Transforming Office Roles

...THE LEAN approach

Lynn Klima RN, MSN, CNP
Director of Clinical Improvement
The Transformation Story

- IHA – Who Are We?
- Transformation – The Beginning
  - PCMH
  - Building the Care Team
- Thinking of the Work in a New Way
  - LEAN
What is IHA?

- 150 Physicians
- 37 APN/PA
- 30 Sites
- 250,000 Active Patients
- 22,000 New Patients in 2008
- 488,000 Patient Visits in 2008
- 2,652 Deliveries
- 700 Employees
What is IHA?

- 5 divisions including Internal Medicine, Family Medicine, Pediatrics, OB/GYN, and Surgery
- After Hours
- Ancillary Services – CT, General Ultrasound, General Radiology
- Specialty Services – Maternal and Fetal Medicine, Pediatric and Adult Neurology, Dermatologic Surgery, General Surgery
- Hospitalist Services at SJMH and Chelsea for adult patients
IHA’s Network of Care

Ann Arbor/Ypsilanti
- Ann Arbor Family Practice
- Ann Arbor OB/GYN Associates*
- Arbor Park Bone Density
- Associates in Gynecology and Obstetrics*
- Associates in Internal Medicine - Commonwealth
- Boyd Gillard Institute of Aesthetic and Dermatologic Surgery
- Child Health Associates - Ann Arbor
- Huron Valley CT Center
- IHA After Hours Care
- IHA Family Practice
- IHA Maternal-Fetal Medicine
- IHA Ultrasound
- IHA West Arbor Obstetrics and Gynecology
- IHA Menon, Miller & Midwives
- Office Procedure Center of IHA
- Pediatric Healthcare Associates - Ann Arbor/Ypsilanti
- Primary Pediatrics
- Walker Gynecology Practice of IHA

Brighton
- Associates in Gynecology and Obstetrics*
- Genoa Ultrasound
- Brighton Family Care Specialists
- IHA Bone Density - Genoa
- IHA Livingston Pediatrics
- IHA Menon, Miller & Midwives*
- IHA Family Pharmacy
- Pamela Davies, MD - Brighton Obstetrics and Gynecology

Canton
- Associates in Internal Medicine - Cherry Hill
- Canton Obstetrics and Gynecology
- IHA Radiology and Cherry Hill Bone Density
- Pediatric Healthcare Associates - Canton

Chelsea
- Associates in Gynecology and Obstetrics*
- Chelsea Internal Medicine
- Chelsea Pediatrics
- Chelsea Surgical Associates

Clinton
- Okey Family Practice

Milan
- Milan Family Practice
- Pinckney
- Pinckney Family Care

Plymouth
- Ann Arbor OB/GYN Associates*
- Child Health Associates - Plymouth
- IHA Plymouth Internal Medicine

*Multiple Locations
Leadership Structure and Committees

IHA endeavors through its evolved and participatory structure to bring all its strengths to the needs of our patients and the community.

**Leadership Structure and Committees**

**Inspired by our Mission**

Integrated Health Associates (IHA) exists to meet community needs through the provision of personalized, high-quality health and medical services to our patients in a manner which results in high levels of patient satisfaction with clinical quality, services, accessibility and value.

**Clinical Quality Improvement Committee**

- Wes Beemer, MD - Chair
- Robert Breakey, MD
- Mary Durfee, MD
- Mark Lindley, MD
- Cindy Elliott

**Clinical Research Committee**

- Wes Beemer, MD
- Jim Marley, MD
- Steve Baranski, MD
- Mary Durfee, MD
- Todd Johnson

**Compensation Committee**

- Wes Beemer, MD
- Bill Elliott
- Steve Baranski, MD
- Chad Brown, MD
- David Winston, MD

**APN/PA Compensation Sub-Committee**

- Wes Beemer, MD
- Bill Elliott
- Steve Baranski, MD
- Chad Brown, MD
- David Winston, MD

**IHA Governing Board**

- Wes Beemer, MD - Chair
- Mary Durfee, MD
- Bill Elliott
- Julie Gardner-Kozma, CNP
- Mike Kucera, MD
- Mark Lindley, MD
- Gayle Moyer, MD
- Melissa Sokol-Kelley, MD
- Nancy Spangler, MD
- Steve Chipp, MD
- Neal Weinberg, MD

