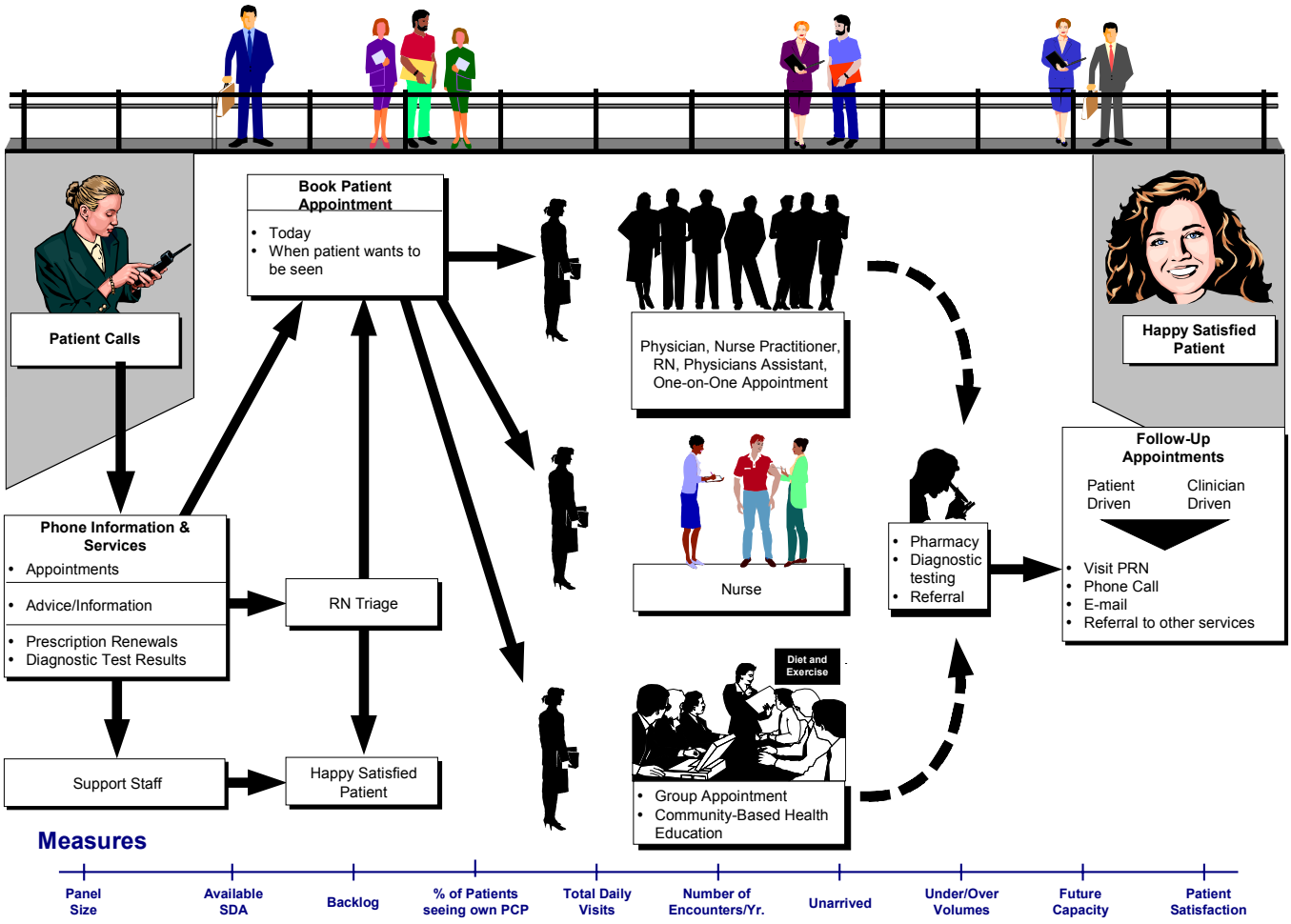
Improving Patient Access to Care



Rev: 3/27/02

2nd Edition

Version 2: Rev 4/2/02

TABLE OF CONTENTS

ACKNOWLEDGEMENTS

It is through collaboration, learning, and many opportunities working with busy health care professionals that we are able to develop this workbook to help other professionals. We are grateful to the busy clinicians who are pioneers blazing new "access" trails to improve patient access to care.

Key to improved patient access are clinical teams learning to cooperate in new ways with each other, optimization of support staff roles, improved processes and systems through practice redesign, and improved internal communication and cooperation in the clinical setting.

This workbook has been developed to support and guide the clinical leader/champion to lead improvement in patient access. The leader should use this tool to guide the clinical teams in access improvement activities.

The collection of materials presented here has been developed over the past decade. Sources for these materials include Mark Murray, MD, MPA, Catherine Tantau, BSN, MPA, the Dartmouth-Hitchcock Health System and hundreds of teams across the United States, England, Sweden and Norway

We welcome your feedback. We wish to continue to build on our collective experiences to help others learn about methods to better meet patient needs and improve patient access.

We are especially grateful to:

Mark Murray, MD, MPA

Catherine Tantau, BSN, MPA

Institute for Healthcare Improvement and Idealized Design of Clinical Office Practices
for their vision, leadership, resources and collaboration
which have helped develop this body of knowledge.

Dartmouth-Hitchcock Health System

Special acknowledgement to Coua Early, AA, for her expertise in graphical and technical design.

INTRODUCTION TO ACCESS SYSTEMS

MARK MURRAY, MD, MPH

"Strategic planning is worthless unless there is first a strategic vision"

-John Naisbitt

Access improvement is the key strategy for success in today's healthcare market. The most common and the most universal issue cited in all patient satisfaction surveys as a determinant of a patient joining a healthcare group, system or provider is access to care. In addition, the most common reason for dissatisfaction and for leaving a healthcare group, system, or provider is lack of access to care. Those organizations and practices that have made significant access improvement have noted increased retention of patients and growth in their market. Access to care needs to be viewed from a patient's perspective: "I can get an appointment (or other service) with my chosen provider at the time I choose."

In many organizations obtaining access to timely care is almost an accident and in fact, some are designed in such a way that it is virtually impossible to reach the goals of our patients. In the past, many organizations have believed that demand was insatiable and unpredictable. They have created false conundrums wherein they felt they had to choose between acceptable access for "urgent" demand or "routine/chronic" demand, between patient satisfaction or provider/staff satisfaction, between patients desires to see their own chosen provider or the convenience of a specific time frame. In addition, many organizations have acted as if delays in access to care were an inevitable part of healthcare or, in some fee for service environments that delays were desirable either to demonstrate popularity or as an assurance of future revenue. Over the last few years these myths have been exploded and the conundrums proved false. Demand is not insatiable. It is in fact predictable. Patients do not have to choose between provider and convenience. In fact patient and provider satisfaction can be fundamentally improved.

In recent times there has been a remarkable transformation in access to care. Some organizations have moved steadily across a continuum of access improvement. The best access is now not seen as an accident but as a result of clearly defined and determined systems of care that have at their center the prime desires of our patients: to have access to their provider at the time that they choose. These new models of access to care are built around these patient desires and in so doing improve not only patient satisfaction but staff and providers as well.

The best access systems are built around two crucial design elements: familiarity and capacity. From patient satisfaction surveys it is known that patients want the opportunity to choose a primary provider and access to that provider when they choose. Patients want to see their own providers not just for "routine" care but most especially for "urgent" care when they are the most sick and the most vulnerable. In addition, exemplary access is not possible without open capacity and flexibility in the appointment scheduling system.

