Presenter Biography: Kate Béténé is currently a Performance Excellence Facilitator at Hennepin County Medical Center (HCMC) in Minneapolis, Minnesota. HCMC has been on its lean journey since 2007, making improvements in ambulatory, inpatient, finance, supply chain, and support services areas. Kate's area of focus is inpatient services. Prior to joining HCMC in 2010, Kate worked with Deloitte Consulting in their IT Consulting Practice for 2 years. She graduated from the University of Wisconsin-Madison with a degree in Industrial Engineering and focus in Healthcare Systems.
These are the topics that will be covered in the presentation. The presentation will begin with some general information about Hennepin County Medical Center and its lean journey, which provides the foundation for this project. A discussion of the goals, scope, and implementation plan follow, as well as an example of the before and after process in the inpatient physical therapy department. The presentation continues with specific information on the implementation process, barriers encountered, and change management methods used. Next is a discussion of metrics used to measure for improvement, along with lessons learned.
Hennepin County Medical Center is:
• Minnesota’s premier Level 1 Adult Trauma Center and Level 1 Pediatric Trauma Center with many nationally recognized programs and specialties
• A recognized system of primary care clinics and retail clinics located throughout Hennepin County
• An essential teaching hospital for doctors who go on to practice throughout the state
• A safety net hospital providing care for low-income, the uninsured and vulnerable populations
• A major employer and economic engine in Hennepin County, and
• A nationally recognized leader in health information technology (1 of only 4% of US hospitals that has achieved the HIMMS Analytics Stage 6 level of distinction).
In 2007, senior leaders at HCMC realized that in order to improve the way they deliver care, they needed to do things differently than they’ve always done it. Lean was selected as the methodology of choice. Now in its 5th year, lean improvement work has been implemented across the medical center and clinic system – from clinics to inpatient units to revenue cycle to the receiving dock to the kitchen to pharmacy.

In January of 2010, a team created an inpatient value stream map in order to guide the work in inpatient areas. They identified value-added and non-value-added activities and worked to create a future state that was more patient-focused and had less systemic waste. This is the basis for the project discussed in this presentation.
This is the current state value stream map that the team created. As seen in the photo by the colored starbursts, there was a lot of waste and pain points identified. A common theme emerged around the lack of a daily schedule for the patient. Pain points included staff not knowing what the plan for the day for the patient was (when testing would take place, etc.), which led to staff being unable to coordinate care or answer patient, family, or other caregiver questions about what would happen for the patient that day.
As previously mentioned, the theme of waste from the lack of a patient schedule led to the question of scheduling inpatient appointments for tests, procedures, and therapies in the same way as is done for outpatient appointments.

In the current state, bedside caregivers did not know what was planned for the patient for the day, apart from the orders entered in the chart. If the patient had physical therapy, an X-ray, an MRI, and an Echocardiogram ordered, there was no way for the bedside caregiver to know when in the day those might happen. This led to patient satisfaction issues when a patient or family member would ask about the timing of a therapy or test that the doctor mentioned to them and the staff would be unable to provide the patient or family member with any information on when to expect that service. This made it difficult for patients to participate in their own care, alert family members to good times to visit, and to mentally prepare for difficult therapies or tests. In addition, if a family member came to visit while the patient was out of their room, it was difficult for the bedside nurse to know where the patient was at any given time and when to expect them to return (i.e. in 5 minutes from an X-ray, or 4 hours from dialysis). Because of these issues, patients and families perceived a lack of coordination of care between departments and caregivers.

