *Fifteen more minutes go by and the oldest child comes back and the next child goes back with the hygienist. This continues for the duration of the children's three appointments.

Scenario Two

April 10: A patient checks in at the front desk for a medical appointment with Sherry Harris. He is an elderly man and uses a cane for walking. Slowly, he makes his way to a chair in the waiting room and sits down to wait for his appointment. You greet him and through brief conversation, learn that he is from Viroqua and travels to SBCHC for his medical visits with Sherry. He is really happy with the care he receives here.

Scenario Three

October 20: A patient is waiting for you in the waiting room and as you approach, you notice that she is noticeably nervous and uncomfortable. You greet the patient and confirm identity. You ask how the patient is today and she tells you that she's a little nervous for her appointment. You know she has cancelled this appointment twice before.

Intra-organizational Referral Training Module II: Practice & Discuss - Conversation Starters

Broadquestions were the most successful conversation starting questions used in the pre-pilot and pilot protocols used in the development of this toolkit. Open-ended questions engage people more deeply in conversations, even brief ones. For this activity, first become comfortable asking open-ended questions. Then, practice using the conversation starters provided and develop some of your own. *For a challenge, complete these activities in interprofessional teams.

Activity #1
Closed-ended questions can easily be answered with "yes" or "no." Open-ended questions are questions that cannot be easily answered with a "yes" or "no" answer, but elicit a more detailed response. **Read through the questions below and identify which are open-ended and which are closed-ended questions or statements.**

1. Have you seen Dr. Strong from our dental department before?
2. Describe your comfort level with our health care providers here.
3. Do you have any questions about what will happen during your visit today?
4. Tell me about your expectations for this visit.
5. Do you understand everything we talked about today?
6. On a scale of one to ten, one being terrible and ten being great, describe how you feel after your visit today.
7. How do you utilize the prevention-based services that we offer here?

Activity #2
Open-ended questions are fresh in your mind. **How can you change the following closed-ended questions into open-ended questions or statements? Write down your solution.**

1. Do you utilize the community-based wellness activities we offer?
2. Are you nervous for your visit today?
3. Did you participate in our annual 5K run/walk?
4. Did you know that we have dental, medical, behavioral health, chiropractic and pharmacy departments here, all under one roof? (Or insert your organization's foci.)

Activity #3
Practice using some of these questions (or the open-ended questions you came up with) to start a conversation about services, events and opportunities at your organization. Use this opportunity think about what workshops, promotions, and foci your organization is providing this season. For example, do you have a health fair, anxiety workshop, or special on kids' sports physicals coming up?

1. Are you aware of all the health and community events we've created for our patients this summer?
2. How do you take advantage of the enriching, prevention-based services we offer here?
3. Are you familiar with all of the services we offer our clients/patients here?

Intra-organizational Referral Training Module III: Practice & Discuss - Cues to Action

Cues to action are specific scenarios, instances, and for some health professionals, identification of symptoms or diagnoses, which are identified as great opportunities to make a referral to another service within the organization. For this activity, first read through the cues to action. Discuss how you might open up a conversation based on these cues. Then reflect on what other situations might present an appropriate opportunity to make an intra-organizational referral in your normal day. *For a challenge, complete these activities in interprofessional teams.

1. A patient verbalizes that he is very nervous, anxious or scared about the treatment he is here to receive today. He has cancelled this appointment twice before.

2. A new patient arrives 20 minutes before her appointment time with completed forms. You have an extra 10 minutes in your schedule.

3. During an exam, a patient reports feeling ready to *maybe* start to *consider* thinking about quitting smoking.

4. A patient reports in conversation that he has been experiencing dizzy spells. You read in his EMR that he has recently changed prescriptions.

5. A patient walks in wearing a t-shirt from another local 5K or community event based on fitness and family fun.

6. Waiting with your patient, you notice a health care professional from another department walking down the hallway in an unhurried way. You smile and make eye-contact with the other health care professional.

7. Your patient has alcohol on her breath at 1pm in the afternoon on a Tuesday.

8. Your patient complains of back pain and stiffness during a check-up.

9. A patient reports trying to lose weight unsuccessfully for many years. He describes diets, exercise plans and pills he's tried to help him and he can't seem to keep the weight off. He's concerned about his blood pressure and cholesterol levels.