**IHA Management Team**

- Cindy Elliott - Chief Operating Officer (CEO)
- Amy Middleton - Director of Marketing
- Linda MacElven - Director of Technology and Information Services
- Jackie Gandel - Director of Clinical Services
- Chris Huda - Director of Technology & Information Services
- Lynn Kline - Director of Clinical Improvement
- Marty Murray - Administrative Services
- Bill Elliott - President & CEO

**IHA Management Team**

- Cindy Elliott - Chief Operating Officer (CEO)
- Amy Middleton - Director of Marketing
- Linda MacElven - Director of Technology and Information Services
- Jackie Gandel - Director of Clinical Services
- Chris Huda - Director of Technology & Information Services
- Lynn Kline - Director of Clinical Improvement
- Marty Murray - Administrative Services
- Bill Elliott - President & CEO

**IHA Operating Team**

- Wes Beemer, MD - Chair
- Mary Durfee, MD
- Bill Elliott
- Julie Gardner-Kozma, CNP
- Mike Kucera, MD
- Mark Lindley, MD
- Gayle Moyer, MD
- Melissa Sokol-Kelley, MD
- Steve Chipp, MD
- Neal Weinberg, MD

**IHA Management Team**

- Cindy Elliott - Chief Operating Officer (CEO)
- Amy Middleton - Director of Marketing
- Linda MacElven - Director of Technology and Information Services
- Jackie Gandel - Director of Clinical Services
- Chris Huda - Director of Technology & Information Services
- Lynn Kline - Director of Clinical Improvement
- Marty Murray - Administrative Services
- Bill Elliott - President & CEO

**IHA Management Team**

- Cindy Elliott - Chief Operating Officer (CEO)
- Amy Middleton - Director of Marketing
- Linda MacElven - Director of Technology and Information Services
- Jackie Gandel - Director of Clinical Services
- Chris Huda - Director of Technology & Information Services
- Lynn Kline - Director of Clinical Improvement
- Marty Murray - Administrative Services
- Bill Elliott - President & CEO
Identifying a Process Improvement Tool

• LEAN
  – Familiarity to all participants
    – IHA pilots
      » Registry function, Test Tracking, Learning Collaborative
  – Local experts
    • Margie Hagene - LEAN
Value Stream Workshop

Value Stream Scope

Scoping

Determine the Value Stream to be improved

Current State Drawing

Workshop Day 1

Understanding how things currently operate. This is the foundation for the future state

Future State Drawing

Workshop Day 2

Designing a lean flow through the application of MQS principles

Implementation Plan

Workshop Day 3

Developing a detailed plan of implementation to support objectives (what, who, when)

Implementation of Improved Plan

Post Workshop 30,60,90 Day Reviews

The goal of mapping!
Objective

To develop a Care Management model for Chronic disease and preventive care with clear IHA role definition and clear sequence of patient contact.
The Clot Thickens
Taking Small Bites…..

• One population: adult chronic illness

• Participants
  • Division Head
  • Division Director
  • Human Resources
  • 1-2 providers
  • Role Representatives
  • Director of Quality Improvement
  • Chief Operating Officer
Identifying Teams
Three DAYS, THREE MAPS
(and a lot of EXCEDRIN later)

- Clinic Map
- Office information map
- Telephone triage map
- 18 Different ROLES
“Ever have one of those days when you’re not sure whether you’re in the zone, out of the box, under the gun, over the hump, or behind the curve?”
“It’s a special hearing aid. It filters out criticism and amplifies compliments.”
## Scope of Practice for Clinical Roles

