SPECIALIST SERVICES COMMITTEE

SINGLE ENTRY MODEL TOOLKIT

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USING THIS GUIDE

Throughout this guide you will see icons referencing available resources, tools or topics for special consideration.

DEFINITIONS AND COMMON ACRONYMS

Single Entry Model	A single point of contact (i.e. single fax line) from which a group of specialists accept referrals
SSC	Specialist Services Committee
MOA	Medical Office Assistant
MOU	Memorandum of Understanding

PREFACE

The ultimate goal of the Single Entry Model of service delivery is to improve the patient experience by improving access to specialty consult and care.

Welcome to the Enhancing Access Initiative!

The Enhancing Access Initiative (the "Initiative") is one of the strategic priorities of the Specialist Services Committee (SSC) and is aimed at supporting interested specialists and their colleagues re-design their referral process to expedite patient access to specialist consult and care. For more information on this and other SSC initiatives click here

The purpose of this guide is to offer resources, contacts, templates and strategies that can be adopted to meet the needs of any specialty practice. Each recommendation is a direct learning from past specialist groups who have participated in the Initiative and each tool has been developed in response to the needs of participating teams. Specialists, administrative support (i.e. Medical Office Assistants), office managers and other stakeholders (i.e. referring practitioners) will all find portions of this guide useful in understanding their own critical role in a Single Entry Model process.

Starting with the Facts

Single Entry Models are an option (not a requirement) for patients and referring physicians.

In keeping with a patient-centered healthcare system, patients and their referring provider can choose whether they wish to be seen by the first available specialist or by a specialist of their choosing with the shared understanding that this may have an impact on how long a patient may wait to be assessed by a specialist.

Single Entry Models can be applied to any specialist practice structure or business model.

Whether a specialist is working on a fee-for-service or alternate payment basis, share a common space or practice in separate locations – Single Entry Models can be and have been implemented in all of these scenarios.

The Single Entry Model is **NOT**

- A 'gimmick' for reducing wait times. They are a proven method for balancing supply and demand among a group of specialists.
- A new concept. This model has been successfully applied by numerous groups of specialists across the province and across Canada already.

BENEFITS OF IMPLEMENTING A SINGLE ENTRY MODEL

For Patients

- Offers more choice by allowing patients the option of being referred to a a particular specialist or be seen by the next available physician
- Equalizes access by rebalancing waitlists across a group of specialists enabling them to maximize all available resources.
- Streamlines the referral process facilitating more accurate estimates of expected wait times and avoiding potential waste and duplication due to incomplete or inappropriate referrals.

For Referring Practitioners

- Eliminates guesswork by standardizing the requirements for a complete referral and reducing burden associated with communicating back-and-forth between the referring practitioner and specialist's office.
- Provides confidence that the patient will be seen by an appropriate provider as the specialist clinic manages patient allocation within their group - removing the need for the referring physician to keep track of current list of clinicians and corresponding sub-specializations.
- Avoids concern of undue delay related to a specialist's vacation or other interruptions in service.

For Specialists

- Improves work-life balance by alleviating concern knowing patients are being appropriately redirected while a specialist is unavailable (i.e. on vacation, sabbatical, or attending to other priorities), avoiding ballooning wait lists awaiting their return to practice.
- Facilitates gradual reduction in referrals for those nearing retirement as they bridge out of their practices.
- Aids recruitment of new specialists by being able to offer a full slate of patients on day one by pulling from the common pool.
- Aligns with the College of Physicians and Surgeons of British Columbia Referral-Consultation Process.

Other Benefits

When a specialist group adopts a Single Entry Model they standardize processes including data entry. This enables them to use the information captured in their shared EMR to identify trends that help generate ideas for continuous quality improvement, operational efficiency and resource planning.

Specialists who have adopted Single Entry Model have found themselves working in less isolation and benefiting from collegial analysis and discussion of their practices. This includes being better equipped to effectively collaborate with system partners such as health authority leadership, on desired improvements across the entire patient journey.

The implementation of Single Entry Models and a shared EMR database creates the opportunity to see, measure and report on patient data across all clinician practices. If there is any concern or reservation about sharing information within your group, it is important to address this up-front as it is one of the key readiness indicators for implementing this service model.

GETTING STARTED

Based on learnings developed by past groups, there are areas which need to be assessed before embarking on this transformation to provide you and your colleagues the best chance of success.

Culture

Based on feedback collected from past groups, culture is routinely named as the number one determinant of success. Groups of specialists that have the key tenets of trust, mutual respect and sense of team possess the foundational pieces that lead to a successful implementation.

Assessing culture is not an exact science, however, things to look for to determine whether you have the right culture include:

- Evidence of working as a team (e.g. are MOAs able to cover for each other when sick or away? Do you meet with any regularity as a group to discuss issues impacting your practice? Do you have a well-balanced call schedule?)
- A shared sense of trust and respect among the group (e.g. are all members able to speak freely and have their perspective considered? Is there a willingness to transparently share practice data among colleagues?)
- Common goals around the desire to continuously improve patient care.

If there are members of your group that possess some, but not all of the above attributes, consider whether a joint leadership model would be more fitting to ensure the project has the necessary support and leadership at each key phase of activity.