10. A middle-aged woman is diagnosed with type II diabetes. She is shaken and upset. She wishes she had someone or a group of peers to learn about her disease with.

11. A patient exclaims that she had a wonderful experience at your organization today. She's really impressed with the way you do medicine and prevention.

Intra-organizational Referral Training Module IV: Practice & Discuss - Role Plays

Practice the following role plays to see how it might feel to interact with a patient with intra-organizational referral making as a goal of the interaction. *For a challenge, complete these role plays in interprofessional teams or with team members you don't normally partner with.

Role Play #1

Professional: Good morning, Mr. Patterson. It's nice to meet you. I understand you are in to see Dr. Strong today. Tell me about your expectations for your visit.
Patient: I have been having a great deal of pain in my lower back. I was nervous to come here today, but I thought I should get it checked out since it has caused me to miss work twice this week.
Professional: Well, you've come to the right place. Dr. Strong is a talented professional. She also works closely with Dr. Johnson, our chiropractor, who is also an expert in back issues and pain management. Our providers work together, sharing expertise for tough cases. When necessary, they can even walk up and discuss their professional opinions with our pharmacists who are right on site.
Patient: I didn't know you had a chiropractor here. I heard you had dentists, too.
Professional: *Challenge: How would you continue or close this conversation?

Role Play #2

Patient: I'm really nervous about my visit today. I hate going to the dentist. I actually feel like I can't breathe and I'm not sure if it's worth the stress to come here.
Professional: You are anxious and dreading this visit, is that right?
Patient: Yes, but it's not just this visit. I mean, I especially hate the dentist, but I've been stressed out and feeling really nervous lately. It's nothing, it's just me.
Professional: Stress and anxiety are a lot to handle sometimes. Part of the mission of our organization is to provide comprehensive health and wellness care for our patients. We have some anxiety workshops upcoming. The workshops are led by our behavioral health team. Here is a post card. Let me know if you have any questions.

Role Play #3

Professional: Morning, Bob. You ready to see Dr. J today?
Patient: Yes, ma'am. I got up, got a cup of coffee and got my walk in. I'm feeling tip-tip and ready for a clean bill-o-health.
Professional: Ha! That's excellent to hear. Bob, did you know that we have sponsor an annual 5K run/walk here? It's a part of our health fair in August during which we offer health and wellness workshops, free health screenings, and health education. It'd be awesome to have you be a part of our events that week. You're a great role model!

Taking it a Step Further
*How could you change these interactions to include your own style?
*What different professionals in your health center could you make referrals to instead of the partners listed in these role plays?

Evaluation

Please use this form to evaluate the content and organization of this toolkit. Your feedback is greatly appreciated and will be used to improve and enrich this resource. Send completed evaluation materials to Kate Noelke at knoelke@scenicbluffs.org, or 238 Front Street, Cashton, WI 54619.

Organization Name: _____

Date: _____

Rating Scale: 1=Poor 2=Fair 3=Satisfactory 4=Good 5=Excellent

	Please Indicate Your Response				
Content Evaluation					
Overall Evaluation	1	2	3	4	5
Introduction	1	2	3	4	5
Overall Training Resources	1	2	3	4	5
Overall Best Practices	1	2	3	4	5
Relevance	1	2	3	4	5
Usability Evaluation					
Conversation Starters	1	2	3	4	5
Cues to Action	1	2	3	4	5
Role Plays	1	2	3	4	5
Scenarios	1	2	3	4	5
Overall Benefit to You	1	2	3	4	5

How could you use this toolkit in your organization or agency?

How have you revised and improved the toolkit?

Please provide any other general feedback.