<table>
<thead>
<tr>
<th>Role</th>
<th>Scope of Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>MA</td>
<td>Acts/works under MD’s license, performing of “tasks” only, some med refills others with the supervision of an MD/RN, rooming – meds list, appropriate documentation, clerical tasks, does not delegate tasks or coach MD, RN, LPN or other MA’s.</td>
</tr>
<tr>
<td>LPN</td>
<td>Works under supervision of RN or MD in person, w/direct access by phone, etc. or written/determined protocol in place when no RN @clinic. May perform all tasks of MA and may educate patients, start IV’s, Foley caths, etc., perform tasks as designated by their licensure, triage w/RN/MD oversight. May facilitate and carry out Care Coordination but may not delegate tasks (to MA or RN) per licensure. May do some med refills, other meds with supervision of RN and delegation after review. (Example?) Makes a “nursing diagnosis”.</td>
</tr>
<tr>
<td>RN</td>
<td>May perform all tasks of MA and LPN in addition to assessing, evaluating and delegation. May determine staff competency, perform planning of patient care coordination based on assessment and evaluation. Completes appropriate documentation. May triage and do med refills. May make a “nursing diagnosis”.</td>
</tr>
<tr>
<td>NP/PA</td>
<td>are on same level of responsibility</td>
</tr>
<tr>
<td>NP</td>
<td>All of the above tasks may be performed. May also make assessments, make medical diagnosis (not just nurse diag.), may order meds, treatments, and diagnostics. Completes appropriate documentation. In IHA, NP’s do not function independently, they are under the supervision of an MD for liability reasons and policy specifications. The treatment path of the patient should be aligned with the overseeing MD. Patient should have an initial visit w/MD and periodic visits w/MD. Need a written protocol to support/guide this. Decides billing and coding level. Is responsible for informed consent discussions. NP may support and coach management of chronic disease patients. Should fill the gap between MD and clinical nursing.</td>
</tr>
<tr>
<td>PA</td>
<td>Must work under supervision of MD. Skill set is not necessarily the same as an RN. Completes appropriate documentation. Need to verify what is allowed within the scope of the PA license. Decides billing and coding level. Is responsible for informed consent discussions.</td>
</tr>
<tr>
<td>MD</td>
<td>May diagnose and order meds, treatments and diagnostics. Is responsible for medical oversight of patient care. May delegate to other staff. Decides billing and coding level. Completes documentation of services provided and verifies its accuracy. Is responsible for informed consent discussions.</td>
</tr>
<tr>
<td>Change</td>
<td>In order to</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>1. Clearly define roles of Care Team by scope of practice</td>
<td></td>
</tr>
<tr>
<td>2. Reassign tasks to appropriate care team role throughout the care cycle of an established patient</td>
<td></td>
</tr>
<tr>
<td>3. Implement more shared medical decision making</td>
<td></td>
</tr>
<tr>
<td>4. Expand care delivery within and beyond the office visit to include a care coordination complement to support the patient and the care team</td>
<td></td>
</tr>
<tr>
<td>5. Increase timeliness, completeness and quality of patient communication</td>
<td></td>
</tr>
</tbody>
</table>
Establishing Pilots

• Four offices to pilot
• 1 provider pilot champion per office
  – IHA Family Medicine
  – Ann Arbor Family Practice
  – Brighton Family Care
  – Commonwealth Internal Medicine
Focusing the work

• Medical Assistant Role:
  – Changes to medical practice assistant
• RN/LPN office role
• Office RN Care Manager
Focusing the work

- Revising job descriptions - 3 clinical office roles for supporting the patient and provider
- Establishing the appropriate tools for training the staff (current and future)
- Developing the training materials
- Developing competency materials to support the changes/ongoing training
Minimal acceptable role to work independently on each listed task based on licensure/certification