When various access approaches are viewed across a continuum of success and improvement, three distinct models emerge. These models can be described as traditional, first generation open access or carve out models and finally, second generation or Advanced Access models. All access approaches fit somewhere along this continuum.

Traditional Model

In the past, in what has been called the traditional model of access, provider's schedules are full and have been full for months. The schedules have been "saturated" in this manner for months with demand created in the past. There is very little flexibility in these schedules. At the same time, demand still presents itself on a daily basis. Routine demand is pushed off until the future at the end of the queue of appointment demand. Urgent demand is either squeezed in as a work –in, overbooked, or overbooked in anticipation of the "no-shows." In addition, when the already filled schedules become super saturated patients are sent to the walk-in clinic, urgent care clinic or to the emergency department for care. Capacity is gained by adding more work. Multiple appointment types, rules and multiple queues for each appointment type characterize these systems. Waits and delays abound. Often organizations will build Urgent Care Clinics to solve this type of access problem. However, when patients are sent to Urgent Care Clinics, not only are they dissatisfied, but three mechanisms of events occur that adversely effect future access: patients are seen for one problem only, the patients go back to their primary providers out of dissatisfaction, and the urgent care providers actively send patients back to their primary providers. At each level of the cascade away from the primary provider, patients become less satisfied and costs rise.

First Generation Open Access

Patients and staff have become dissatisfied with these traditional systems. Patients want to see their own provider when they are ill and vulnerable. The first step in improving these approaches is to understand that demand is predictable. In the early 1990's numerous investigators found that if demand was stratified into "urgent" and "routine," that the demand for "urgent" care could be predicted. In an effort to respond to patient desires to see their own provider when ill and with the understanding that demand for "urgent care" was predictable, capacity and improved access was gained by accurately predicting urgent needs on a daily basis and then "carving out" a portion of the saturated schedule to respond to that need. Patients with urgent illnesses could then be appointed with their own providers. These systems have been called "Open Access." This change improved access. However, certain predictable and consistent problems arose. If the future schedules are visualized, it becomes apparent that the label of "Open Access" is incorrect. In fact, these systems are closed. The future schedule is either filled with "routine-return" demand or it is held/preserved/reserved for same day urgent care. Thus a patient calling the practice who does not meet the qualifying criteria for a "same day" appointment, a patient who declines such an offer or a patient seen today by the provider and asked to return in a time frame shorter than the length of the queue for routine-return, cannot be accommodated. Often these patients are asked to call back "on the day they want to be seen". But again, if they don't qualify for a same day visit, there is no capacity. If they are appointed into a same day appointment, the predictions based on "urgent care" needs start to erode. In addition, there is a tension to create another appointment type: a "same day-next day" or a "same week". When more capacity is filled with tightly controlled and reserved appointments, the queue for "routine" begins to extend. Many organizations have encountered problems with regulatory agencies when this queue lengthens. Finally, in most practices, the temptation to steal tomorrow's reserved appointments becomes just too great and appointments are "pre-booked" into formerly reserved slots. Thus, ultimately, these systems break down.

Second Generation Open Access/Advanced Access

In just the last few years, further improvements have occurred. Some organizations have determined that just as demand for "urgent care " is predictable, total daily demand is also predictable. In addition, they have come to realize that it is the stratification of demand into "urgent" and "routine" that has lead to inflexible systems: when demand is thus stratified, the future schedule is either filled with "routine" or reserved for "urgent." These organizations have found that since demand for care is predictable and if unnecessary backlog is eliminated, the fatal problems encountered in First generation systems can be mitigated. In Advanced Access organizations decide to do all today's work today.

In order to move to these Advanced Access models the issue of backlog needs to be addressed. It is the backlog of patient appointments, which keeps the schedules saturated. Backlog is any demand first encountered in the past and pushed unnecessarily into the future. At the same time, there is an acceptable backlog: any demand encountered in the past that either because of clinical need or because of patient desire is pushed to the future. When unnecessary backlog is reduced and an appointment is offered on the same day for all problems, the wait time or delay for any "routine" problem becomes today and appointments don't have to be reserved in anticipation of "urgent" needs. Full future capacity is gained.

As with all systems there are drawbacks. In order for each provider to do all today's work today, the size and the risk adjustment of the panel or population cared for by that provider is crucial. In addition, it must be recognized that there will be some fluctuations in demand on a daily basis. These fluctuations need to be absorbed by the individual provider. However, these fluctuations have been found to be no more variable than the variability seen in traditional models where the number of "over-books" is balanced against a high no-show rate.

The organizations that have moved along the access improvement continuum toward these Advanced Access models have enjoyed improved patient satisfaction, a reduction in cost, a higher likelihood that patients will see their own provider for all visits and improved staff and provider satisfaction.

In summary, access is determined by capacity. In traditional models capacity is gained by adding more work onto already saturated schedules. The theme for these systems is: " do last month's work today." In first generation open access systems (carve out models), capacity is gained by holding/preserving/ reserving appointments in anticipation of predicted same day demand. The theme is: "do some of today's work today." In Advanced Access systems, capacity is gained in the future by doing all today's work today and hence, the theme is: "do all today's work today."

Expected "Bumps"

Implementing these systems is not easy. It takes meticulous planning, patience, and confidence that it will work. It will. To look at access to care in this way requires looking through the patient's eyes, having faith in the predictability of demand based on sound measurement, and the perseverance to journey through some rough times. Backlog reduction may require more work for an extended period of time. Shifting accountability to management of a patient panel and away from appointment slots requires an understanding of populations and demand. Doing today's work today requires faith every day that there will be more work tomorrow. Implementing these systems requires supply side flexibility, the development of clearly defined contingency plans, continuous monitoring through measurement, and the development of teams.

Access Systems			
	Minimal Carve Out "Traditional"	**Carve Out** "First Generation"	**Open Access** "Second Generation"
	Full/Reservoir	Carve Out (partial reservoir)	Create (counter intuitive)
Primary sorting/ matching criteria	PCP/Clinical	Clinical/PCP	Provider Presence
Overflow/Full	♦ Urgent Care ♦ ED ♦ Future ♦ Provider Choice	♦ Other Providers (adverse reward) ♦ Urgent Care ♦ ED ♦ Future ♦ Evenings	♦ None ♦ Future: Provider driven/ member driven
Accountability	Appointment slots	Appointment slots	Panel
Unique Issues	♦ Access provider driven and poor	♦ Mismatches ♦ Tension ♦ Third appointment type ♦ Long queue for routine ♦ Crunch ♦ "Black Market" (recalibrate)	♦ Supply side/variability ♦ Limited by panel size ♦ Need to tolerate variability

WHAT DOES IMPROVED ACCESS MEAN?

What does improved access mean from the following perspectives?

Patients: "I can be seen on the day I call by the person I wish to be seen by."

"I no longer struggle with frustrating triage systems."

Providers: " I do today's work today, spend less time explaining scheduling delays to patients and end my day more predictably day to day."