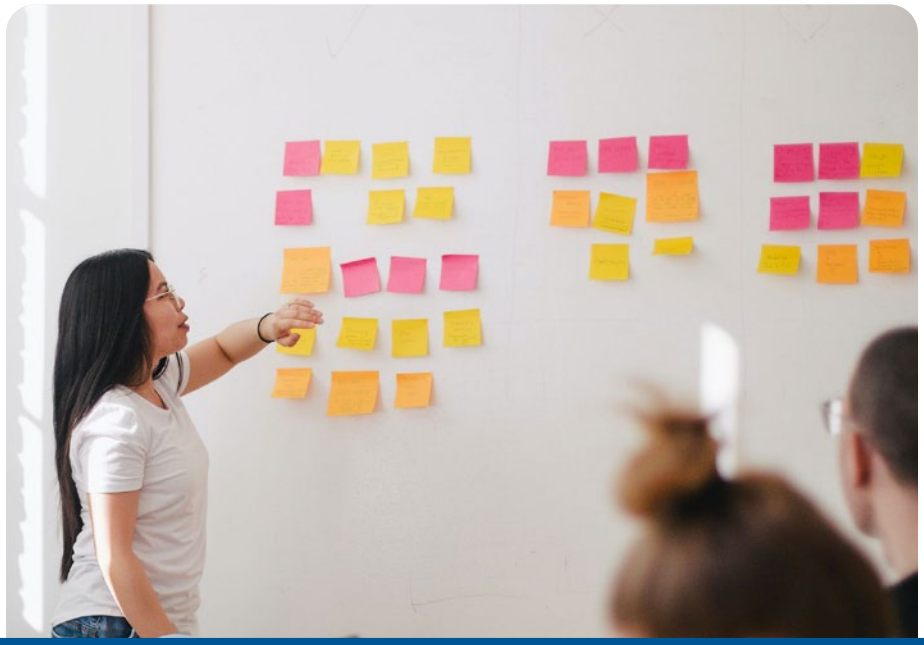
Leadership

Unanticipated challenges are inevitable in change efforts and will require strong leadership to overcome them. Prior to starting, reflect on whether you and your colleagues are equipped with a physician and MOA lead (or leads) who have both the time and drive to face these challenges, paired with the trust and respect of the broader group to help bring everyone through successfully.

Key attributes of a successful project leadership team (physician and MOA) include:

- Experience in a leadership role including change management
- A desire to improve the referral process and an advocate for change
- Willingness to commit to timelines, role expectations and deliverables
- Solutions-oriented and encouraging
- Tech-willing / tech-savvy

Consensus based leadership is recommended for the Physician and MOA lead roles. Your group may also consider selecting a different Physician Lead for phase 1 and phase 2.



In every change effort, it is inevitable that you will face challenges – this initiative is no different.

Part of determining whether the challenges you and your colleagues will face will be easily surmounted lies in taking a moment to look clearly and honestly at the realities of your current state before you begin.

Engagement

There is a significant difference between passively accepting and actively supporting the success of a change. Before you begin, it is encouraged to have a candid discussion among all members of the group (staff included) regarding the significant effort and time this project will require.

If you are unsure of the amount of time and effort this commitment to improving your practice will have on yourself and your colleagues and would like to gain greater insight, reach out to SSC staff to connect with clinicians and staff who have already implemented to hear their experiences.

Outcomes and Goal Alignment

Before you embark on a new path, it is important to know where you're going. Clearly articulating desired outcomes and metrics by which to determine whether you have met those goals or not will help both group cohesion and decision-making throughout the process. Aligning the team at the beginning of the project through both documentation as well as in-person meetings and regular communication will ensure the overall goals and objectives are understood and are consistently being met. It is suggested to document key milestones so that the journey is in smaller, bite sized pieces. This allows you to create momentum from step by step success, while keeping the final goal in mind.

If you are interested in pursuing this initiative but are unsure whether the timing is right for you and your colleagues, feel free to reach out to SSC staff to discuss prior to project initiation.

Change Management

This project requires a high degree of business process change and change is hard. Therefore, proper change management will be a critical success factor. Consider educating yourself on change management or involving a Change Coach.

SETTING THE FOUNDATION

Vision and Values

As part of the engagement process with your colleagues and clinic staff, defining your collective vision and values will help set the tone of the project at the outset. Having a clearly articulated shared vision of what you as a group hope to accomplish will aid decision making throughout - particularly at points where you face challenges or differences of opinion within the group.

Values are equally important and can outline how you agree to work together not only through the duration of the project, but into the future. Clear values act as an anchor by which everyone can be held accountable.

Roles and Responsibilities

Some roles within this project will be formally defined through the Project Agreement with the Doctors of BC (e.g. physician lead, lead MOA, project manager, etc.), however there will also be a need to identify roles and responsibilities across all members of the group. Ensuring every member of the team (including clinicians and office staff) have a role to play within the project not only supports clarity in understanding who is responsible for what, but also builds buy-in and a sense of ownership of the finished product.

Time Commitment and Meetings

It is no secret that physicians consistently face multiple demands for their time and dedicating the necessary attention to ensure a successful implementation of this project can be challenging. Prior to starting, determine with the group what the best frequency and timing of project meetings is as well as possible strategies to ensure input can be collected from those unable to attend. If certain individuals are consistently absent from meetings, it may be worth revisiting the schedule to ensure reasonable levels of engagement and input from the entire group.