In addition to issues with communicating the schedule to patients, the therapy and testing areas struggled with efficiency and productivity. Each area had developed localized ways of scheduling their patients (using paper schedules, a department whiteboard, etc.), but those schedules were not viewable by anyone outside their department. Therefore, patients would often be “double-booked” for services, leading to collisions of care. A common example would be the therapist (following their paper schedule according to the order they planned to see patients) arriving at a patient room only to find
the patient not in the room because they were away at a test. Essentially, it was a first-come, first-served method that didn’t serve anyone well. The therapist would then need to spend time rearranging their time and guessing when that patient might be back in the room so they could come back and provide the needed service.
From the value stream mapping activity, it was clear that the lack of a patient schedule was a theme, however there was no quantifiable data from nursing or patients regarding a patient schedule. A 3-question survey was taken of nurses and patients on a med/surg unit. Nurses were asked whether their patients have procedures or therapies scheduled for the day, to which 88 percent said yes. When asked if they knew when those tests and procedures were scheduled to happen, 85 percent did not. Finally, the responses to whether there would be value in having a schedule were more mixed, but the majority agreed that it would be valuable or helpful.
Additionally, a small survey of patients was done to ask their perceptions of having a schedule. Of the 5 patients interviewed, all had tests, procedures or therapies during their hospital stay, only 20 percent knew when they were scheduled to happen, and 80 percent agreed that it would be valuable to have a schedule for the day.
After confirming that staff and patients did indeed view the lack of a patient daily schedule as an issue, the problem was approached through focused rapid improvement events. Areas to include were grouped (i.e. therapies, cardiac testing) and kaizen events were planned to work on eliminating waste within each area and create standardized work for scheduling inpatient appointments. In addition, one kaizen event focused on nursing’s role in communicating the schedule to the patient and patient-centered whiteboards were created.
In determining which departments to include, several criteria were established. The criteria were developed based on recommendations from the electronic health record vendor as well as simple cost-benefit analysis. Early in the process, the question was asked as to who should create appointments to see the patient. Due to the specialized nature of therapy and testing areas in a hospital, alternative priorities for nursing staff and using the lean principle of pull systems rather than push systems, it was determined that the therapy or testing area that receives the order to provide patient care will be responsible for scheduling the patient for that service in coordination with the patient’s nurse.

Additionally, for therapies, tests or treatments that took less than 15 minutes with the patient, the cost in terms of time to schedule was greater than the benefit of avoided collisions of care and information to patients. For example, it was determined that respiratory therapy oxygen checks (with a length of about 5 minutes) would not be scheduled, however pulmonary function tests (which typically take 30 minutes or longer) would be scheduled.

It was determined that special attention would be paid to scheduling appointments for patients that would need to leave the floor for their therapy, test, or procedure. This would alleviate the issue of family coming to visit a patient and the bedside nursing being unable to verify the location of the patient and their approximate time of returning to the unit.

Finally, it was determined that resources that are shared between inpatient and outpatient (especially radiology testing areas) would schedule inpatients so that the resource could be appropriately scheduled and there would not be conflicts with inpatients and outpatients needing the resource at the same time.
A set of overarching goals was developed for the projects to guide the work done by each improvement team. The primary goal was to keep the patient informed of what their schedule is for the day for all of the important reasons mentioned earlier. Secondly, the goal was to provide more coordinated care through the use of a central, electronic schedule where every department could access the patient’s schedule and avoid scheduling the patient for a time when others were treating the patient. This then leads to the third goal of improving departmental efficiency by reducing defects of patients unavailable for appointments, therefore better utilizing staff and resource time.

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**Goals of Inpatient Scheduling of Tests and Therapies**

1. **Keep patient informed** of what their schedule will be during the day
2. Keep staff – nursing, physicians, support departments – informed of appointments for each patient so we can **provide coordinated care** and avoid collisions of care
3. Allow support departments to better utilize their resources by **reducing defects** of patients being unavailable for appointments
Once the areas to be included were chosen with the criteria identified above, a readiness assessment was performed to understand the scope of the work needed to achieve the end goal of all areas scheduling inpatient appointments in Epic. The departments were rated on a scale of 0 to 10, with 0 being not at all ready and 10 meaning that the criteria was already met and in use. The areas were rated based on the extent to which their scheduling workflow had been analyzed already, whether there was a scheduler in that department already identified, whether they had the Epic technical pieces identified and built, whether they were already scheduling real-time appointments in Epic (for inpatients or outpatients), whether they had a process in place for rescheduling appointments real-time, and finally a cultural assessment of their ability to accept the change. The assessment showed that some areas would require very little work to achieve the goals of the project and that other areas were virtually starting from the beginning. This analysis led to the creation of a timeline for implementation.

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<thead>
<tr>
<th>Department</th>
<th>Workflow Analyzed</th>
<th>Scheduler Identified</th>
<th>Epic Visit Types/ Templates</th>
<th>Scheduling Real-Time in Epic</th>
<th>Re-scheduling</th>
<th>Acceptance of “New Normal”</th>
<th>Overall Readiness</th>
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<tr>
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While the kickoff was a kaizen event with the therapies group, the workflow analysis quickly showed that this would be a significant culture change and Epic build for those departments. They were not only used to using paper rather than electronic scheduling, but they also worked more from a patient list than a schedule. Therefore, after the first event, it was decided to start in radiology, where they already had the technical capability to schedule inpatient appointments and some areas already had processes in place for doing so. Therefore, the concept was able to be tested more readily and implemented more quickly. Next was cardiac testing areas, followed by neurological and respiratory areas. Finally, a kaizen event was held to improve the process for communication with the bedside nurse and the patient themselves.