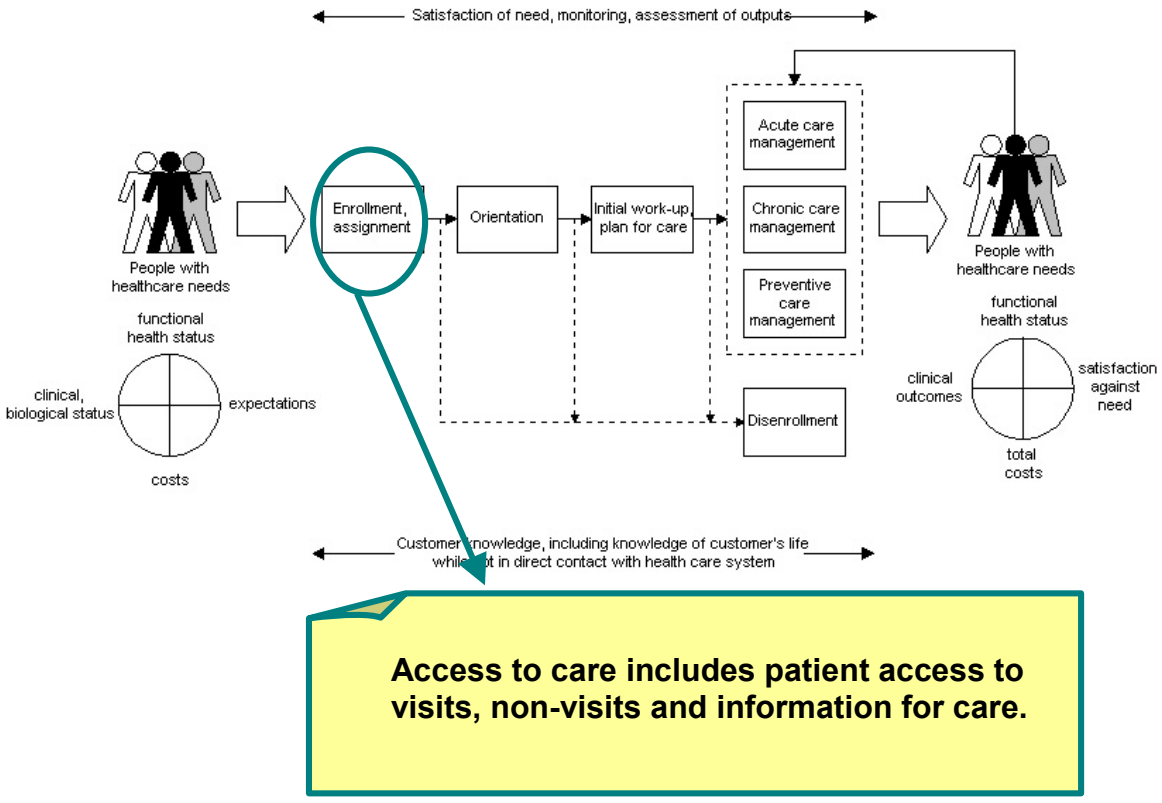
Scheduling Staff: "I spend less time triaging and arguing with patients on the phone. I no longer spend time chasing down providers trying to squeeze in patients. I no longer spend time working around a rigid scheduling system trying to game the impossible appointment slots. I enjoy my job much more, being able to meet patient needs in a short conversation."

RNs/Nurses: "Limited triage is needed since patients can be seen. I have more time to make valuable contributions to patient care based on my education, training and licensure."

Staff: "We are enjoying a happier work environment, less angry patients, less time spent on scheduling and fewer no-shows which used to be a time waster for us."

"We have greater office efficiency and predictability of our work days."

This graphical display shows the high level journey of a patient through a care experience. The first step is for the patient to gain entry or access to the system.



IMPROVING PATIENT ACCESS TO CARE

Action Plan

1. **Pre-work Review**
   - ❑ Assessing Your Practice – Practice Profile
2. **Know Your Demand**
   - ❑ Panel Size
   - ❑ True Demand
   - ❑ External Visit Demand
   - ❑ Patient Preferred Scheduling
   - ❑ Internal Visit Demand
   - ❑ Clinical Triage Telephone Tracking
   - ❑ Non-Visit Demand
3. **Know Your Practice Capacity**
4. **Shape and Reduce Your Demand**
5. **Increase Your Supply Capacity**
   - ❑ Provider schedules and time off
   - ❑ Maximize roles in the practice
   - ❑ Utilize Guidelines and Protocols
   - ❑ RN Triage and Phone advice
5. **Work Down the Backlog**
6. **Plan for Contingencies**
7. **Redesign Your System**
   - ❑ 1. Maximize Roles
   - ❑ 2. Protocols
   - ❑ 3. Separate responsibilities for visit and non-visit activities
   - ❑ 4. Synchronize Patient, Information and Provider
   - ❑ 5. Evaluate Key Supporting Processes to Identify Waits, Delays and Inefficiencies

Practice Profile

Aim: Provide an organized method to assist practices in collecting information and data to identify opportunities which can lead to a master schedule which accurately matches supply and demand in the most efficient manner.

Site Name:	Site Contact:	Date:

Ⓐ *Know Your Patients:*

Take a close look into your practice, create a "high-level" picture of your PATIENT POPULATION (panel) that you serve. Who are they? What resources do they use? How do the patients view the care they receive?

Est. Age Distribution of Pts:	%
birth - 10 years	
11-24 years	
25-64 years	
65+ years	
% Females	
Est. # (unique) pts. in Practice	

List Your Top 10 Conditions/Diagnoses	

❷ Access/Pt. Satisfaction Scores* (*Pg 5*)	% Excellent
Experience via Phone	
Length of time waiting during appointment	
Saw who I wanted to see	
Length of time to get appointment	

Patient Population	
# Pts. seen in a day	
# Pts. seen in last week	
# New pts. in last month	
# Disenrolling pts. in last month	
Encounters per provider per year	
Out of Practice Visits	
Hospitalization Rate	
Emergency Room Visit Rate	

Disease Specific Health Outcomes
Diabetes HgA1c =
Hypertension B/P =
LDL <100 =

List Your Top 10 High Utilizers Pts. who are frequent users of your practice services.	

Ⓑ *Know Your Practice*:

Create a comprehensive picture of your practice. Who does what? What hours are you open for business? How many and what is the duration of your appointment types? How many exam rooms do you currently have?

Current Team	FTE	Comment/ Function	3rd Next Avail.		❶ Cycle Time
Enter names below totals			PE	Non-Urgent	Range
MDs Total					
NP/PAs Total					
RNs Total					
LPNs Total					
LNA/MAs Total					
Secretaries Total					
Others:					

Does your practice meet regularly as a team? *(circle one)*

Yes **No**

Frequency:_____

Margin after Costs:

Do you offer any of the following? *Check all that apply.*

- ☐ group visit
- ☐ E-mail
- ☐ Web site
- ☐ RN clinics
- ☐ phone follow-up
- ☐ phone care management
- ☐ disease registries
- ☐ protocols/guidelines
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

Days of Operation	Hours Open
Monday	
Tuesday	
Wednesday	
Thursday	
Friday	
Saturday	
Sunday	
# Exam Rooms	

Practice Manager:

MD Lead:

Nurse Lead:

Appointment Type	Duration	Comment:

❺ Staff Satisfaction Scores (Pg 7)	Percentage
How stressful is practice? % Not:	
Recommend place to work? % Agree:	

Ⓒ *Know Your Processes:*

Track cycle time for patients office visit from the time they check in until they leave the office. Use Patient Cycle Tool. List Ranges of time per provider on the table.

Draft. Rev: 3/20/02

1. KNOW YOUR DEMAND

Panel Size

How many patients are in my care?

This measurement is used to identify the number of patients a particular physician is responsible for. In a fully capitated environment, it is easy to measure the size of the practice since patients must identify a primary care provider.