Governance, Terms of Reference and Conflict Resolution

Although it may seem overly formal, putting thought to how you will function as a group including defining a process for decision making and conflict resolution, can avoid many pitfalls down the road. It is recommended that as a group, you determine in advance whether you will make decisions based on consensus or majority rule, and how to manage disagreements. A consensus decision making model might also be useful for decision making especially for larger groups. This ensures that when issues arise, an agreed upon approach for resolution is already known and can be actioned. If these processes are unfamiliar to you, your project manager can help you work through these foundational pieces at the outset.

PHASE 1
DESIGN AND PLANNING

Phase one outlines the deliverables for the first 3 months of your journey including:

1. A Memorandum of Understanding (MOU) signed by all specialists practicing in the same specialty in a local area
2. Selection of a suitable project manager
3. Stakeholder engagement
4. Draft triage plan
5. Consensus around the electronic medical record (EMR) vendor of choice
6. Development of a project charter

The SSC has a template MOU you can use for this purpose.

Memorandum of Understanding signed by all specialists.

For a project manager job description when reviewing candidates, contact the SSC.

A project manager is selected who will be committed to the duration of the initiative.

Memorandum of Understanding

One of the first steps on your way to implementing a Single Entry Model is to secure agreement and notify all similar specialty physicians that service a catchment area. This process results in a written Memorandum of Understanding (MOU) between similar specialists.

Even if a specialist does not want to participate, he or she needs to sign the MOU as evidence that they are aware of the change happening locally.

Selection of Project Manager

The Enhancing Access Initiative is intentionally a physician-led initiative with each project requiring a physician and MOA lead to be the primary drivers of the work. With that said, a project of this size requires a significant amount of time dedicated to administrative work.

This includes but is not limited to:

- Facilitating the design phase and working with clinicians and staff to map out the new process Planning and executing regular project meetings
- Documenting and tracking group consensus and action items
- Tracking physician and MOA time and facilitating appropriate and timely payment
- Working with the selected vendor to communicate the new model as well as scheduling
- Training completing required reporting to SSC
- Managing the overall project and associated milestones/ deliverables including accurate, real-time budget tracking

A dedicated project manager can be leveraged to work alongside the physician and MOA leads, ensuring that the above activities are properly managed and ensuring all stakeholders are being engaged and updated as appropriate.

Project Stakeholder Communication

Having reached initial agreement among your group by signing the MOU, the next step is to identify stakeholders outside of your immediate group of clinicians and staff that will be impacted in some way by your new service model.

Although you and your colleagues have control over the operations within each of your practices, success of this initiative hinges on the willingness and participation of all elements of the system that touch your patients' journeys. Early engagement is far more effective than waiting until the new process is in place, not only because it enables buy-in from key players, it also offers the chance to capture valuable insights from different perspectives which can help avoid issues during implementation.

To create a complete list, think through the patient journey and map out who else in the healthcare system plays a role that may be impacted by your planned change.

This includes but is not limited to:

- Referring colleagues and their staff (both within primary care and other acute care providers as applicable)
- Your local Division of Family Practice
- Health authority partners and resources (e.g. imaging, labs, OR staff, etc.) as applicable. This includes any key HA leadership representatives.

Ensure to think about which stakeholders (health authority) you should be involving or need approval from. Once all stakeholders are identified, it is recommended to create a communication plan that will outline how and when they will be engaged throughout the project and what are the expected outcomes. The communication plan should also outline your approach for providing clear guidelines sharing your new referral process and referral form.

If you are unsure who within your local health authority you should be reaching out to, connect with SSC staff to help identify and navigate the appropriate contacts based on your location and specialty.

Draft Triage Plan

The draft triage plan aims to give your group the opportunity to discuss triaging options that could work and to understand what this new triaging process would mean for each group member. Your triaging process can be tweaked in phase 2 through a Plan-Do-Study-Act QI approach and throughout the project to ensure it meets your needs. This is also an opportunity to align your vision of central intake. For example, is it more important to keep patients seen in the past or to ensure that they are seen faster by another Specialist? Another key discussion item for your draft triaging plan is which methodology will you use to define the first available Specialist?

Selection of an Electronic Medical Record (EMR) Vendor

In addition to the process design, assuming this is not the current configuration of your group, the other largest undertaking and greatest project expense is the amalgamation of all participating specialists onto a single EMR.

The Doctors Technology Office (DTO) EMR Resource Page can be found HERE

Doctors Technology Office (DTO) - EMR Resources

The process of EMR vendor selection begins by each group assessing their current state (e.g. you may already be on one vendor product, multiple vendor products, paper, or some combination), as well as the EMR platform's fit for the requirements of central intake and referral pooling. This will help determine whether to consolidate to a single instance of an incumbent EMR or go to market seeking an alternative.

Available resources include:

- EMR Data Portability Guide
- EMR Data Conversion Checklist
- Physician's Guide to EMR FAQ
- Guide to E-Faxing Solutions
- Forms Guidelines and Best Practices

The SSC is vendor neutral and therefore does not recommend one product over another.

