



**ACHIEVING A NEW STANDARD IN PRIMARY CARE FOR
LOW-INCOME POPULATIONS: CASE STUDIES OF REDESIGN
AND CHANGE THROUGH A LEARNING COLLABORATIVE**

**CASE STUDY 1: REDESIGNING THE PATIENT VISIT
PROGRAM AT THE JEROME BELSON HEALTH CENTER**

Pamela Gordon and Matthew Chin

[Click here](#) to view the overview report.

CENTER PROFILE

The Jerome Belson Health Center on East 149th Street in the Bronx is one of four full-time and three part-time health centers in New York City operated by the Cerebral Palsy Association (CPA) of New York State. It serves a developmentally disabled population of children and adults, many of whom have multiple physical handicaps and chronic health conditions. Many patients use wheelchairs and travel with advocates who communicate patients' needs to providers. The Belson Center plays an indispensable role in providing quality health care for this population, which in general has limited treatment options because most primary care facilities are not equipped to meet their special needs.

In operation since the 1980s, the Belson Center serves approximately 1,200 clients. Providers at the busy clinic see an average of 1,500 patients a month for a total of 18,000 visits a year. The single-floor facility is located in a lively urban setting, across the street from Lincoln Hospital and surrounded by small businesses and residential apartment buildings. The immediate community is largely Hispanic, although the multi-ethnic and multi-generational clients who use the center arrive from all over the Bronx, upper Manhattan, and occasionally, Queens. Many clients attend a day program in the same building as the health center; for them, visiting the doctor involves walking down the hall.

The center provides a spectrum of medical and specialty services, including primary care, psychiatry, dentistry, dermatology, podiatry, neurology, ophthalmology, rehabilitation programs, and wheelchair repair and maintenance.

CENTER CONDITIONS PRIOR TO REDESIGN

A Cramped Waiting Room and Limited Examination Space

In keeping with its mission, the Belson Center seeks to provide quality primary care to developmentally disabled patients who cannot find adequate services elsewhere. To this end, the center is fully handicapped accessible. Even so, numerous drawbacks in the facility's physical layout forced patients to spend up to 68 minutes for every visit.

Joanne Maviglia, who oversees all of the CPA's health centers in NYC as its administrator of health services, describes both the space and the use of the space as "terrible." Wait times were too long. Handicapped clients made as many as five stops during each visit.

The first stop was the hectic entranceway of the building. There, patients checked in at a clinic desk located close to the welcome desk for Belson's day program. The proximity of the two check-in points often created confusion. After check-in, patients traveled to a separate waiting area where they sat until they were called into an exam room. There, a medical assistant performed a preliminary evaluation. Finally, patients moved to another exam room to meet with a doctor. The center only has two exam rooms. One room always was used for collecting pre-exam information, instead of both rooms being used by doctors to see patients. The last stop for patients was a return to the registration desk to schedule their next appointment.

"Productivity wasn't as good as we thought it could be," says Maviglia. She adds that leadership knew "the staff was frustrated with the physical space and we really didn't know what we needed to do to change it."

CPA turned to PCDC for help. The two organizations had an ongoing relationship. PCDC provided loans for a CPA construction project in Brooklyn, after which the entire CPA organization took part in PCDC's Revenue Maximization program, with excellent results. CPA registered for Redesigning the Patient Visit, a program with a track record of helping community-based health centers successfully reduce patient cycle time. The Belson Center was chosen as the pilot site and participated in the Redesigning Collaborative between November 2001 and April 2002.

THE REDESIGNING THE PATIENT VISIT LEARNING COLLABORATIVE

Redesigning the Patient Visit is a rigorous training program that helps health centers analyze their patient visit process, from the moment patients walk through the door to the moment they exit the facility. With the visit under microscopic analysis, center personnel

learn to appreciate the patient experience from the patient’s point of view. Health centers significantly decrease wait times through tight-knit teamwork, tracking visit time, and making office procedures more patient-focused. These changes improve productivity, staff and provider attitudes, and patient satisfaction.

A Learning Collaborative Model

Like all of PCDC’s operations programs, Redesigning the Patient Visit is structured according to the model of a learning collaborative, which takes place over several months. PCDC staff members facilitate the presentation of the collaborative and also serve as coaches for participating health centers. Acclaimed reengineering expert Roger Coleman, an innovator in the field of organizational transformation, leads the collaborative, assisted by experts at the firm Roger Coleman Associates. As Coleman describes it, participants in the learning collaborative embark on an in-depth journey of discovery about their health center and its operations. Key to the successful completion of this journey is a commitment to two critical elements of the learning collaborative: collaborative principles and collaborative stages.