In a fee-for-service or mixed payer practice, it is more difficult to determine the panel size.

Why Measure Panel Size?

Understanding how many patients a physician is responsible for is the beginning step to population knowledge. With additional knowledge a practice can begin to develop new models of care matching patient needs and practice staff.

Suggested Process

Measure the number of "unique" patients seen over an 18 month period. Unique patients are different patients, not the visits. You can obtain a fair approximation of the panel size through this method.

Another method is to count the number of daily requests for appointments and then divide this number by .008 to get an approximate panel size. This denominator is used based on experience that .006-.008 of all patients will call for an appointment daily.

Example: Daily requests for appointments = 18 requests

18/.008 = 2250 approximate patients in the panel

Maintenance

Periodic measurement of panel size using the above process assists the practice to know if it is growing or decreasing.

Red Flags

The panel size is decreasing

- Suggests the practice is losing patients and more in-depth analysis needs to be completed to understand why patients are leaving or why patients are not seeking the practice for care.

The panel size is increasing

- It will be important to review the patient population and compare to the desired panel target size. Growing panels can be an indication of the success and desirability of a practice, new enrollment time of the year, high patient satisfaction, etc.
- It is important to always be mindful of the practice outcomes and satisfaction along with determining patient subpopulation care models to determine if the correct number of providers and support staff are in place to provide care.

True Demand

What is the True Demand of my panel?

True demand can be broken into true visit demand and true non-visit demand. What are the patients needs, the frequency, and volume of requests? The only way to know True Demand is to measure it, you **CANNOT USE HISTORICAL** data to determine demand, since historical data measures supply, not demand.

Why Measure True Demand?

If the panel size is known, then demand will arise out of it. Based on past research, typical daily demand of a mature system ranges from .007-.008 of the panel size.

Estimated Daily Demand = Panel size (x) .0075 - .0080

Suggested Process to Measure True Demand

Use visit demand worksheets to collect data on the following:

True Visit Demand (See External Visit Demand, Patient Preferred Scheduling Survey, and Internal Visit Demand worksheets)

External Visit Demand (including deflections[1])

Patient Preferred Scheduling Survey

\+ Internal Visit Demand

TRUE VISIT DEMAND

True Non-Visit Demand (See Non-Visit Demand and Clinical Triage worksheets)

Telephone Requests for non-visit activities

\+ Triage requests

TRUE NON-VISIT DEMAND

[1] Deflections are patients who go to the emergency room, urgent care, walk-in clinic, another provider, etc.

Measuring Visit Demand

Following are examples of visit demand logs which will help you track your visit demand:

- External Visit Demand Log
- Patient Preferred Scheduling Survey
- Internal Visit Demand Log
- Clinical Triage Telephone Tracking Log

External Visit Demand

External visit demand is generated by the patient, referring providers, emergency department, urgent care centers, and so on.

Suggested Process

The phone receptionists track all phone requests for appointments using the External Visit Demand Log to determine external demand for appointments.

External Visit Demand Log

External demand is the total of all demand on the practice. This includes requests made by phone, walk-ins, E-mail and Web requests, faxes, etc. External demand also includes those requests that are deflected to others such as Acute Care, Emergency Department and others. Put a tally mark in one of the listed categories each time the event occurs. Total the demand for the day, and then total for the week in each category. Note which days are "high volume" days. Monday, Tuesday and Friday are typical high volume days in clinical practice.

Practice Name: _____ **Dates: _____**

Day of Week	Walk-ins	Phone/V-mail req for appt.			Inpt Consult	E-Mail/ Web requests	Fax requests	MD Call Consults	Deflections				Other Request	Total
		Today	Tomorrow	Future					Acute Care	ED	Other			
Monday														
Total														
Tuesday														
Total														
Wednesday														
Total														
Thursday														
Total														
Friday														
Total														
Saturday/ Sunday														
Total														
Week Total														

Rev: 3/11/02

Patient Preferred Scheduling

This survey worksheet assists the practice in learning what patient demand for appointments really is. Track this for one week. The Schedulers script will assist in the utilization of this worksheet

Suggested Process

Schedulers Script for Discussing Appointments with Patients

This script is intended to guide appointment schedulers who are in the process of assisting the practice to determine WHEN patients really would like to be seen. Often, data is collected which tells us what the patient was given for an appointment, rather than what they would prefer. It feels awkward for schedulers to ask patients what they want and then not be able to give them the time/date the patient would prefer due to current scheduling practices. The following has helped many schedulers explain to patients what you are trying to do.

"Good morning, General Internal Medicine"

"We are in the process of trying to improve how we do scheduling in General Internal Medicine. I would like to ask you a few questions to help us improve how we do scheduling based on what you would like. I may not be able to give you the appointment that you would really like today, but we promise we are working on this for the future"

Do Survey

Give Appointment

"Thank you very much for helping us improve our scheduling process."

The attached survey can be modified as needed. It is important to learn if the patient could choose whatever appointment they wanted and document this finding.

Patient Preferred Scheduling Survey

Patient #	**Why** would you like an appointment? (What seems to be the problem?)	How **soon** would you like to be seen?	Do you have a preference as to **what day** you would like to be seen?	Do you have a preference for **what time** of day you would like to be seen?	Do you have a preference to what **provider** you see?	How **satisfied** are you with this appointment?	**Additional Comments**
1		Today Tomorrow days: 2 3 4 5 6 weeks: 1 2 3 4 months: 2 3 4 5 6 >6	Yes: M T W Th F S Su No	Yes: 8a-12p 12-4p 4p-5p 5p-9p other No	Yes Who?: No	Very Satisfied Satisfied Not Satisfied Very Dissatisfied	
2		Today Tomorrow days: 2 3 4 5 6 weeks: 1 2 3 4 months: 2 3 4 5 6 >6	Yes: M T W Th F S Su No	Yes: 8a-12p 12-4p 4p-5p 5p-9p other No	Yes Who?: No	Very Satisfied Satisfied Not Satisfied Very Dissatisfied	
3		Today Tomorrow days: 2 3 4 5 6 weeks: 1 2 3 4 months: 2 3 4 5 6 >6	Yes: M T W Th F S Su No	Yes: 8a-12p 12-4p 4p-5p 5p-9p other No	Yes Who?: No	Very Satisfied Satisfied Not Satisfied Very Dissatisfied	
4		Today Tomorrow days: 2 3 4 5 6 weeks: 1 2 3 4 months: 2 3 4 5 6 >6	Yes: M T W Th F S Su No	Yes: 8a-12p 12-4p 4p-5p 5p-9p other No	Yes Who?: No	Very Satisfied Satisfied Not Satisfied Very Dissatisfied	
5		Today Tomorrow days: 2 3 4 5 6 weeks: 1 2 3 4 months: 2 3 4 5 6 >6	Yes: M T W Th F S Su No	Yes: 8a-12p 12-4p 4p-5p 5p-9p other No	Yes Who?: No	Very Satisfied Satisfied Not Satisfied Very Dissatisfied	

Internal Visit Demand

Internal visit demand is the follow up appointments generated by the Provider. By measuring the number of appointments generated by the providers, you can begin to understand what the internal demand of a practice is!

Suggested Process

There are several ways to measure internal visit demand:

- Each provider tracks how many return visits they generate daily

  OR

- The scheduler tracks how many patients request a return visit by the Physician at the end of the visit

Internal Visit Demand Log

This tracking tool will help you in understanding the demand that is generated from within the practice. By provider, place a tick mark each time a follow up appointment is generated by a provider. Total the demand for the day, and then for the week for each provider. Note which days are "high volume" days. Monday, Tuesday and Friday are typical high volume days for office practices.