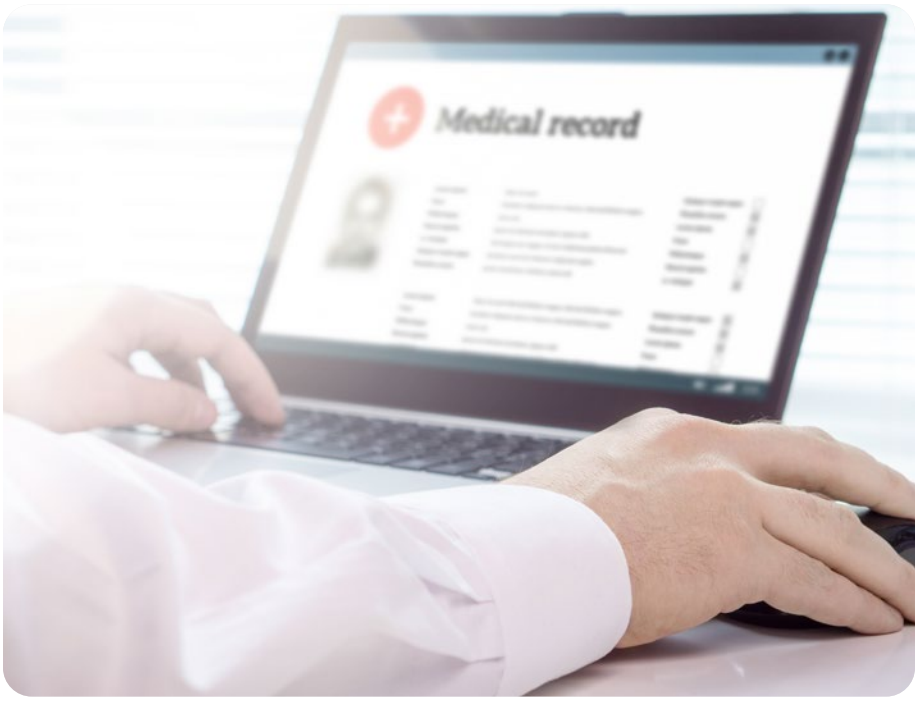
You and your colleagues will have to review the various options and determine which EMR functionality will best support your desired future state. The EMR vendor of choice will play a critical role in assisting with the transition and should be selected with care.

Once determined, your group will enter into a new contractual arrangement with the EMR vendor for a shared database instance as well as consulting services support for database migration, data-cleanup, central intake process design, training, and analytical reporting.

If you are unsure of what vendors are on the market with the capability to support Single Entry Models, contact SSC staff for information.

Take some time to think through all requirements of your EMR. Insist on a demo of the central intake features to ensure your selection criteria is taking all aspects of your practice into account – now and into the future. The demo should include data reporting and visualization, dashboard capabilities and any relevant add-ons such as patient portal, reminders, patient forms, dictation, transcription, etc. Many vendors now have a 'sandbox' or an online practice version of their software that you can request to get a sense of how an EMR will look and feel in clinical practice. Ensure the EMR vendor quotes includes all the features you are interested in implementing.

It is important to note that EMR vendors may have several requests for similar types of support and therefore may already have bookings which only a select group of their team can support. To avoid surprises or unanticipated delay, once you have finalized your vendor selection, connect with them early to determine the possible timeline and be sure to include that information into the project schedule. Additionally, if you are moving from one vendor's platform to another, you will need to inform your current vendor of the transition and the request for data migration.



It will be critical to include all staffing perspectives (inclusive of MOA, office manager, physicians) as use and functionality of the EMR will impact all team members. Do this early on, and include ways to provide updates to all team members as the process moves along.

All vendors have different capacity capabilities based on their size therefore giving them as much lead time as possible will ensure you reach your project deliverables around EMR integration.

Before making a final decision on which EMR vendor is right for you and your colleagues, it is a good idea to ask for a reference from the vendor of other clients within the same specialty to learn more on how the EMR works in their clinical practice.

EMR vendor selected.

When determining your project milestones ensure to take into account the impact of existing adjunct projects, summer vacations and to allow sufficient time for all physicians to merge into the same EMR and stabilize.

Contact SSC staff for a Project Charter template

Project charter completed.

Development of a Project Charter and Workplan

After completing items 1-4, you and your colleagues will be far better equipped with the information necessary to complete a detailed project charter and budget.

This can all be accomplished by using the SSC project charter template which helps outline the purpose, develop the plan to address issues as they inevitably arise, determine which stakeholders to notify, define how to evaluate the project and develop an appropriate budget.

Since each project has different requirements depending on their starting point, a project charter can be lengthy; however, the value in completing one is it sets the baseline from which your project will begin while helping you think of topics to address before they become a challenge later on.

Prior to finalizing your project charter and budget, it is important to review all elements of Phase 2 and 3 to ensure you've included all necessary activities and corresponding budgets.

PHASE 2
IMPLEMENTATION

Once your project charter and corresponding budget have been approved, you are ready to move into the operational phase of your project. Phase 2 outlines some of the common processes, questions to ask, resources to use and tips onhow to go about the work.

Key activities and deliverables for phase 2

- Review and signoff of software license agreements
- Cost sharing agreement
- Data sharing agreement
- Communication plan and stakeholders' engagement
- Current state workflow analysis
- Future state workflow design
- Central fax line setup
- Redesign referral form and import into EMRs
- Referral triaging and management process
- Branding and website
- Data cleanup
- EMR configuration
- Data migration and testing
- EMR Data remediation
- SOPs creation
- EMR training
- Go live plan
- Go-live on common EMR database
- Data analytics and reporting
- Launch of new referral form and process
- Post go-live support
- Post implementation review and evaluation
- Stabilization
- Handoff for sustainment
- Project closeout

Questions to ask yourself when creating your workplan

- Is there a physical move of offices planned?
- How large is your group?
- Are you already on the same EMR and same database?
- How big is the change in process and form?
- Do you run clinics in the health authority that will be impacted?
- Are there any existing adjunct projects within Health Authority?

