Change Project

Standardizing Healthcare Referral Management

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April 15, 2018

Introduction

Over the past three years, I have been a part of an idea brought to light by a physician group made up of more than 500 medical providers in the state of Colorado. There was a need for a centralized department that would save millions of dollars by standardizing multiple services such as patient appointment scheduling, provider-to-provider referral management, and 24/7 nurse triage service available to the organization's patients as well as potential patients needing medical advice from a registered nurse. A healthcare call center was created to serve as a centralized resource center capturing patients across the Denver and mountain region.

Cause for Change

Much of the initial support was distant and many of the startup responsibilities fell on the center's staff. The call center came to be known as a Virtual Resource Center, a virtual front desk to the clinics it serviced. Since its establishment, many attempts at standardization have been made, and although many of them were unsuccessful, there were substantial accomplishments that have kept the center moving forward.

As one of two instructors, responsible for creating and delivering training to the non-clinical team, I chose to redirect the focus of the training and development department to aid in a major goal that involved our referral management service and its plan to onboard 53 primary care clinics in the Denver and mountain regions by the end of 2018. The clinic onboarding process itself had been quite slow over the past 3 years only managing to onboard about 20 clinics to its referral service. 2018's aggressive goal could only be accomplished with coordinated efforts by ensuring all processes needed to deliver quality referrals were consistent with each referral coordinator. Due to the diverse levels of knowledge and experience that each associate brought, workflows have been inconsistent which has led to productivity values on opposite ends of the spectrum.

To address workflow inconsistencies, knowledge gaps, and repeated basic referral training, the Training and Development team is leading a change project to implement a Quality Assurance (QA) program to ensure standardized workflows are consistent amongst all associates, and by result, proactively identify if any gaps in learning exist.

Although the scope of this project is quite large, this paper will only focus on implementations made by the training and development team.

Planned Intervention

In December of 2017, the training and development team (TAD) began meeting with team supervisors and leads to prepare for the upcoming change of focus. Prior to the start of 2018, a Project Gantt chart was prepared to implement a QA program. Several key milestones as well as project challenges were identified.

This change proposal exists to address a major problem, repeated "refresher" training. Supervisors and team leads often request associates be re-trained due to inconsistencies in workflows when managing referrals. Most of these inconsistencies are caused when new hires are brought on to the referral management team. These new hires are typically referral coordinators that have been working directly with providers at primary care clinics for the same organization. When a job opportunity opens with the call center, these individuals are

onboarded bringing with them a differing understanding of the referral workflow. Although this knowledge has proven extremely beneficial to the knowledge base of the call center, contradicting information continues to deviate from the standard causing a lot of frustration within the team.

Project goals to address these problems and assumptions:

- Standardization – By defining clear process milestones with smaller attainable goals it would make what would be a complex process much easier to follow encouraging motivation in employees. Multiple "achievements" or milestones increases engagement and higher knowledge retention. A standardized process has many benefits which address multiple problems discussed in this proposal.

  A standard process will:
  - Reduce the cost of onboarding by shortening training time;
  - Reduce number of job aids and learning materials that once addressed different workflows;
  - Increase productivity by reducing time wasted trying to locate appropriate materials needed for given workflow, and;
  - Simplify the evaluation process.

- Routine communication between leaders – Recurring meetings with referral team leadership and the training team will ensure there's a clear understanding of the referral management process. Referral Coordinators will be able to receive consistent answers from all leaders when questions are asked. This will build trust in leadership and encourage positive behavior. Meetings will occur bi-weekly to discuss status of projects, major roadblocks, and learning gaps.

- Knowledge Base – It is impossible to have an entire team with equal levels of experience; however, knowledge and experience can be shared. To address the knowledge gap, a knowledge base will be created and accessible by all members of the referral management team, including leads and trainers. Associates will be able to instantly share information which satisfies both veteran and new employees. The knowledge base will be optimized to reduce number of files shared and instead consolidated into one or two master documents. This is one solution to accommodate the needs of diverse participants.

- Training – change to a blended learning model by using TalentLMS and assign pre-requisite eLearning modules to complete prior to the mandatory referral refresher. Training and Development team will follow the ADDIE model to improve team performance with the standardization process.