Practice Name: _____ **Dates:** _____

Provider	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Total
Total							
Total							
Total							
Total							
Total							
Total							
Total							
Total							

Rev: 3/11/02

Clinical Triage Telephone Tracking

Patient phone calls directed to the triage staff often result in many activities being conducted besides phone advice.

Suggested Process

Each triage staff member tracks resultant activity of the call to help further define visit and non-visit demand.

Clinical Triage Telephone Tracking Log

This tracking log will assist you in understanding the nurse triage phone call volume, why patients are calling, and what actions the RNs are taking. These data can help identify opportunities to change processes and roles to support the RN to function in a more appropriate role. Put a tally mark each time one of the phone calls is for one of the listed categories. Total the calls for the day, and then total for the week for each category. Note which days are "high volume" days and sessions which are high volume. Monday, Tuesday and Friday are typical high volume days in office practice.

Week of: _____	Phone Advice		Need to check with Provider for advice		Message for Provider		Appointment for Today		Appointment for Tomorrow		Appointment for Future		Test Results		Prescription Refill		Referral Information		Other		Other		TOTAL
	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	
Monday																							
Total																							
Tuesday																							
Total																							
Wednesday																							
Total																							
Thursday																							
Total																							
Friday																							
Total																							
Saturday/ Sunday																							
Total																							
Weekly Total																							

Measuring Non-Visit Demand

Following is an example of the Non-Visit Demand Log which will help you track your non-visit demand:

Non-Visit Demand

Patients have many needs that don't always require a visit but do generate activities that the staff must complete.

Suggested Process

Telephone receptionists or schedulers should use this worksheet to track non-visit demand of the practice. Knowledge of this will help to redesign processes and match practice resources.

Non-Visit Demand Log

Demand on the practice can also be generated by non-visit requests. Such requests can be for prescription refills, lab results, insurance form completion, etc. Put a tally mark in one of the listed categories each time the event occurs. Total the demand for the day, then total for the week for each category. Note which days are "high volume" days. Monday, Tuesday and Friday are typical high volume days in the office practice.

Practice Name: _____ **Dates:** _____

Day of Week	Prescription Refill	Test Results	Need Information	Form Request	Referral Info	Msg for Provider	Talk with Provider	Nurse Triage	Misdirected Calls		Other Request	Total
Monday												
Total												
Tuesday												
Total												
Wednesday												
Total												
Thursday												
Total												
Friday												
Total												
Saturday/ Sunday												
Total												
Total												

Rev: 3/11/02

2. KNOW YOUR PRACTICE CAPACITY

"What resources do we have available to meet our patient needs?"

- Office hours of a practice
- Appointment types, lengths, and frequency
- Staff schedules
- Provider availablity and schedules

All set the framework for improving capacity to better meet the needs of patients

Use the following worksheet to document your current days and hours of being open. Also list your appointment types and lengths.

Days of Operation	Daily Operational Hours
Monday	
Tuesday	
Wednesday	
Thursday	
Friday	
Saturday	
Sunday	
Number of Exam Rooms	

Appointment Types	Duration	Comment

Appointment Types, Lengths and Frequency

Over time, many practices have created a plethora of appointment types to sort patient requests and to meet individual provider preferences. Gaining insight into how many different appointment types, along with the variation in lengths of appointment types among providers will give clues that will help you begin to decrease the variation to improve efficiencies. Decreasing the number of appointment types and using "building blocks" of time such as 10 to 15 minute blocks to build appointment times will result in less frustration for schedulers trying to provide patients with appointments, happier patients, and more efficient processes.

Practice Staff FTEs[2]

Practice capacity includes all roles and functions. Use the following Practice Staff FTE worksheet to list current resources in your pratice.

Practice Staff FTE Worksheet

Your Current Team Members	FTE	How Does this Role Support the Clinical Microsystem Aim?	How Do You Use Information Technology to Support Your Role and Care Delivery?
Enter names and total FTEs			

[2] FTE is Full Time Equivalent. It is the percentage of time a provider engages in an activity based on 1.0 being a full time equivalent.

Practice Supply Worksheet

Once you have a basic understanding of who is in your practice, you can gain further insight by filling out the Practice Supply Worksheet.

Practice Supply Worksheet

Clinical Group	Clinical FTE *face-to-face pt. time	Sessions/Week	Hours/Week	Total Hours
List each person by name	Insert Clinical FTE by each individual	Insert # of sessions/week by individual	Insert # hours/week by individual	Insert total hours by group/week
Physicians ◆ ◆ ◆ ◆ ◆	◆ ◆ ◆ ◆ ◆	◆ ◆ ◆ ◆ ◆	◆ ◆ ◆ ◆ ◆	**Physician Total:**
NP/PA ◆ ◆ ◆ ◆ ◆	◆ ◆ ◆ ◆ ◆	◆ ◆ ◆ ◆ ◆	◆ ◆ ◆ ◆ ◆	**NP/PA Total:**
RN ◆ ◆ ◆ ◆ ◆	◆ ◆ ◆ ◆ ◆	◆ ◆ ◆ ◆ ◆	◆ ◆ ◆ ◆ ◆	**RN Total:**
MA/LVN/LNA ◆ ◆ ◆ ◆ ◆	◆ ◆ ◆ ◆ ◆	◆ ◆ ◆ ◆ ◆	◆ ◆ ◆ ◆ ◆	**MA/LVN/LNA Total:**
Other ◆ ◆ ◆ ◆ ◆	◆ ◆ ◆ ◆ ◆	◆ ◆ ◆ ◆ ◆	◆ ◆ ◆ ◆ ◆	**Other Total:**

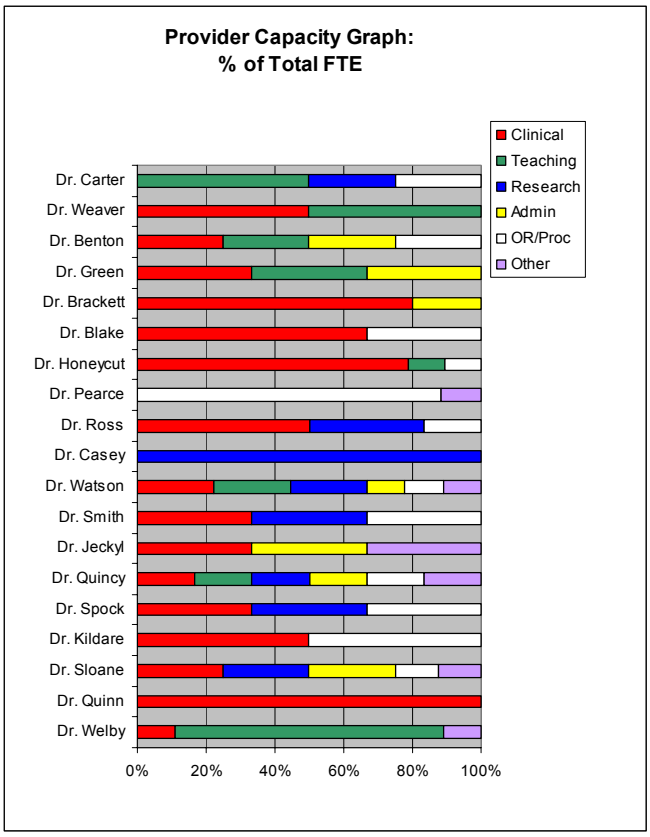
Once you have completed the Practice Supply Worksheet, review the practice supply by day of the week and by sessions to identify variation in supply of the practice. Once you have identified certain days or sessions that do not have consistent numbers of providers, the schedules should be adjusted to smooth out supply.