Do not reinvent the wheel; many similar groups have already standardized their referral form. Contact the SSC to get in contact with other teams to get a sample of their referral form.

Forms that are too lengthy – although perhaps more clinically valid - are unlikely to be adopted and could hinder the success of your new service model.

Standardizing referral criteria and forms

The creation of a central intake process hinges on a shift toward standardizing the referral intake and screening processes across all participating clinicians. Often this results in the creation of a new, standardized referral form.

Before jumping into form design, it is encouraged to focus first on the critical data points and supporting documentation (e.g. labs, imaging, etc.) required for each referral type to facilitate timely review and triage and only after the minimum requirements are defined, should you shift to redesigning the referral form.

Although the specialists engaged will collectively determine the standard criteria, it is important to remember success depends on uptake of the new process by referring colleagues. As such, it is imperative to engage a representative group (i.e. referring providers including as applicable family practice physicians, emergency room physicians or other providers) into the early parts of the design phase to collect their input and feedback.

Although it may seem ideal to collect significant amounts of data at the point of referral (particularly for those interested in use of technology in automated triage) the current reality is that in the absence of broad inter-operability, referring physicians often have limited time to conduct the assessment with the patient and complete the referral form.

Considerations and Best Practices: Form Development

While longer-term strategies are being developed at the provincial level regarding data transfer and sharing between providers, please consider the following Forms Guideline Best Practice if you are planning to develop a new form or revise an existing form.

For this initiative, it is recommended that the new form is ready 12 weeks in advance of Go-Live date. This allows for necessary engagement with EMR vendors of referring physicians, any final adjustments and time for testing. Not allowing for this time can result in lengthy delays and added costs if having to make changes after it has been built into the referring providers' EMR systems.

Electronic form development might not be available for some EMRs for which referring practitioners will have to use your fillable PDF form.

Be sure your new form is ready 12 weeks in advance for any final adjustments and time for testing.

Finalized referral form tested and scheduled to be embedded in referring provider EMR systems.

EMR Migration Planning and Execution

For those groups not yet on a single instance of an EMR, the process of planning and executing the migration (even when staying with the same vendor) is one of the most substantial undertakings of the project and will require cooperation from a number of project stakeholders.

These include:

- Participating specialist group and staff
- Specific vendor staff dedicated to this work
- Each of the current vendors (if any) that clinicians will be moving away from to facilitate current data to be accessed, transferred and checked for data quality and completeness.

Although much has been learned through past implementations of this model, it is still a relatively new concept for many (physicians and EMR vendors alike), and each group will have unique requirements including clinical and workflow nuances which will need to be considered and integrated into the future state

As a result, it will be important to work with your EMR vendor of choice early and often to ensure lines of communication are clear at the outset and expectations can be managed on both sides.

Thorough current state mapping and future process design prior to moving forward with implementation will aid all involved in developing a good understanding of the unique needs and future desires of you, your colleagues and staff and help to avoid issues and redesign work happening after launching the new model.

Trying to coordinate across multiple vendors may cause significant delay to the project if some or all do not meet agreed upon timelines.

It is a good idea to build additional 'buffer' into the project schedule to account for possible delays.

If during the project you are facing challenges or have concerns with your vendor that are not being sufficiently addressed, reach out to SSC staff sooner rather than later as they can help support you in addressing the issues.

While planning the project schedule, in addition to determining a realistic timeline based on the availability of your vendor of choice to complete the transition to a merged instance, you will also need to determine availability from the vendors you and your colleagues are leaving (if any) as you will not be able to complete the transition without the necessary information from the previous vendor. It is recommended to use a stagged approach to bring all physicians into a common EMR instance and have each clinic stabilize before merging the next one.

If your current state includes a mix of vendors, it is likely you will face added challenges trying to coordinate across all vendors to ensure the necessary data in the correct format, is available in time for when the new vendor of choice needs it for testing and migration. This can cause significant delay to the project if some or all do not meet agreed upon timelines.

Maintain regular communication with each stakeholder heading into and throughout this process. If your project has a high number of stakeholders involved for this particular element of the work,

Maintain regular communication with each stakeholder heading into and throughout this process. If your project has a high number of stakeholders involved for this particular element of the work,

Although the focus will largely be on the referral and waitlist functionality as that is what is being targeted for improvement, it is important to remember that the vendor needs to migrate ALL of the data within your systems including billing, charts and all other information housed in your current EMRs. It is crucial to allow for sufficient time to test the data that is migrated to your new EMR instance to ensure accuracy of migrated patient data.

That, compounded by the fact that each individual clinician and MOA tend to use their EMRs slightly differently, makes for a significant amount of work and effort required to integrate numerous, unique instances into one single instance which is coherent and immediately functional.

What may at times appear as "nothing happening" on the part of the vendor could in fact be extensive work being done behind the scenes to ensure that when you Go-Live on your new system, other than the intentional changes, all else should be as you left it.