Collaborative Principles: Identifying Roadblocks on the Path to Change

Five strategic principles guide health centers throughout their journey:

Build a high-functioning team.

The Belson team originally included the site director and her executive secretary, the charge nurse, an occupational therapist, and the medical director. The group found the process of working together challenging at first. They worked through their differences—an important aspect of the team building process—and evolved into a united and positive force, even after the site director and secretary left the team when they left the organization. As Diane Disanti, an occupational therapist who became co-team leader with charge nurse Joyce Moss, explains: “Some members were skeptical that this wasn’t going to work. Yet after a month or two we all learned to collaborate.”

Cultivate leadership support and involvement.

Disanti underscores the significance of leadership support in accomplishing Redesign goals. “We have management who are really involved,” she notes. “It helps when they think what we’re doing is important. Having the head office show that they care makes a difference” in terms of getting the job done.

Track data and map the process from the patient's perspective.

Tracking allowed the team to see “things we hadn’t seen before when we’re so caught up in the day-to-day,” Disanti continues. “The team was out there with clipboards, following a patient through the process, dissecting the visit by taking it step by step . . . [ultimately] we really made some changes that increased efficiencies.”

The primary data tracked by the Belson team included:

- Average patient cycle
- Number of patients seen per provider
- Number of hands-off during each patient visit

Open lines of communication.

In an active, hectic, and high-pressured work environment such as Belson, being “caught up in the day-to-day,” as Disanti puts it, tends to be the general rule. It is all too easy in such an atmosphere to pay attention to immediate work demands while forgetting that staff and providers share a connection. The action of one person has an impact on the actions of others.

Utilize the expertise of PCDC coaches and program leaders.

Roger Coleman, his team of associates, and PCDC’s facilitators and coaches have traveled the redesign road with many organizations over the years. Coleman is described by Maviglia as “a phenomenal speaker and motivator” and is available for consultations at each of the learning sessions as well as by e-mail. Several of his associates and PCDC staff members serve as coaches for various centers participating in Redesign.

REDESIGNING THE PATIENT VISIT PRINCIPLES

Time-Tested Principles that Bend

Each PCDC operations program teaches both the core principles common to all collaboratives as well as a distinct set of organizing principles. These program principles are not a set of cookie-cutter operating instructions that are applied rigidly to all situations. Rather, the program principles work because each team can bend them according to its facility’s needs.

“Communicate directly and with urgency to colleagues” is one of 12 Redesign principles central to the success of the program. Many participating centers have found that walkie-talkies help staff speed up the patient visit. For example, a medical assistant can schedule a patient’s follow-up visit with the staff member at the registration desk using a

walkie-talkie. By the time the patient leaves the exam room, the appointment is scheduled and the patient just needs to pick up a written reminder.

Belson could not use walkie-talkies. Reception in the building is poor, and patients “pull them off because they are interested in seeing what is on our heads,” says Moss. Instead, the Belson team began to rely on the intercom system to communicate better. “Since we have telephones everywhere, we used the intercom on them to communicate with each other instead of walking, and that saves time,” explains Moss.

Applying Principles Creatively: Generating Change

Each successful adaptation outlined below—arrived at in some cases through considerable trial and error—generated change that resulted in greater efficiency, decreased cycle time, and enhanced staff and patient satisfaction.

Principle: Don't move the patient.

Before Redesign:

Patients went to an exam room where the nurse took vitals, and then on to another exam room to meet with the provider.

After Redesign:

Patients settle in one exam room and the nurse and provider come to them.

Principle: Eliminate needless work.

Before:

Patients made five stops during a visit.

After:

Patient now only makes three stops per visit.

Before:

Patients registered at a desk located some distance from the waiting room; they then went to the waiting room and sat until they were called.

After:

A registration desk was constructed inside the waiting room so that patients can sign in, wait to see providers, and pick up next-appointment slips in one place. Combining several processes at one location reduced the total number of stops.

Before:

Patient charts were filed in an area far from the registration desk; retrieving them meant extra work and extra time.

After:

All medical charts are kept in an area next to the front desk in the waiting room, making it easier and less time-consuming for staff to pull charts.

Principle: Increase clinical support.