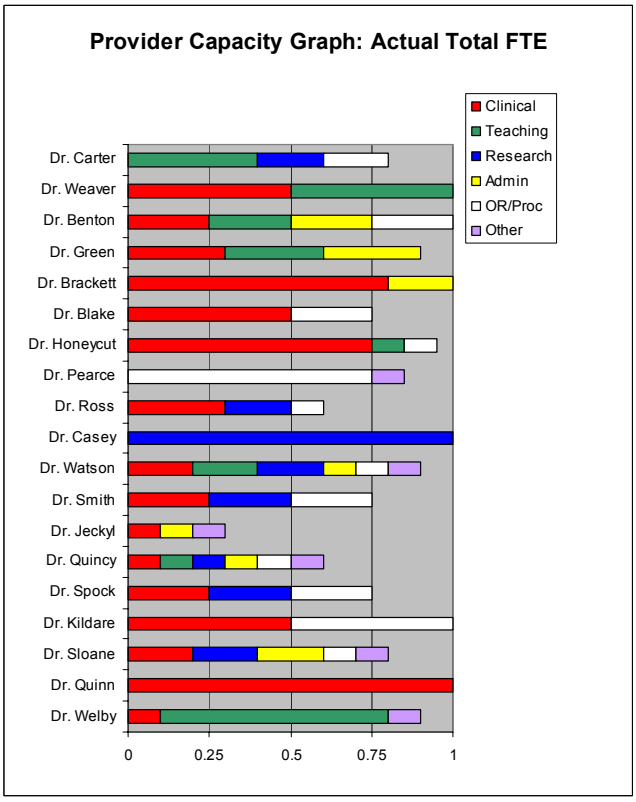
Through FTE[3] analysis, practices often learn that providers have competing interests and the amount of time available for clinical care may be less than expected. The following table is an example of providers in an academic setting.

Practice Capacity Graph Tool from Excel

	Clinical	Teaching	Research	Admin	OR/Proc	Other	Total FTE
Dr. Welby	0.1	0.7	0	0	0	0.1	0.90
Dr. Quinn	1	0	0	0	0	0	1.00
Dr. Sloane	0.2	0	0.2	0.2	0.1	0.1	0.80
Dr. Kildare	0.5	0	0	0	0.5	0	1.00
Dr. Spock	0.25	0	0.25	0	0.25	0	0.75
Dr. Quincy	0.1	0.1	0.1	0.1	0.1	0.1	0.60
Dr. Jeckyl	0.1	0	0	0.1	0	0.1	0.30
Dr. Smith	0.25	0	0.25	0	0.25	0	0.75
Dr. Watson	0.2	0.2	0.2	0.1	0.1	0.1	0.90
Dr. Casey	0	0	1	0	0	0	1.00
Dr. Ross	0.3	0	0.2	0	0.1	0	0.60
Dr. Pearce	0	0	0	0	0.75	0.1	0.85
Dr. Honeycut	0.75	0.1	0	0	0.1	0	0.95
Dr. Blake	0.5	0	0	0	0.25	0	0.75
Dr. Brackett	0.8	0	0	0.2	0	0	1.00
Dr. Green	0.3	0.3	0	0.3	0	0	0.90
Dr. Benton	0.25	0.25	0	0.25	0.25	0	1.00
Dr. Weaver	0.5	0.5	0	0	0	0	1.00
Dr. Carter	0	0.4	0.2	0	0.2	0	0.80

[3] FTE is Full Time Equivalent. It is the percentage of time a provider engages in an activity based on 1.0 being a full time equivalent.





3. SHAPE AND REDUCE YOUR DEMAND

"How can we manage our demand differently?

Once you understand your true demand, you can begin to explore ways to decrease demand or manage it differently.

Changing scheduling and practice habits is not easy. Key to successful improved access implementation is reviewing how providers currently practice and schedule. Change ideas include the following:

- *Decrease appointment types.*
  Over time, many practices have created multiple appointment types to meet individual provider preferences and to sort patients and reasons for appointments. Schedulers have a daunting challenge, spending much of their time trying to match patient need with the list of appointment types.

  Standardizing appointment lengths is also important to keep supply constant and provide less confusion for schedulers. Many practices use "building blocks" of 10 or 15 minutes. If a practice decides to standardize appointments from 20" to 15", the practice gains 36 appointments per week.
- *Eliminate automatic return visits at standard intervals*
- *Increase intervals for return appointments*.
  Instead of automatically rescheduling patients for 3 months, first question if the follow-up is really needed, and then consider extending the interval to 4 months. If you had 10 patients in a week's time that were rescheduled for 4 months instead of 3, you would gain 2.5 appointments per week.
- *Utilize alternatives to face-to-face office visits such as phone calls, E-mails and group visits.*
  Consider interacting with patients in a different way. Maybe an RN could do some follow-ups by phone or a visit rather than an interaction with the provider. E-mail or a website can provide an alternative to visits. In some cases, a patient could be instructed to call if they experience certain symptoms or make certain observations rather than automatically scheduling a visit. Provide group visits for subpopulations of patients, offer advice when appropriate via the phone and increase interactions via the web or E-mail.
- *Maximize actions at each visit.*
  If activities are scheduled for a future appointment, do it at the current appointment so the future appointment can be cancelled. Do as much as you can with patients at every visit rather than reschedule in the future.
- *Optimize patient involvement in their care, utilizing educational materials to increase patient knowledge, which can lead to an increase in self care.*
  If a practice can distribute common illness brochures or booklets, the patients can be better informed and better able to care for themselves before contacting the provider.

  For example, if a practice distributes brochures on upper respiratory infections, pharyngitis, etc, at the beginning of the fall the patient can engage in self care before calling the practice.
- *Nurses can manage subpopulations of patients*.
  An example in one clinic, the RNs manage the care for stable patients with congestive heart failure, hypertension, hyperlipidemia, and anticoagulation therapy (coumadin). In collaboration with the provider, plans of care are developed with guidelines which support the RN providing care as defined.

4. INCREASE YOUR SUPPLY CAPACITY

"What are the options besides hiring additional staff do we have to increase our capacity?"

Maximizing provider and staff schedules, patient scheduling systems, optimizing roles in the practice and designing idealized processes lead to increased supply and capacity. Staff schedules should be consistent to meet patient needs. Supply needs to meet demand.

Provider/Staff Schedules and Time Off

A few ideas on how to increase supply/capacity of your practice include:

- Once you review the scheduling of providers and match the availability to the patient need, some providers may need to work different sessions or days. Providers who are in surgery or do procedures, outreach, or have administrative time should review the scheduling of these activities and determine if there might be an option to move the occurrence of the activities.
- The above is true for all staff in the practice and should be evaluated.
- A clear practice for "time away" that contains contingency plans to meet patient needs should be in place. Many practices determine the maximum number of providers who can be absent at one time. A request policy and process should be in place to help keep minimum numbers of providers in the practice. Frequently, practices will require 3 - 12 months advanced notice of intended time away.
- A process should be developed to create a proactive plan to manage patient demand while providers are absent from the practice.
  - The following is a helpful process to manage time away:
    - The week after the provider is scheduled to be off, the provider's schedule is "frozen" for no scheduling
    - During the week of the provider's absence, the AM session is unfrozen and can be used for scheduling.
    - The week the provider returns, the PM session is unfrozen to accommodate same day requests.