Again – keeping lines of communication open with regular status reports will aid in understanding current status and ensure all involved are confident in the progress being made.

Although your project manager will play a critical role in handling much of the day-to-day activities and management through the implementation, it is important to ensure that the physician group (or delegate representative physician) has clear and direct communication channels with the vendor as well. The relationship between you, your colleagues and your vendor of choice will last well beyond the timeline of the project so relying entirely on your project manager will risk leaving you and your colleagues feeling unsure of how to access support after project completion.

The relationship between you and your vendor will last well beyond the timeline of the project. It is important to ensure that the physician group (or delegate representative physician) has clear and direct communication channels with the vendor.

Creation of a Central Fax Line

A key element of developing a central intake for referring providers is the creation of a single fax line that will feed into the new system.

In order to determine the best means of integrating this step into your new system, work with the EMR vendor you have selected to find out what integrated faxing functionality exists in their system, if any (including corresponding cost), or if this will need to be achieved through a third-party solution.

If there are currently multiple fax lines, determine a process by which those fax lines will eventually be disabled and communicating to colleagues and staff who continue using the old numbers.

Cost Sharing Agreement

The group should create a cost sharing agreement that outlines each Physician's share responsibility for one-time and recurring costs including e-faxing, website, etc.

Data Sharing Agreement

For those groups not already on a shared EMR instance, prior to going through the migration process it is important to ensure a data sharing agreement is in place between providers that clearly documents what data are being shared, and how the data can be used.

In some cases, a data sharing agreement is provided by the vendor as part of the process of transitioning to a shared database. Connect with the vendor you have selected to determine whether this is the case or if this will need to be completed as a separate activity.

Ensuring to plan for now and into the future, it is important that the agreement not only outlines the terms of the data as you combine and actively practice day-to-day in this new model, but also outlines the agreed upon process in the event one or more physicians leaves the group in the future.

It is important to evaluate project success by measuring and monitoring ongoing metrics as selected by your team.

Data Collection and Evaluation Planning

One of the benefits of implementing a Single Entry Model is the ability to collect and report on data across all members of the group – offering insights into broader trends across your patient population.

Phase 3 will speak to this in more specifics, however, in order to set yourselves up to do this successfully, processes for data collection and quality need to be designed into the system at the beginning to ensure useful information comes out at the end.

As a group, consider some key metrics that would be useful to be able to track and report on into the future. Although there will be many areas of interest and curiosity, it is recommended to focus on a targeted number of key metrics (less than 10) that you really want to focus on and then ensure that the appropriate data definitions and collection processes are built into the workflow so reliable, clean data can be extracted and analyzed. Identify the metrics early so you can confirm the ability of your EMR to provide those metrics accurately when selecting your EMR vendor during the planning phase.

Some example metrics for your project could include:

- Measure and monitoring of wait times (time from receipt of referral to date of first consult)
- A reduction in inappropriate and/or incomplete referrals
- Satisfaction of referring providers with the new service model
- Satisfaction of patients with the new service model
- Satisfaction with participating clinicians and staff of the new service model

Standardizing as much as possible at the beginning will give you much more accurate data reporting to measure project success and future endeavors.

Data in is data out - it will be up to you as a group (including MOAs and clinic staff) to agree to standard data entry practices. (e.g., research, operational decisions, care decisions, recruitment, OR time, etc.). To capture baseline data, you might need to ensure data required for reporting is captured in a standardized way and previously entered data might also require cleanup. For complex data reporting requirements, consider budgeting for a Data Analyst.

Go-Live Planning and Communication/Engagement Strategy

Considerations for Go-Live:

- How will you communicate with referring providers and their staff, informing them of the change and clearly outlining the new process as it pertains to them?
- How and who will manage issues from referring providers and staff who run into problems with the new model?
- Consider increasing staffing levels over the short term until all members of the team are comfortable with the new system and office efficiency returns to normal.
- Who are your allies to help support referring providers who may be resistant to the new model?
- How will you support each other and your staff to ensure issues are communicated early and often so they can be addressed rather than becoming longstanding issues?
- How can questions or concerns from colleagues and staff be communicated and addressed prior to Go-Live?

Communication and Engagement Tips

Communication with all stakeholders will be critical and if done well, can offer considerable support to the success of your new model.

Below are some items for consideration to integrate into your planning (and be sure to add necessary budget for each item you incorporate).

Website and Branding

The biggest transition that will be most visible to your referring providers and patients will likely be that you are now operating as a cohesive team of clinicians and staff rather than separate practitioners. As such, one of the activities past groups undertook to support this shift was the creation of a new brand and website to represent the new, unified service.

In addition to building awareness of your new service, a website can also offer a place to house key information including:

- A copy of the new referral form
- Your new central fax number
- Patient education materials on how to best prepare for their visit and/or care for themselves while awaiting access to your services
- Access to patient portals or other virtual care options as applicable
- Instructions on how to access urgent care from your group
- Any other information that you think would be useful

Look through websites from groups that have adopted Single Entry Models to get ideas on how to further leverage this tool – there may even be relevant materials of interest to you that they would be willing to share.

Other Communication Channels

Groups in the past have used multi-pronged approaches to communication and engagement with referring providers and patients which may be suitable for your group as well.