Due to the nature of the work (building a schedule within the electronic health record), some updates to Epic were able to be made during the kaizen events, but more major changes were pulled out to be managed in a project management format in 2011. An implementation plan for those departments requiring significant Epic changes (which required testing and intensive training for users) was then created in collaboration with internal Epic analysts, with the main focus being the therapies departments. Dialysis and pulmonary function lab required Epic build and some training, but only for a dozen people, whereas the therapies included over 85 people. Therefore dialysis and pulmonary function lab had go-live dates early in 2011, after which the project team moved their focus to the therapies group.
From the research done at the beginning of this project, no other facility is scheduling inpatient appointments both testing areas and therapies. Several are scheduling one or the other, but by having most inpatient appointments scheduled, more information is available for each patient with fewer collisions of care. Additionally, after testing out the change with therapies initially scheduling their appointments on the inpatient rehab unit, other disciplines began asking to be able to schedule their appointments as well, so they were added on to the end of the project. One important design note is that the implementation took advantage of Epic’s built-in mistake proofing capability to ensure that a patient cannot be double booked into two places at once. No department is given the authority to overbook an appointment form another department. For tests that might be higher priority than the currently scheduled appointment for that particular patient, the areas each have a process for communicating with the department who is currently scheduled with that patient to let them know to reschedule. For emergent cases, there are options in the system to allow the service to be completed regardless of the open times in a patient’s schedule.
Before the implementation of inpatient electronic appointment scheduling, inpatient physical therapists would write out their schedule on this whiteboard (1), update a patient Kardex system, (2) as well as maintain patient lists and documentation within Epic. Every day at the end of the day, 8 therapists would stand at the board and verify that Epic, the whiteboard, and the Kardex system all matched. In addition, the secretary would copy the information from the whiteboard onto a piece of paper (3) to send to the floors with therapy times, most of which would become outdated as soon as the day started and patients were moved because of collisions of care.
After implementation, all inpatient physical therapy appointments are now scheduled in Epic, which allows the therapist to make sure the patient does not have any conflicting appointments. While the therapists were not comfortable getting rid of the Kardex system, the two steps of writing all appointments on the whiteboard and then copying them to a piece of paper have been eliminated. Instead of hunting for an outdated piece of paper, the inpatient nurse and any other interested caregiver can now go to the main inpatient screen to see the patient’s most up-to-date appointment schedule.
As previously mentioned, not only did the therapies group need significant Epic build to be done, they also required significant process changes to the way they did their work. As is always the case, change is difficult and the groups required significant change management efforts in order to succeed. Those efforts started out with a focus on the area managers and director. The first question seems straightforward, but it was very difficult for the management team to come to consensus on who should schedule the appointments within their respective areas. The question was whether clerical staff or therapists should schedule the appointments. To determine the best way, the management team visited two other hospitals in the metro area who were using Epic to schedule inpatient appointments; one hospital had the clerical staff schedule and the other had each individual therapist schedule. The management team was able to understand the pros and cons of each method and weigh those against their current processes and staff attitudes. In the end, it was determined that each therapist would be responsible for managing their own schedule, largely due to the fact that that was the current model and therapists, as professional staff, appreciated being able to manage their time and caseload according to what was best for both their efficiency and their patients’ individual needs, without having to somehow communicate that information with clerical staff for scheduling. One of the key concerns with having therapists schedule their appointments was whether or not they would continue to be able to meet their productivity targets (measured by time spent with patients at the bedside). Therefore, it was determined that productivity measures would be closely tracked, and if after a stabilization period after go live there was significant impact to therapist productivity, the idea of having clerical staff schedule appointments would be revisited.

With that key decision made, the management team selected a group of super users – therapists from each discipline who were either technically savvy, known to be early adopters, or simply influential among their peers – were selected to participate in weekly design meetings.