Maximize Roles in the Practice

Maximize the role functioning in the practice to *ensure "the right person doing the right action at the right time*."

- Leverage each team member's abilities.
- Preserve the relationship with the patient through the physician educating the patient about alternatives to care within the practice and maximizing roles. This helps keep the patient honest and not "stretch" the truth when requesting services.

Suggested Process

- Sort functions within the office to create "work stations" to design standardized ways to do processes.
- Create a role for MAs to manage all the paper needs within the practice and manage messages, prescription renewals, test result reporting.
- Design a role for MA/LPN/LNAs to be responsible for the flow of patients through the office during a visit. Standardize steps of the visit that all support staff can be oriented to and be held accountable for through performance management.
- Develop a role for RNs to manage subpopulations of patients, e.g. Nurse Clinic.

Utilize Guidelines and Protocols

Use of guidelines and protocols will help increase visit capacity by standardizing care which may be given over the phone. Roles are freed up to see other patients in the practice.

Physicians and other health care professionals have developed health care guidelines based on the best scientific evidence. These guidelines provide a standardized way to respond to patients and give consistent information and advice.

Suggested Process

More than 45 guidelines for the prevention or treatment of specific health conditions are available through ICSI to view and download. www.icsi.org. The practice can use these guidelines as a "spring board" to help generate consensus and a possible adapted guideline which fits the practice needs.

- UTI, hypertension, hyperlipidemia, otitis media, sinusitis and pharyngitis are a few examples.
- The RNs discuss guidelines and protocols with the patients.
- The clinical team reviews the guidelines and protocols to gain team consensus.

RN Triage/Phone Advice

The RN Triage role is a clearly outlined role and process for providing care and advice to patients, using agreed upon guidelines from the providers

Suggested Process

- Follow the ICSI guidelines mentioned in the Guidelines section earlier in this chapter.
- Utilizing electronic templates to simultaneously document triage care while talking with the patient improves efficiency
- The number of triage RNs available should be matched by the demand of patients which varies by day of week, hour of day, and if post holiday. Flexibility is the key.
- Key to the morale of nurses is ensuring involvement in providing direct patient care in the practice. Optimizing the RN role can increase capacity in the practice.

5. WORK DOWN YOUR BACKLOG

How many patients are booked at some future time or are on a waiting list to be seen?

Backlog

The backlog of your practice consists either of patients waiting to be scheduled or patients who have been scheduled into the future. Some of the future appointments are appropriate, such as age-specific exams, but much of the future appointments are placed there because of the saturated schedule today. Backlog consists of:

- The number of appointments in the future weeks/days waiting to be seen by the provider.
- Appointments we could do today, but are currently deflected to other areas or in the future.
- Appropriate backlog: Patient driven – declining appointment offer of today and provider driven returns which includes clinical visits driven by prescribed intervals, e.g. prenatal exams, follow-up visits.
- Inappropriate backlog: Any work deflected from the past into the future, anything we could have done today if the patient would have been seen today.

Suggested Process: Backlog Worksheet

1. Determine Your Backlog
   What is your Backlog that must be reduced before being able to do "today's work today?"
   - Review patients with future appointments or on waiting lists
     - Does this patient really need an appointment?
     - Has the patient's needs been met and do they no longer need the appointment?
     - Can patient needs be addressed by a phone call?
     - Can someone else on the care team provide the care?
     - Determine if a patient in today's schedule could have future needs taken care of today to eliminate the need for future appointments

2. Develop a Strategy to ***TEMPORARILY*** increase supply to manage the backlog of patients.
   Develop a strategy to work down the backlog that includes a starting and ending date.
   - Determine a start date to start the backlog reduction and a date to target backlog reduction completion.
   - Determine how many patients need to be seen in order to meet the deadline
   - Providers need to choose how to work down the backlog:
     - Add sessions to days
     - Add sessions on weekends
     - Add hours at the beginning or end of the day
     - Use lunch time
     - Use administrative time
   - Other temporary strategies to consider include:
     - Add appointments
     - Add a care team member – temporary hire
     - Temporarily close the practice
     - Temporarily off-load teaching (academic setting)

Some providers have lifestyle preferences and are unable to work down backlog – which means the provider will work longer hours to see all patients who want to be seen in the same day along with the backlog.

Providers who choose to work down backlog reap the benefits of putting in the extra time in advance.

Backlog Reduction Worksheet

Backlog Calculation/Reduction Worksheet

Complete this worksheet for EACH provider in the practice.

Provider Name: _____ **Current Date**: _____

Backlog: *Fill in the number of backlogs to the right of the category, then add for the Total*

New Patients:
PE:
Follow Up:
Other:

TOTAL BACKLOG: [ ] ❶

Introduction: The steps here will help you understand and work to reduce your backlog.

Step #1	Step #2	Step #3	Step #4
Review Future Schedule with provider to determine appropriateness of appointments. Some patients might have been seen recently and don't need the appointment, some patients might be able to receive a phone call instead of the visit. Enter below the total number of patients removed from each category **Total:** _____ ❷	Review the Pending lists, Reminder lists, lists of patients waiting for appointments using the same criteria as looking at the future appointments. Enter the total number of patients removed from each category. **Total**: _____ ❸	**Add** your totals from **Step #1** and **Step #2** (❷ & ❸): ❷ + ❸ _____ ❹ **Subtotal** Subtract the **Subtotal** ❹ from the **Total Backlog** ❶ to obtain Real Backlog Total. ❶ - ❹ _____ **Total Backlog by Category**	Calculate the number of appointments and sessions needed to see the patients left on the backlog. # of Appointments = # of Sessions =

- Make a plan for reducing your backlog
- Develop your plan
- Determine how you will work down the backlog - Temporary capacity or demand alternavites. e.g. Refer to Increase Capacity or Decrease Demand Sections.
- Review the following ideas to help determine what is the best for you and the team. These are typically TEMPORARY for a period of time.
  - Add sessions to days
  - Add sessions on weekends
  - Add hours at beginning/end of the day
  - Use lunch time
  - Use administrative time for patient time if possible

In addition, here are some other strategies:
- Add appointments
- Add a care team member - temporary hire
- Temporarily close the practice
- Temporary off-load teaching

My Plan to Work Down the Backlog:
Backlog reduction Start Date: _____
Backlog reduction End Date:_____

6. PLAN FOR CONTINGENCIES

What can we proactively plan to do in certain situations?

Contingency Plans

A contingency plan is a plan of action that can be used in the event of unplanned demand or decreased supply in order to meet patient needs.

Why Plan for Contingencies?

Contingency plans are developed by the team to ensure flexible responsiveness to variation in patient demand, specifically additional demand. Contingency Plans are proactive methods to implement; yet repeated use of them can add additional stress on the team and requires re-evaluation of the practice demand and supply. The unexpected is often predictable and the practice should be able to be plan and act in a pro-active fashion.