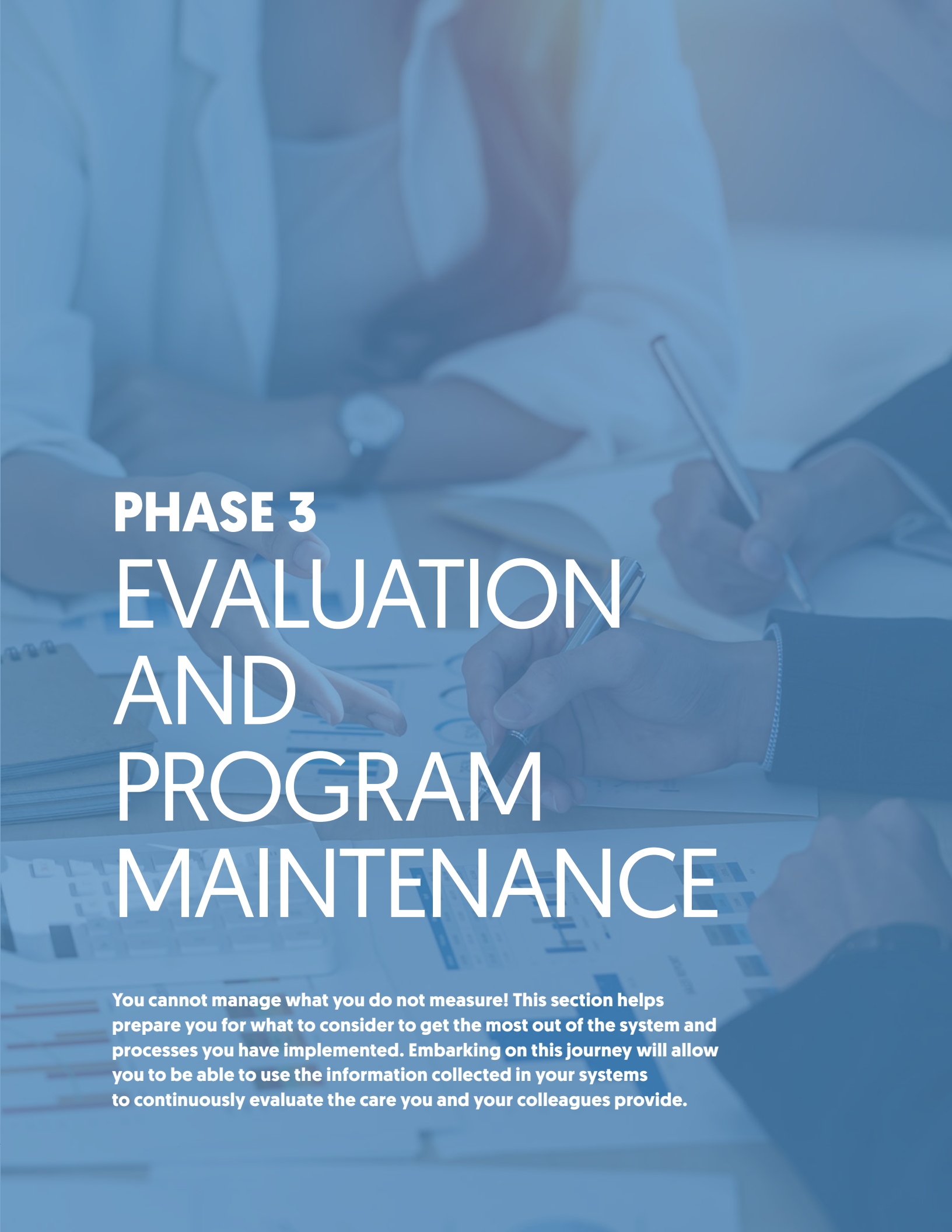
These could include:

- Mass mailing/faxing to all referring providers and staff
- Attending/presenting at local Division of Family Practice events
- Hosting events specific to local MOAs to present on the new model
- Updating the information/listing on Pathways BC pathwaysbc.ca/info
- Working with local Divisions of Family Practice to leverage their existing communication channels, as appropriate
- Crafting personalized letters from clinicians within the group outlining the purpose and goals of the new model
- Any other creative or innovative ideas to reach your target audience and communicate the value of your new service

Based on the experience of past groups, it will take time and continued effort on the part of your team to achieve 100% adoption of the new model by referring partners. As a result, expect there to be a need for continued, iterative communication and engagement while the new process takes hold. The most effective selling feature will be making the model work so referring providers see a decrease in the amount of time patients must wait to see you. Leveraging groups you have engaged from the beginning - including those who contributed to the development of the referral form - will help encourage those more reluctant to shift to the new process. Consider engaging with a subset of referrers (and their MOAs) who are either not providing sufficient data or adequate quality of referrals.

At a certain point you will need to assess the level of adoption and degree of remaining hold-outs at which point you may shift tact. If you feel you have done everything in your power to encourage, support and educate your referring colleagues and the vast majority are able to use the new process without issue, it may become time to stop accepting the “old process” from the few who have not shifted their processes. At this point (which will be different for every group and is recommended to be assessed carefully), it may be time to create a form letter clearly reiterating the new requirements by which a referral will be accepted.

Again, leveraging supports within your local Division of Family Practice and other resources to keep this transition positive and collegial is always preferred and likely more successful in the long run.