<table>
<thead>
<tr>
<th>Minimum role</th>
<th>Task</th>
</tr>
</thead>
<tbody>
<tr>
<td>LPN</td>
<td>teach/educate</td>
</tr>
<tr>
<td>RN</td>
<td>Assess presenting condition (MA's not trained to assess)</td>
</tr>
<tr>
<td>LPN</td>
<td>Has knowledge regarding meds/reconciliation, procedures, immunizations, treatments (ex. managing treatments)</td>
</tr>
<tr>
<td>RN</td>
<td>Can best determine patients level of preparedness to follow a treatment plan</td>
</tr>
<tr>
<td>LPN</td>
<td>Assist patient to set goals to achieve treatment plan</td>
</tr>
<tr>
<td>RN</td>
<td>Interpret results</td>
</tr>
<tr>
<td>MA</td>
<td>Administer treatment (ie. in-office labs, in-office procedures, meds)</td>
</tr>
<tr>
<td>NP/PA</td>
<td>Order treatment</td>
</tr>
<tr>
<td>RN</td>
<td>Physical assessment</td>
</tr>
<tr>
<td>NP/PA</td>
<td>Ordering labs</td>
</tr>
<tr>
<td>MA</td>
<td>Processing orders</td>
</tr>
<tr>
<td>MA</td>
<td>Medical record preparation and reconciliation</td>
</tr>
<tr>
<td>MA</td>
<td>Vital signs</td>
</tr>
<tr>
<td>NP/PA</td>
<td>Template review for complete visit</td>
</tr>
<tr>
<td>NP/PA</td>
<td>Communication w/specialist/ER ; logistics</td>
</tr>
<tr>
<td>MA</td>
<td>Scheduling next appointment</td>
</tr>
<tr>
<td>MA</td>
<td>Patient forms</td>
</tr>
<tr>
<td>MA</td>
<td>Provide waivers for patients declining services</td>
</tr>
<tr>
<td>MD</td>
<td>Review PCMH agreement</td>
</tr>
<tr>
<td>RN</td>
<td>Provider does mutual goal setting w/patient</td>
</tr>
<tr>
<td>RN</td>
<td>Telephone triage – assessing</td>
</tr>
<tr>
<td>MA</td>
<td>Telephone messaging</td>
</tr>
<tr>
<td>RN</td>
<td>Prescription refills</td>
</tr>
<tr>
<td>RN</td>
<td>Determine recall plan</td>
</tr>
<tr>
<td>MA</td>
<td>Enact recall plan</td>
</tr>
</tbody>
</table>

* This list is not all inclusive
Variations of the Pilot

• **Family Care Team** approach championed by Dr. Peter Anderson in his book: “Liberating the Family Physician”.
• No additional resources/FTE’s associated with the pilot.
• Budget neutral
• Working within the scope of practice
• Medication reconciliation and complexity of the patient drive the scope of the work.
• 1 provider/ 2 support staff
Planned Care: Implementing the Model

1. **Run registry**
2. **Pre-call**
3. **Task**
4. **Chronic Condition Visit**
5. **Recall**
6. **f/u appt scheduled**
7. **Planned care follow-up: phone/face to face**

The cycle continues with Run registry leading back to Pre-call.
Care Mapping
Diabetes

**Clinic Visit**

Provider:
- Validates assessment and completes physical
- Established contract/goal setting

Office RN/LPN: completes assessment and reviews with provider, completes visit, discharge education
  - Med reconciliation

Medical Practice Assistant: intake on stable patient population, administers treatments, immunizations, EKG

**Ongoing planned care**

Provider: unstable patient population/newly diagnosed

Mid Level Provider visit: ? Stable patient population/intensive lifestyle coaching?

**RN Care Manager Care Team Support**

Group Visit
- 1-2 group visits

Pre-call to assess/order chronic disease and prevention tests
  - Medication reconciliation

3-4 telephone follow-up visits
  - after all ER/inpatient visits
"I think diabetes is affecting my eyesight. I have trouble seeing the consequences of poor food choices."
## Office Visit Terms Defined

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition/Guideline</th>
<th>Who</th>
<th>How / Templates / Tools</th>
</tr>
</thead>
</table>
| **Pre Call**                | - When: 1-3 days prior to office visit  
- Content: Medication reconciliation, determine if all testing is complete, order tests if needed, any paper work or forms needed, check demographics ("prepare patient for their visit"). insurance verification, update PMH and Social Hx as needed. | -                                         | - Planned Care template  
- Health Maintenance  
- Registry  
- Tracking template  
- EMR templates  
- ? |
| **Huddle**                  | - When: daily basis and more frequently as needed.  
- Content: review patient appointments for the day to ensure optimal workflow and template management. | - Care team (ex. provider, RN/LPN, MPA, RD, Pharm) | - Appointment Ist  
- EMR  
- |
| **Post Call / Planned Care Call** | - When: within 2 weeks of the patient being seen in the office.  
- Content: discuss predetermined plan of treatment -specific to the patient, teaching/support, confirm next contact date, discuss medications? | - RN/LPN                                  | - Planned Care template                           |
| **Medication Reconciliation**| - When:  
- See policy                                                                  | - RN/LPN                                  | - Med module                                    |
| **Triage**                  | Triage is a communication process to assess a patient's health concern. Determinations are made utilizing evidenced based protocols which may include the need for additional patient education, advice and appropriate follow-up care. | -                                         | -                                               |
| **Plan In Hand**            | - When: A document that the patient will leave the visit with  
- Content: current/updated medication’s, testing/referrals ordered, appointment date | -                                         | -                                               |
## Roles LEAN Process Grid for Pilot