Before:

The center did not have enough clinical support staff to help providers.

After:

The team recommended hiring another patient care assistant, and management approved the hire.

Principle: Communicate directly and with urgency.

Before:

Clerical staff occasionally phoned patients to remind them of appointments.

After:

As part of their daily work routine, staff members now consistently telephone patients the day before to confirm appointments.

Before:

Patients arrived, checked in, and waited. Clinicians did not know a patient was there unless they came out and looked for themselves.

After:

Staff at the registration desk tells nurses and medical assistants when a patient arrives.

Before:

Clerical and clinical staff knew that patient flow through the office was inefficient, yet nobody knew exactly how long a patient visit took, nor did they have common goals for decreasing visit time or increasing efficiency and productivity.

After:

The team posted a data chart in the clinic room that displayed the staff's success in moving toward its goal.

Before:

There was no official outlet for patients to give feedback to staff.

After:

Patients were encouraged to fill out sheets at the front desk noting their concerns as well as their appreciation.

Principle: Exploit technology.

Before:

Patients left the exam, stopped at the registration desk, and scheduled their own appointments.

After:

Nurses consistently employed the underused intercom system to speak to the front desk to schedule patient appointments.

Principle: Match capacity and demand.

Before:

Provider saw 2.85 patients per hour with each patient, spending almost 70 minutes per visit.

After:

The number of stops was reduced from five to three and the processes streamlined for greater efficiency and flow. These improvements allowed providers to see 4.5 patients per hour, which represents an increase in productivity of 57.9 percent. Patient cycle time fell to 41 minutes from 68 minutes, for a decrease in cycle time of 40 percent.

Principle: Get all the tools and supplies you need.

Before:

Exam rooms were stocked with standard examination tables.

After:

At the team's recommendation, leadership authorized the purchase of a specialized multi-purpose exam table that makes it much easier for disabled patients to get on and off and more efficient for providers to examine them.

Principle: Create broad work roles.

Before:

Clerical staff checked patients in and made follow-up appointments, with limited connection to the clinical work in the back rooms.

After:

Clerical staff assumes more of a clinical role, following up on the whereabouts of patients and knowing each one's location at all times.

- They notify nurses as soon as a patient arrives and again if a patient sits in the waiting room for more than ten minutes.
- They greet patients on their way out with slips for follow-up appointments that are made by the nurse over the intercom from the exam room and the clerical staff member.

Before:

Medical assistants and nurses attended to patients only when a patient was ready to be seen.

After:

Nurses undertake certain clerical responsibilities such as scheduling patients for appointments and making copies of materials needed for charts.

Principles: Organize patient care teams and start all business on time.

Before:

Clerical and clinical staff operated independently, fulfilling their distinct job responsibilities without understanding how their actions or inactions affected their colleagues' jobs and the quality of the patient visit.

After:

The team brought the staff together in ways that encouraged teamwork, awareness, and accountability.

- Clerical and clinical staff learned about each other’s job responsibilities at meetings and luncheons.
- During 10-minute morning huddles at the start of each day, a ritual that continued post-redesign, support staff members were encouraged to consider themselves part of the clinical team. During the huddles, staff plans out each day together, defines responsibilities, identifies who may need help during the day and who will step in to assist, and goes over the day’s schedule in order to anticipate patient, supply, and equipment needs.

Principles: Prepare for the expected and do today’s work today.

Before:

Staff pulled patient charts the day before an appointment in preparation for a patient’s visit, but charts were not consistently checked for complete information.

After:

Charts are pulled, and before a provider sees a patient, all employees pitch in to make sure the folders are complete and include lab reports and information from outside specialists or hospitals. All charts are filed before the end of the day.

Utilizing Principles Strategically: Overcoming Obstacles to Change

Trial-and-error implementation of program principles clears bottlenecks in the patient visit path and stimulates visit flow. These principles also help centers negotiate new hurdles that arise because the organization is undergoing a major change. There are many examples of typical obstacles that are confronted and overcome.

Collecting Data: A “Grueling” Process, Ultimately Worthwhile.

Maviglia is frank when she describes the data collection process for the Belson team as “grueling.” The team members carved time out from their regular schedules in order to follow patients around. Then they had to meet consistently to discuss their discoveries, make decisions on which new procedures to implement, and follow through with their ideas—in addition to meeting the demands of their regular jobs.