PHASE 3
EVALUATION AND PROGRAM MAINTENANCE

You cannot manage what you do not measure! This section helps prepare you for what to consider to get the most out of the system and processes you have implemented. Embarking on this journey will allow you to be able to use the information collected in your systems to continuously evaluate the care you and your colleagues provide.

After the excitement and activity of the launch of your new service, as the day-to-day routine returns to a more normalized pace, you may find some team members fall back into old habits with data entry and definitions – this is particularly risky if the system is not yet setup to be doing regular reporting and analysis allowing these behaviors to go relatively unnoticed.

Depending on the vendor you chose, data analysis capability may still be in the development process or it may already be an integrated function. Either way, if you have applied the advice around data standards identified in phase 2, you are well setup for analysis and evaluation as the functionality becomes available to you.

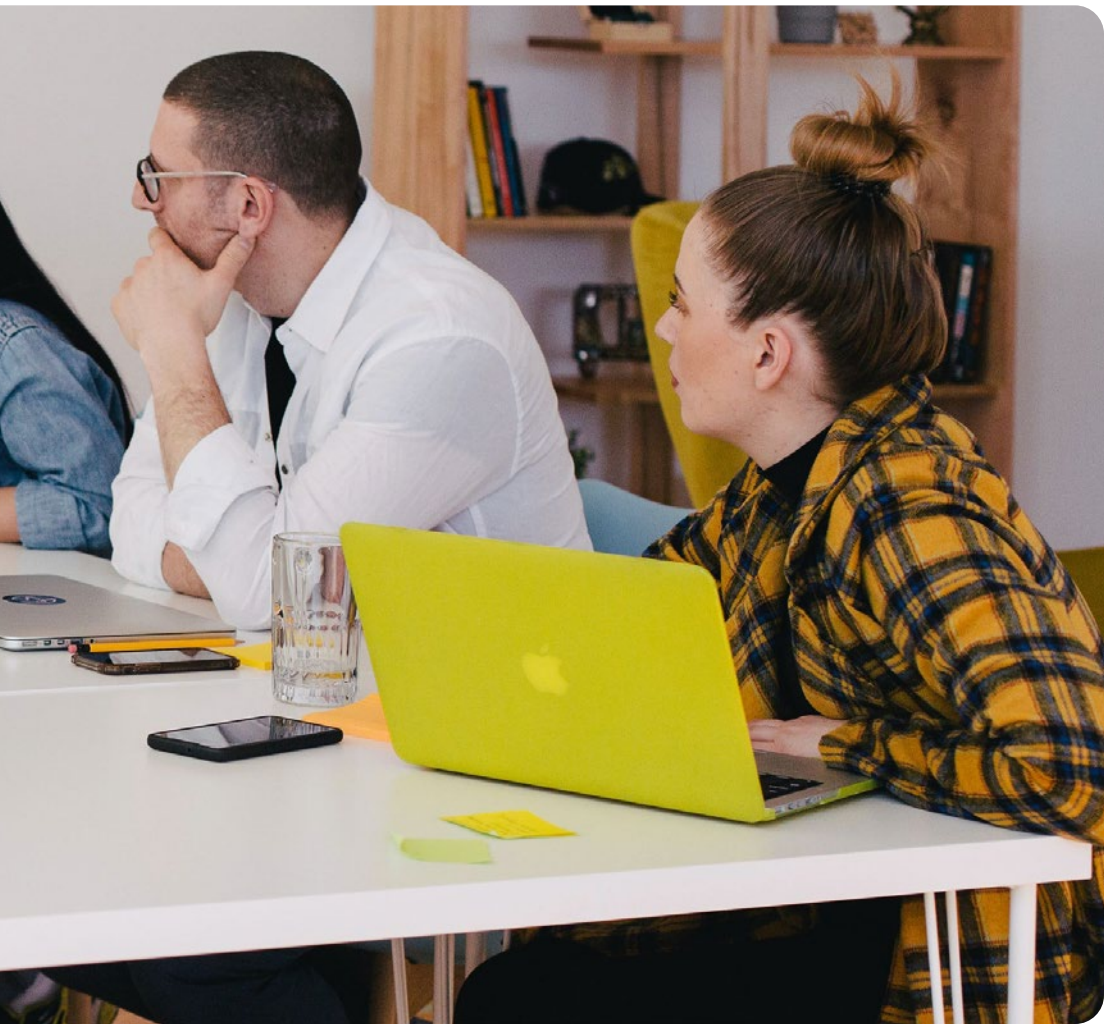
Many past groups have also implemented the practice of holding regular business meetings where clinicians and staff can get together and discuss key topics including any issues, concerns or improvement ideas on the new service model. This is a good opportunity to select a few key metrics that can be reviewed as a group to assess how the process is working and whether there are any additional actions to be taken as trends become clearer.

Identify someone within the group (physician or clinic staff depending on skill and interest) who can act as the data quality manager for the group to ensure agreed upon standards are being maintained. This could also be a rotating role to allow for various members to share the accountability rather than having one person carry the responsibility alone.

AVAILABLE RESOURCES

Please contact SSC staff for any of the following resources:

- Memorandum of Understanding (MOU)
- Project Charter template
- Budget Template
- Project Manager Job Description
- Frequently Asked Questions (FAQ)
- Monthly report template
- Final report template
- Sessional form



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