<table>
<thead>
<tr>
<th>Process</th>
<th>Role</th>
<th>Protocols</th>
<th>Templates/ IT tools</th>
<th>Training Needs</th>
<th>Outcome</th>
<th>To Do/Who/When</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Call</td>
<td>RN/LPN Care Manager MPA</td>
<td>Chronic Condition standing orders for pre-call. Preventive Care standing orders for age groups Standardized process for scheduling and capturing t code visits. Med reconciliation policy (done)</td>
<td>• Registry • HM • EPM/demographics • Med Module • Vault • ICS • Fam/Social HX • Lab template • Future labs • Diagnostic • T code billing</td>
<td>EPM • Scheduling • Verification • Demographics • Med Reconciliation process • T code billing process • Med Reconciliation process</td>
<td>Standardized process for all components of pre-call.</td>
<td>IT training session. Office workflow development (office pilot teams). IT site training to office workflow. Develop standing orders for chronic care and preventive care pre-call. Packet of training materials/all protocols for all staff involved in the pilot.</td>
</tr>
<tr>
<td>Clinic Visit</td>
<td>RN/LPN MPA Provider</td>
<td>Huddle protocol Rooming standards for chronic disease and preventive visits. Rooming workflow for chronic disease and preventive visits.</td>
<td>• Pt Update form • Master IM/FM • Iadult HX/PMH • HM • DM template • VS and DM flowsheets • VAULT • ICS • HPI • ROS • PE • Assessment Plan</td>
<td>Template training Using scenarios 2010 Preventive Guidelines Diabetes Standards of Care RD/CDE Diabetes Educational Programming</td>
<td>Standardized process and documentation for clinic team.</td>
<td>IT training session RN/LPN/MPA shadow with providers. IT shadow at site. Ongoing: Healthstream HX taking by</td>
</tr>
</tbody>
</table>
## Roles LEAN Process Grid for Pilot

<table>
<thead>
<tr>
<th>With Care Manager/Nursing Staff</th>
<th>RN/LPN Care Manager</th>
<th>Med refill protocol Smoking Cessation Advise and Counseling</th>
<th>Planned Care Visit Template Diagnostic Template HM</th>
<th>Self-Management and Motivational interviewing training TBD</th>
<th>Standardized process for all components of the post call</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lab template/in office lab testing Procedure template IMMS template Fam/Soc HX/Allergy Smoking template McKesson educational materials In office lab testing</td>
<td></td>
<td></td>
<td></td>
<td>Smoking Cessation Training BOOST Teach Back 2010 Preventive Guidelines</td>
<td>Diabetes Standards of Care RD/CDE Diabetes Educational Programming</td>
</tr>
<tr>
<td>CHARGE CAPTURE Check out E/M Coding overview</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

6/3/2010
## Roles LEAN Process Grid for Pilot

<table>
<thead>
<tr>
<th>Provider</th>
<th>Other Work</th>
<th>Telephone Triage Policy</th>
<th>Smoking Cessation Counseling</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specific to scope of role</td>
<td>ER visits</td>
<td>ER follow-up policy</td>
<td>Telephone Triage Class</td>
</tr>
<tr>
<td>RN/LPN Care Manager</td>
<td>Telephone Triage Policy</td>
<td>Chart Abstraction standard of care</td>
<td>Standardized process for capturing key categories of other work.</td>
</tr>
<tr>
<td>PAQ buddy protocol</td>
<td>Telephone Triage Policy</td>
<td>Telephone Triage Class</td>
<td></td>
</tr>
</tbody>
</table>

- Vault
- Phone template
- Registry
- Chart Abstraction standard of care
- IVC
- After Hours/Hospitalist
- Med Module
- PAQ work
- Recall process
- Spencer letters
- NextMD refills/communication
- Standardized reports
- ICAT requirements
Adult history print out

1. Open patient’s chart
2. Click on Document Icon in Tic-Tac-Toe
3. Begin to Type Adult in File Name field
4. Highlight Adult_Histories.NGN
5. Click Generate (or Offline)
Healthy Changes Action Plan