Addressing the root cause of our major roadblocks is the first phase in implementing a successful standardized referral management process. By implementing just a few changes, the referral management process can expect increased productivity, cohesiveness, shared knowledge, and a reduction in time and money wasted. Trainers will gain more time to create quality learning materials to improve processes and meet learner competency baselines.

Timeline for implementation:

January	
1-12	Perform Needs Assessment to identify performance gaps.
15	Identify current state of performance and desired state of performance.
23	Evaluate technology to determine current features to improve referral management processing productivity. Submit IT Requests for technology updates, inquiries, and changes.
February	
2	Update current Knowledge Base in SharePoint.
3	Collaborate with SMEs to consolidate knowledge materials into categories based on facilities managed per team.
12	Design Session: Quality Assurance form - includes building, content discussion, and assigning weight to each criteria/section being graded.
13	Design Session: Quality Standards Definition Document.
14-23	Create and assign eLearning courses for standard referral process to Referral Management team to be completed prior to instructor-led course.
March	
5-9	Deliver instructor-led training on new standard referral process.
12-16	Test Quality Assurance form for 1 week for initial improvement feedback.
19	Make changes to Quality Assurance form.
20	Calibrate Quality Assurance form for 30 days to receive productivity reports on new process.
April	
20	End of QA calibration period. Make final adjustments based on feedback.
30	Send course survey and follow-up evaluation.

Evaluation

To accurately evaluate the success of the above interventions, instructors and referral team leadership will be analyzing multiple reports. Data will be obtained monthly via automatically-generated reports provided by the Electronic Medical Record system, Learning Management System, and phone system. Data obtained from

these reports will be compared with performance level requirements and used to create associate scorecards which are discussed with individuals at the beginning of each month.

The training department will analyze course feedback from Learning Management System to measure retention, identify topics that need further explanation, and review real-time course feedback.

Although cost-benefit payoff is not readily available to trainers or referral team leadership, quarterly reports can be discussed during a meeting with operations management and department director. It can be assumed; monetary savings are likely gained when training onboarding timeline is reduced.

Expected Findings / Potential Issues

I expected to run into the following obstacles when implementing this change:

- **Technology & Reports:**

I expected slow implementation from our IT team at creating reports from our Electronic Medical Record system. These reports are crucial for evaluating employee progress specifically for tracking the total number of referrals processed per day, time each referral is completed, and number of referrals that need to be re-processed when focus is on quantity.

- **Knowledge Base:**

It's been about a year since SharePoint was implemented as the center's knowledge base and most of the non-clinical team has adapted to using the site since PTO requests are now required to be submitted through SharePoint.

I expect a small learning curve when the above intervention is implemented. Navigating through the site should be simpler when resources are divided into respective teams. Associates would simply look for their team folder to access their materials.

- **Training:**

An issue I envisioned early on was the recent transition to the LMS. There are only a limited number of eLearning courses available and utilization is at around 20%. I expect an increase in utilization when the pre-requisite courses are added and assigned to the referral team members. Since the LMS sends an email notification to assigned course users, I anticipate questions regarding sign-in instructions and password reset requests.

Due to the short timeline for creating eLearning courses, there is a high probability that courses may not be designed appropriately which affects course data. To combat this probability, only short, introductory courses will be created and required completion prior to attending an instructor-led course. During which in-depth training will be provided. Evaluation and post-course assessments will be created through the LMS for documentation and tracking purposes.

- **Resistance:**

Although the referral team has been requesting a refresher training on a standard referral process, I am concerned about 5-10% of the team will show resistance to the new standard. Many team members have years of experience processing referrals and used to certain workflows. I am expecting collaboration and discussing during instructor-led training since the course has been designed following constructivism principles.

This team has been working independently for about two years with little to no expectations regarding their daily responsibilities, which leads me to believe there will be lots of resistance when QA is implemented and expectations are placed. I plan to combat this resistance by working collaboratively with them during training, and placing the focus around the patients we impact. With the support of the supervisor and team lead, I expect this resistance to dissipate when emphasis is placed around the patients we serve and the values of the organization.