The management team was also responsible for identifying any reporting needs that they had so that the system could be designed accordingly and reports built to meet their requirements. Finally, the management team decided on a go-live date and was responsible for scheduling all of their staff to attend a 2 hour training session in the 2 weeks before go-live.
The super user group met weekly for 3 months to discuss workflows and make design decisions. They standardized workflows, analyzed the current process in each of their departments, participated in system demos to understand how the system works and how they might use it best in their respective areas, and what the future state workflows would look like after go-live. They evaluated their current scheduling tools (Kardex system, whiteboards, paper schedules, methods of patient prioritization) and determined what would happen to those systems after go-live. They worked through many “what-if” scenarios such as ill calls of therapists, weekend and casual staff scheduling, and patients being too ill for therapy and needing to cancel. The group also defined appropriate change and cancel reasons to be added to the system for inpatients, to be used as a defect tracking measurement. Each of the super users was given significant one-on-one training and practice time before go-live, which allowed them to become the first point of contact for questions from their peers and to provide extra hands-on support to users during go-live. Finally, though they initially struggled with the idea of change as much as their peers, they became role models of acceptance for their peers during go-live. At one super user practice session close to go-live, it was as if the light bulb went on for one of the super users, and from then on, the attitude seemed to be, “If Margaret can do this, then so can I!”
The super user group also developed some rules of the road for scheduling inpatients. While some were specific to their particular department, they developed a set of guidelines for all to follow. It is important for example to schedule an appointment for the actual amount of time the therapist expects to take with the patient face to face, not longer (which would block that patient from having another service even though they were available) or shorter (which means someone else might assume the patient is available and they are not). Along the same lines, it is important that appointments are canceled or rescheduled in real-time so that the patient’s electronic schedule reflects the reality of their availability for services. In addition, a decision was made not to add travel time to appointments that would take place off the floor, so areas need to allow for that as they schedule appointments. One limitation of the system is that there is not a way in HCMC’s current build to automatically cancel appointments upon discharge, so those need to be manually canceled. Several of the therapy departments had a system for prioritizing their patients to be seen, so a method was defined to capture that information electronically. Finally, one significant positive change for the therapists with electronic scheduling is the ability to directly schedule interpreters as needed rather than having to schedule via the telephone (and inevitably waiting on hold for significant amounts of time).
As the changes were communicated to the larger groups of therapists through staff meetings, open labs, and dialogue with the super users, several themes emerged regarding the perceived barriers to change. The first was the perception that doing anything in the computer would take significantly more time than the old way of doing things and that this would take away from time that they wanted to be spending at the bedside, caring for patients. It was difficult for them to adjust to the idea of sticking to a schedule and updating it in real-time, since their previous process allowed them ultimate flexibility to move through their list of patients – to the detriment of anyone trying to know when to expect the therapist. They also raised concerns about how to schedule in coordination with longer tests or treatments. Finally, their main question was, “What’s in it for me?” and while the project team worked hard to detail the benefits to productivity and efficiency, in the end, the answer is that the main benefit is patient-centered care, which benefits all members of the care team.
Metrics – Was it an Improvement?
The next slides will discuss a variety of metrics that are being tracked that show improvement based on the 3 goals of the project (keeping patient informed, coordinating care, reducing defects). However, in a project such as this, the numbers don’t tell the whole story, since a large part of the work was focused on cultural readiness and change. Feedback 9 months post-go-live from staff and managers provides insight into the success of the project and eventual acceptance of the change. Of course, many of them seem to have completely forgotten the growing pains and chief complaints from before go-live and are very happy with the new normal. They have become instrumental in helping to find ways to continue to improve the system, fix defects, and adjust to Epic upgrades, and overall, management and staff see this as a positive change.
One of the primary metrics used to evaluate the success of the project was the rate and type of defects encountered by therapists as they worked through their caseloads. Our 3rd goal in the project was to increase therapist efficiency by reducing collisions of care. Data was collected during the therapies kaizen event in June of 2010 to understand the primary barriers to being able to successfully complete a treatment with patients. The data was collected from direct observation and therapist defect reporting for over 300 patient visits. The data reflects the two primary causes of defects being that the patient was discharged before the therapist saw the patient and that the patient was unavailable. In 28 percent of the cases, the patient was unavailable at the time the therapist had arranged (on their personal schedule) to see the patient due to a collision of care. This was due to a number of factors, including the patient being off the floor for another service, someone else providing a service at the patient bedside, or the bedside nurse providing cares. Another notable defect is the 13 percent of the time that the patient refused therapy. Further investigation showed that in order to successfully participate in therapy sessions, which are sometimes painful or difficult, some patients needed to be prepared in advance either mentally or by receiving pain medication before the session. Because the patient and the patient’s nurse did not know when to expect the therapist, neither of these were possible.
After go live of electronic inpatient scheduling for therapies, a summary of the defects was again collected, though this time the data was able to be collected electronically via an Epic report on cancellation reasons for over 4,500 therapy appointments. The graph shows several new defects that were not tracked in the manual data collection but that make sense in the electronic scheduling format (i.e. scheduling error) or were options that the super user and management group wanted to be able to report on (i.e. patient incompatible/inappropriate). In comparing the before and after pareto, note that the primary defect of the patient being discharged before the therapist saw the patient was not affected by inpatient scheduling. However, after inpatient scheduling went live, appointments cancelled due to the patient being unavailable (i.e. collisions of care) dropped from 28 percent to just 11 percent. Additionally, the percentage of time an appointment was cancelled because of patient refusal dropped from 13 to 8 percent. Finally, the percentage of patients who did not participate in therapy sessions due to illness or fatigue (which includes patients in too much pain to participate) dropped from 13 to 8 percent, likely because patients were able to be pre-meditated for therapy sessions and therapists were able to see the patient’s schedule and evaluate when to schedule that patient based on other appointments already scheduled (i.e. not scheduling back-to-back with another intensive therapy session).