Name: ____________________________  Plan Date: 06/08/2009

I have agreed that to improve my health I will: (from DM flowsheet)

________________________________________________________________________

My specific goal for next month is:

________________________________________________________________________

The steps I will take to achieve my goal are:

________________________________________________________________________

How Much: ___________  When: ___________  How Often: ___________

Things that could make it difficult to achieve my goal include:

________________________________________________________________________

My plans for overcoming these difficulties include:

________________________________________________________________________

Support / resources I will need to achieve my goal include:

________________________________________________________________________

This is my rating on how sure I will be able to complete my action plan:
☐ on a scale from 0 (unsure) to 10 (very sure).

DM Ed details:
☐ DM Binder  __ / __  Needs RN PCV follow up:
☐ Brochure  __ / __  Submit F/JU appt  ☐ 1 up submitted

Save Action Plan  ☑ implement chronic disease management
Planned Care Follow-Up

Date: 03/19/2009  Time: 9:52 AM
DOB: 03/29/1968  Age: 41 Year
Insurance: Midwest Health Plan
Previous App: 03/25/2009
Next App: 04/20/2009

Chronic Problem
- Alcohol Abuse-in Remiss
- Depr/Anxiety with PTSD
- Diabetes Uncompl Type II
- Lumb/Lumbosac Dsc Degen
- Diabetes Type II
- COPD

Substance abuse issues.

Chronic Condition Goals from visit on: 02/18/2009
Select condition being discussed
- Asthma
- CAD
- CHF
- DM Diabetes Uncompl Type II 250.01
- HTN
- DME
- Future Orders
- Lab Master
- Disease Management
- Check Out

PCP: Mark Zawisa MD

Actions this Visit
PCV Follow up Hx  In office  Phone Call  Mins 15

Date  Time  Condition  Notes
03/19/2009  10:40 AM  Diabetes  3/19/09 9:53AM Post visit follow up. Discussed self care goals for Diabetes on visit date: 02/18/2009. Pt. states is not checking BS, hasn't check any since OV. Discussed self care goals for: Diabetes on visit date: 02/18/2009. Pt. states has been depressed & hasn't been working on goals. Pt. states walked outside for approx 30 minutes a couple of times when feeling depressed. Pt. states has not seen a psychologist.

Submit to Superbill

AADE Goal Orders

Date  Category  Review  Goal Set  Staff
02/10/2009  Healthy Eating  Make better food choices  Mark Zawisa
02/18/2009  Self manage goals  eat less, get a little more activity  Mark Zawisa

Healthy Changes
Quality Measures

– Increasing Provider productivity
gross margin/ visit
visits/month

- Increasing accuracy and completeness of documentation
  % “plan in hand”
  % medication reconciliation accuracy

- Improve overall quality of care
  Diabetes/Adult Prevention Metrics
Quality Metrics

• Provider Satisfaction
• (30-60-90)
  • Amount of time able to spend with patients
  • Quality of Care you are able to provide
  • The amount of time spent working outside of the office on office work
  • Staff are reliable to carry out orders
Quality Metrics

- **Staff Satisfaction**
  - My job makes good use of my skills and abilities
  - I feel empowered to go the extra mile when serving our patients
  - At the end of the day, I feel less stressed and better supported
“You have to learn about thousands of diseases, but I only have to focus on fixing what’s wrong with ME! Now which one of us do you think is the expert?”
Quality Metrics

• Patient Satisfaction
  • How prepared did you feel today coming in for your visit?
  • How prepared did you feel to carry out your plan/goals from the visit?
  • Were you happy with the time you spent with the provider?
Maintaining the momentum

• Keeping the group meeting
• Bi-monthly touch base calls with pilots
• Regular updates at key leadership meetings
• Ongoing collaboration with I.T. for infrastructure development.
• Outcomes reporting
• Integration into Healthstream
Our Future State… next steps

Completion of the pilot (late fall 2010)
Definitive staffing model
Reporting of outcomes/pilot to leadership groups
Implementation of the new job roles/revised job descriptions
Role out to other divisions in the organization

Future:
MBA reception role
Reception/billing specialist
Support team members: APN, Dietician, SW
It’s kind of fun to do the impossible!

Walt Disney