Description of Implementation

Standardization

Referral management has been a focus of the organization for the last two years but has been greatly impacted by a major Electronic Health Record system implementation. Due to this massive upgrade, new workflows were needed. Fortunately, the call center is one of the largest groups managing referrals which meant it likely determined the new referral management standard.

We approached the standardization phase by following Lean core principles: Focus on patients, value, and time, using continuous improvement and respect for people as the foundation. (Toussaint & Gerard, 2012) Our first step was understanding the work each employee is doing during an 8-hour day. These observations, or assessment, determined the team's current performance state.

Two 8-hour design sessions were then scheduled with the team lead and supervisor to discuss workflow process maps and determine desired state of performance as well as performance gaps/needs. A new standard was then created for each workflow involved.

Communication

Performance barriers and learning opportunities captured from QA evaluations have been added to the agenda for a bi-weekly meeting with Training and Development, Referral Supervisor and Team Lead.

The goal of this meeting is to discuss new hire onboarding, upcoming client additions impacting team performance, general team performance barriers, and analyzing of new and previously discussed problems.

Knowledge Base

Due to the team's fast growth plan, a new site was created to house all referral management associate resources. Within this site, folders have been created per facility and region including quick links to the master insurance document, job aids, templates and forms.

The biggest change for the Knowledge Base implementation was the addition of an extensive Complete Providers List necessary for locating and updating specialist information reducing the number of repeated outbound calls made to these clinics to collect information.

Learning Management System

Implementing a Learning Management System has been a very slow process and there are plans to continue creating courses within the system. All new hire onboarding will be in classroom setting and ongoing referral training via the LMS.

TalentLMS will be used to address the need for ongoing training unless one-on-one training is needed.

Training

My initial concern was receiving resistance when asked to change the way the team had been doing their work for the past three years. Rather than delivering a new standard process the traditional way –show, practice, evaluate– I chose to follow a constructivist theory approach and use active techniques to explore and ask questions about real-life problems.

Keeping adult principles in mind, learners had the opportunity to share their life experiences to work collaboratively and create goals that the entire team can work towards, which increase team accountability and opened the conversation about QA.

Courses, whether online or instructor-led, included scenarios based on real-life problems, interactive activities that allow exploration, and content for self-reflection. Formal assessments or grading were omitted and replaced with knowledge checks throughout each section.

Findings

- **Technology & Reports:**

Our findings for technology and reports were as expected. We knew requesting for reports to be created would take time so this task was one of the first to take priority at the start of this project. Reports continue to be improved but they're sufficient for evaluating team performance on a basic level.

- **Knowledge Base:**

Unfortunately, expanding the knowledge base into a new site within SharePoint took last place in our priority list. In the mean time, all resources will continue to live within a share document library in

SharePoint until a team restructure is established in the coming months. Along with this expansion, we will consolidate and update some tools to support the team's new process standard.

- **Training:**

  When designing the curriculum to introduce the new standard process, we followed the Backward Design model and began by first determining our desired results then designed courses based on those learning outcomes. This model fit perfectly with our lean core principles because it eliminated time wasted from doing learning activities for the sake of doing them. (Bowen, 2017)

  Instructor-led training was delivered in a way that followed the constructivist learning model. Emphasis was around case-based scenarios to better engage learners and work collaboratively as a team to discuss and solve common problems affecting patient healthcare delivery.

  There was a total of three half-day sessions each consisting of workers that managed referrals for the same set of clinics. Grouping these learners together was very successful because discussion was relevant and solutions to shared problems were agreed upon by everyone. Sessions were extensive to allow time for discussion and review since we eliminated formal assessment and grading, again, following the constructivist learning model. (Hein, 2016)

Conclusion

Implementing this change took a great deal of time, which I imagined it would, but the most valuable lesson I learned from this project was how powerful focus and determination really are when change is needed. At the beginning of the year I realized our leadership team was stuck in a "fixing" mode rather than a proactive one. Big things needed to happen for our teams to be successful.

I used my strengths as a natural critic and began to analyze everything we did as a department. Doing so led me to find need in the way we processed our referrals. I knew that by improving this team would greatly impact not only the call center but thousands of patients seeking care at the clinics we serviced. This project brought the most value because it focused on patients, time, and created a culture that is open to change and continuous improvement.

References

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