Resources

Web Resources

Agency for Healthcare Research and Quality (AHRQ)
http://www.ahrq.gov/research/findings/factsheets/errors-safety/improving-quality/index.html

Interprofessional Education Collaborative
https://ipecollaborative.org/

Minnesota Department of Health Toolbox
http://www.health.state.mn.us/divs/opi/qi/toolbox/

National Committee for Quality Assurance (NCQA)
http://www.ncqa.org/

Scenic Bluffs Community Health Centers
http://www.scenicbluffs.org/

Wisconsin Primary Health Care Association (WPHCA)
http://www.wphca.org/

Suggested Reading/Literature

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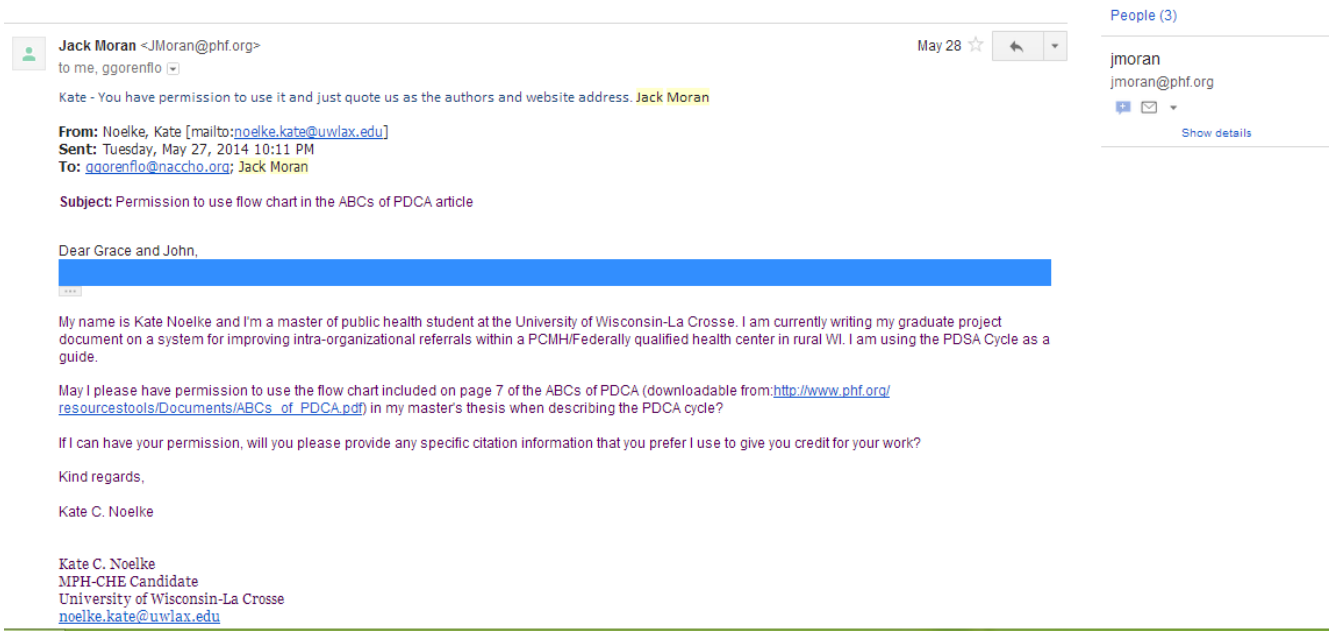
APPENDIX S

PERMISSION TO USE ABCS OF PDCA FIGURE



Jack Moran <JMoran@phf.org> May 28

to me, ggorenflo

Kate - You have permission to use it and just quote us as the authors and website address. Jack Moran

From: Noelke, Kate [mailto:noelke.kate@uwlax.edu]
Sent: Tuesday, May 27, 2014 10:11 PM
To: ggorenflo@naccho.org; Jack Moran

Subject: Permission to use flow chart in the ABCs of PDCA article

Dear Grace and John,

My name is Kate Noelke and I'm a master of public health student at the University of Wisconsin-La Crosse. I am currently writing my graduate project document on a system for improving intra-organizational referrals within a PCMH/Federally qualified health center in rural WI. I am using the PDSA Cycle as a guide.

May I please have permission to use the flow chart included on page 7 of the ABCs of PDCA (downloadable from:http://www.phf.org/resourcestools/Documents/ABCs_of_PDCA.pdf) in my master's thesis when describing the PDCA cycle?

If I can have your permission, will you please provide any specific citation information that you prefer I use to give you credit for your work?

Kind regards,

Kate C. Noelke

Kate C. Noelke
MPH-CHE Candidate
University of Wisconsin-La Crosse
noelke.kate@uwlax.edu

People (3)

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