“This was very time-consuming, challenging, and demanding,” Maviglia says. The team members kept focused by using several management strategies: the data tracking principle, consulting their coach, solidifying their teamwork skills, and communicating openly and routinely. Once the team began to see the results of its efforts, members began to feel that all their hard work had been worthwhile. “They were very proud of what they had done,” says Maviglia.

Building the Team: From Initial Apprehension to Appreciating the Power of Teams.

Putting a multi-disciplinary team together does not guarantee that the team will be effective. Team members need time to get to know each other while they learn about the collaborative process. People were given specific tasks during the prework phase, which helped break the ice. Preconceived notions slowly disappeared, and team members began to appreciate the power of working together.

Implementing New Procedures: Resistance to Change, Enlisting Support.

Team members were bonding, but they still had to deal with non-team staff resisting changes to the status quo. “People didn’t know what we were doing,” says Disanti. “They felt we were in their way.”

Communication was key to eliminating this hurdle. “Management gave us money to treat the staff. We had breakfasts and luncheons. That helped a lot,” Disanti continues. Workers “became more open to listening to us as we treated them with respect and told them we needed their input. Doing the visuals helped a lot, too. Everybody was working to see the numbers get better.”

Positive feedback from patients also helped employees’ understanding of the program goals. “When the secretary read ‘great job’ on the patient feedback sheet, that made her feel good,” explains Disanti. Receiving positive responses also helped employees be more receptive to criticism.

Belson’s Unique Issue: Transportation.

Early on, the Belson team recognized that the transportation of patients to and from the center had an impact on cycle time. But transportation was beyond the control of the redesign team. The team adjusted the measurement of cycle time to include the actual time that the patient spent in the center at the visit itself.

THE DATA: DRAMATIC NUMERICAL RESULTS

Pre-Redesign	Post-Redesign
Cycle time: 68 minutes	Cycle time: 41 minutes ↓ 40%
Productivity: 2.85 patients per hour	Productivity: 4.5 patients per hour ↑ 58%

BEYOND THE DATA: BEDROCK OF A HIGH-PERFORMANCE ORGANIZATION

The documented improvements in Belson’s efficiency illustrate the success of its Redesign journey. But beyond those numbers, Belson underwent a deep, permanent shift in its organizational culture because of the PCDC collaborative approach. This shift let Belson

begin operating like a high performance organization for the first time. Some of the fundamental organizational transformations that took place at the Belson Center include:

A Patient-Centered Attitude

- The health center's personnel shifted the focus of their workday from making life convenient for clerical and clinical staff to putting patients' needs and the quality of the patient experience above all other concerns.

Heightened Morale

- Provider morale was enhanced because of increased productivity and efficiency and an overall sense of work done well.
- The morale of clerical employees improved because clinical staff came to understand and respect their responsibilities and to involve these workers more fully in the clinical process.

The Power of Teamwork

- All employees worked together as a team to achieve shared goals. Team members took responsibility and were accountable for the vision of the entire center.

Committing to Communication

- All employees were routinely informed of center progress and given the opportunity to provide input on procedures during daily and weekly meetings.

SUSTAINING THE OUTCOMES: CONTINUING ON A STRATEGIC JOURNEY

Thrilled with the transformations engendered by Redesign, Belson Center employees are determined to sustain their new, patient-centered approach and the positive outcomes it produced. Both management and employees are aware that maintaining these hard-won gains will require an ongoing, vigilant effort. They are confident of success because they have come to appreciate the results achieved during the Redesign journey.

Key changes made in center procedures and its physical plant:

- Adding an additional patient care staff member
- Constructing a registration desk in the patient waiting area
- Purchasing a multi-purpose examination table designed for disabled patients

- Instituting daily morning huddles
- Utilizing intercom technology in order to schedule appointments
- Training nurses to undertake certain clerical duties
- Training clerical staff to communicate consistently with provider staff

Plans to ensure continued success:

- Continued weekly meetings with team members who are passionate and committed to Redesign principles
- Continued involvement by a senior leader who embraces Redesign principles, provides ongoing support, and is willing to allocate financial resources for new staff and necessary equipment when possible
- Ongoing tracking of cycle time to highlight areas where there are breakdowns in communication, paperwork, or procedural flow

Ultimately, participation in this PCDC operations program reshaped the entire attitude and outlook of the Belson Health Center while producing dramatic increases in productivity. “Redesign gave us a broader picture, more of a holistic sense of our work place,” says Disanti. “It brought us together as a team versus each of us coming in and just doing our job.”