In addition to a change in the types of defects encountered by staff and a reduction in those related to collisions of care, an analysis of the defect rate also showed a significant overall reduction in the number of defects encountered by staff. Before implementation of electronic scheduling for inpatient therapy appointments, therapists were encountering an average of 63 defects per day (for the reasons shown in the previous graphs). At an average volume of 190 orders per day for physical therapy, occupational therapy, and speech pathology, this calculates to an average defect rate of 33 percent. Every third patient was unable to be seen at the time the therapist arrived to see the patient. After implementation, the defect rate dropped to an average of 39 per day, for a defect rate (assuming similar pre and post therapy volumes) of 21 percent, or every fifth patient being unable to be seen at their scheduled time based on reported data. This translates to an estimate of a 38 percent reduction in defects, translating to a more efficient therapy staff.
In addition to measuring defects, as previously mentioned, the therapy managers were concerned about the effects of scheduling on their productivity. The agreement was that if therapists became significantly less productive (measured by the amount of time they are able to spend delivering bedside therapy), the decision to have therapists schedule their own appointments instead of clerical staff scheduling for them would be revisited. In this graph, the target line is green, and the goal is to be at or below target. As expected, in the month following go-live (as shown by the dotted blue line on the graph), therapists were less productive as they worked to learn the new system of scheduling. However after that initial learning curve period, their productivity returned to at least pre-implementation levels. Productivity is affected by many factors including staffing challenges related to position vacancies, leaves of absence, vacations, and fluctuating hospital census, not only inpatient scheduling. However, the data does not show a need to reevaluate the decision to have therapists manage their own schedules due to reduced productivity, showing that the correct decision was indeed made regarding who should schedule.
In addition to tracking staff efficiency due to reduced collisions in care, one of the goals was to increase coordination of care from the patient’s perspective. One key metric tracked to measure that coordination is the mean response to the Press Ganey Patient Satisfaction Survey question of “the staff worked together to care for you.” The data is tracked historically and was then analyzed post-go-live. As a note, Press Ganey Survey responses are generally tracked based on the date the survey is received, which includes a lag time from the time the patient was actually discharged from the hospital to the time they sent back their survey. For the purposes of this analysis, pre-go-live is considered to be a received date of May 2011 and earlier. The weighted average mean (weighted by number of survey respondents per month) before implementation of inpatient scheduling was 85.2, whereas the post-go-live weighted average mean was 86.4. Using a T-test to test for significance of a difference in the means, the test gives a p-value of 0.03, which confirms that the mean post-implementation is statistically significantly higher than the mean pre-implementation. Therefore, patients are noticing more coordination of care among staff members.
Since the primary goal is to communicate information about the schedule to patients, new whiteboards were purchased for every unit in the hospital to provide a place to communicate the schedule, along with other important patient-centered information. There are currently whiteboards in each patient room with a space to write the nurse’s, doctor’s, and aide’s names along with diet and activity restrictions. However there was not enough real estate on the current whiteboards for nursing to communicate scheduled activities with the patient. A search for best practices in patient-centered care led to the inclusion of the above fields in addition to the patient schedule. The beside nurse will be responsible for updating the boards each shift as they assess their patients and discuss the plan for the shift with the patient. The design is finalized, however due to quality issues in the production of the boards and infection prevention restrictions for installing them, they are not yet available in all patient rooms.
It is expected that the installation and use of the patient-centered whiteboards will further increase communication with patients. However in the meantime, the responses to the Press Ganey Patient Satisfaction Survey question of “the nurses kept you informed” is still being tracked. The fact that the patient’s schedule for the day is now located in one place in the electronic health record (and not on multiple pieces of paper or on multiple screens), is making it easier for the bedside nurse to refer to the patients schedule and communicate it with them verbally either each shift or when the patient asks. Similarly to the previous Press Ganey metric, a T-test was performed on the weighted average means, and the analysis shows a p-value of 0.02, again confirming a statistically significant difference in the means before and after inpatient scheduling go-live. This metric will be tracked on an ongoing basis.
Finally, as with each project, there are some lessons learned along the way. It is recommended that an up-front conversation happens in the project group to determine which, if any, services, tests, procedures, or therapies always take precedence over others by setting up a “pecking order” list, if applicable. In the case of HCMC, it was determined that the priority of a particular test in relation to other tests was largely dependent on the individual patient’s condition and physician preferences. However, if it is determined that radiologic tests will always take precedence over physical therapy, for example, that needs to be included in the build of the system. This discussion came about because of the concern that if all disciplines scheduled appointments in Epic for the patient, there would not be enough slots in the day for everyone to schedule. However, this was seen not to be the case, especially if staff followed workflow rules of cancelling and rescheduling appointments when needed, which leads to accurate times in the system. Ensuring that the scheduled times reflected reality translated to caregiver confidence in the schedule and therefore willingness to share the schedule with patients. Of course, it is still important to communicate to patients that the scheduled times may change based on a number of factors (their condition, other patients with emergent needs, etc.), but communicating an expected time for a test or therapy allows patients to prepare.

In addition, as with any process change, including a move from paper-based to electronic systems, change management is a key component of project management and necessary for the success of the project. It is important to take the time to understand the culture of the areas involved and discuss any resistance openly. The actual changes to the electronic health record were minimal compared to the cultural change required to make the implementation successful. Without the “people” aspect, the system could have been designed and built in several days, but each decision was emotionally connected to a change in the way someone did their work, so care was needed to help those doing the work understand and accept the changes.

Finally, it was important to have a project manager who could help bridge the gap between those doing the work and those designing the system, since the two groups had very different objectives and perspectives. The
“process” people understood their current workflows and how to do the clinical work but had a hard time seeing how that could possibly look different in the future. The “technology” people understood the details of the electronic health record, design questions that needed to be answered, and how to build the system accordingly, but without understanding the workflow of the therapy departments, it was hard for them to suggest ideas to optimize the design to match the workflow. Therefore, having an objective third party who understood how the technology worked and also had an understanding of the requirements of the therapy departments to match or even improve their workflows, was essential.
In conclusion, the key goals of the project were accomplished: implementing a system to keep patient informed, allow staff to coordinate care, and reduce defects and inefficiencies of service departments as they provided care to patients. Instead of each individual department having knowledge of and optimizing their own schedule and sub-optimizing the whole, scheduling inpatient appointments in Epic allowed globalized information sharing and coordination. Each department now has standard work for scheduling inpatients and communicating with the bedside nurse. In addition, Epic’s built-in mistake-proofing capabilities (not allowing multiple departments to book appointments for the same patient for the same appointment time) have helped to ensure more coordinated care, improve departmental efficiency and disciplined adherence to process, and decreased staff frustration of planning their day only to have to rearrange it each time because the patient is unavailable. Finally, due to the success of the project and word-of-mouth, other areas who were not included in the original scope asked to be included and have the ability to schedule appointments for the inpatients that they work with. One example of this is the Cancer Center, who performs bone marrow biopsies at the bedside for inpatients and would like to have that time scheduled so other departments know the patient is not available. As previously mentioned, the more departments scheduling their appointments in Epic, the more information available to caregivers who are then able to provide that information to patients, keeping them informed.
Questions?

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