Suggested Process

- Daily huddles at the beginning of the workday and throughout the day to review the patient appointments for the day and proactively match demand to supply. (See Huddle Sheet, pg 30.)
- Develop time away processes with proactive planning to accommodate demand during provider absences.
- Develop flexible, multi-skilled staff who can respond as needed to meet patient demands and needs. This will require training for staff to help them know each other's jobs so when needed, they can step in and provide additional resources.
- Manage demand variation in a pro-active fashion. Once the practice is aware of variation in demand, it becomes the work of the practice to adjust supply according to the predictable demand fluctuations. The practice learns to plan pro-actively rather than react in a non-productive fashion.
- Add more appointments at certain times. Again, based on the demand of the patients and being able to predict seasonal fluctuations, the practice may need to add additional appointments throughout the year. Examples of this would be adding a flu shot clinic in the fall, or doing a physical "fair" during the summer for children needing sport physicals.
- Plan for predictable seasonal increases/decreases. If the practice plans according to demand knowledge, additional appointment times could be added, additional staff could be obtained, vacation time might be encouraged during known "slow" periods for the practice.
- Anticipate unusual, but expected events. Plan for the predictable. If certain patients bring extra family members for their visits, identify this early in the practice and plan accordingly by adding additional time. If some patients are chronically late, plan accordingly.

Huddle Sheet Example 1

Huddle Sheet

Practice: _____ **Date: _____**

Follow ups from Yesterday
"Heads Up" for Today: (include sick calls, special patient needs, staff flexibility, contingency plans)
Meetings:
Review of tomorrow and Proactive Planning

Rev: 3/26/02

Huddle Sheet Example 2

Huddle Worksheet

Practice: _____ **Date:** _____

	Day	Schedule (Specify # of each type) FU	Schedule (Specify # of each type) New	Open Appts	Pt Cancel	Pt No Show	Don't Need to See Pts	# Pts Resched for Later Date	# Appts ID'd and Filled	# Pts Taken Off Backlog	Sched Review with Provider	Patient Specific Actions/Contingency Plans
	Yesterday											
1												
2												
3												
4												
	Today											
5												
6												
7												
8												
	Tomorrow											
9												
10												
11												
12												

Comments/Plans/Goals

Meetings:

Staff:
- Sick Calls
- Time away

Rev: 3/26/02

7. REDESIGN YOUR SYSTEM

"How can we increase our practice efficiency and quality while increasing patient satisfaction and staff morale?"

Redesign of your practice involves critically evaluating current processes, systems and roles. Once the evaluation or "diagnostic phase" is completed, you can begin to develop tests of change to implement new processes, systems and models of care.

Eliminating variation in practice and standardizing treatment for common illnesses can improve efficiency in the practice.

Capitalizing on electronics and other tools to help cumbersome processes become more efficient and changing physical space and flow of patients can improve office efficiencies and outcomes and improve morale of the staff.

Creating ideal and efficient office practices begins with exploring processes and roles within the practice to identify opportunities to make improvements and increase efficiencies of the office. The office environment should be viewed as systems of "continuous flow." Seamless handoffs, exceptional customer service, and efficient practices to meet patient needs should be the goals of the clinical teams. The office practice environment is a living system that requires constant monitoring and adjustments of sub-processes to create an ideal office practice.

1. Maximize Roles

Reviewing roles of staff in the practice to understand if training, education, and licensure are being optimized for each role can provide opportunities to design new roles and expectations. Clinical teams need to take the time to "reflect" on their current processes within the practice and be challenged to identify change ideas to test to improve the office environment. These clinical teams include every member of the office practice from the receptionist/secretary, RN, MA, LPN, LNA, and all providers. Every member has a valuable contribution to make in this system.

Ensure all of the roles in the practice are maximized to meet patient needs. Several methods to determine this is the use of Activity Surveys and review of state regulatory bodies in relation to professional licensure and scope of practice, and determine the gap in current practice. Once this is determined, roles can be re-explored to better meet patient needs (see Activity Sheet example, pg 33).

Activity Sheet Example

Activity Survey - Blank Forms

Position: ***Providers*** MD NP PA Resident (Circle One) Name:_____

Instructions: The purpose of this worksheet is to gather data on the amount of time you spend performing various activities. Please indicate (estimate) the percentage of time spent performing each activity listed below. Keep in mind, we are seeking to obtain data related to a "typical" period of work. Estimate the average amount of time, over the course of a typical work period (e.g. a week or a month), you spend on the activities listed on the attached table. Try not to represent either a worst case scenerio (i.e., a crisis) or a best case scenerio. Estimate the average amount of time (as a percentage of your total time) you typically spend on these activities during a "normal" period. This is not a detailed time study. If an activity you perform is not included, please add to the list. Make sure that all of your activities are included. The sum of "% of your time" column should equal 100%.

Activity	% of Your Time
See Patients in Clinic • review chart history • assess/ diagnose patient • determine treatment plan	
See Patients in Hospital • •	
Dictate/Document Patient Encounter • dictate encounter • review transcriptions & sign off	
Write Prescriptions • •	
Complete Forms • referrals • camp/ school physicals	
Follow Up Phone Calls • answer patient messages & requests	
Evaluate Test Results • review results and determine next actions	
Manage Charts • •	
Miscellaneous • CME; attend seminars; attend weekly meeting • • •	
TOTAL	**100%**

2. Protocols

Use standard protocols to optimize use of other providers (nurse, nurse practitioner, and physician assistant). Identifying high volume diagnoses in the practice that patients might benefit from a protocol or guideline which has been agreed upon by the providers in the practice can increase efficiency of the practice. Evidence based guidelines for common ailments can be found at www.ICSI.org

3. Separate responsibilities for visit and non-visit activities

Key to successful high performing practices is the separation of visit and non-visit activities for support staff. A medical assistant who is attempting to escort patients into exam rooms, do vital signs, prepare the patient for the provider visit AND finish forms, do test reporting, prescription refills, referrals forms and other functions can not be efficient.

Separation of the visit and non-visit activities leads to shorter turn around times for activity completion, happier staff and happier patients. Practices usually rotate staff a minimum of weekly to the two functions.

4. Synchronize Patient, Information and Provider

- *Start on time*

  First AM, PM and evening appointments need to start on time. Experience has shown when the session starts late, the whole day continues to be late and never catches up. It is important to explore reasons for late starts. Causes can range from the patient arriving late, equipment, supplies or information not present for the appointment to providers or support staff not being ready to start or not being physically present. To ensure starting on time, the practice needs to agree philosophically to the importance of starting on time. Exploring causes of not beginning on time through data collection and brainstorming can help the practice find opportunities to improve and meet the goal of starting on time.

- *Registration by phone*

  If the practice calls several days or the night before an appointment, this would be a perfect time to add more value to the phone call and confirm and update patient registration information in advance of the appointment rather than on the day of the appointment. This new process would eliminate the step of registration at the check-in of the practice.

- *Chart review to make sure chart is complete, accurate and present for the appointment.*

  Ensuring all information is present to enhance the patient visit is key. Support staff should determine when the chart review will occur, the day before or the morning of the appointment, and allot appropriate time to do a thorough review of the chart identifying labs, diagnostic studies, and other pertinent information is present for the patient and the provider. Eliminating waste of time and delays through this process increases the practice efficiencies.

- *Health checklists to ensure needs are covered*

  Identifying key health prompts can ensure comprehensive care delivery without waste or re-work later. Identifying checklists for patients with diabetes, CHF, or hyperlipidemia help ensure all necessary care is delivered. Also, the use of age-specific preventive guidelines helps to plan for the day visits. (See Health Checklist Example, pg. 35)

Health Checklist Example[4]

Preventive Health Recommendations

FOR AGES: 25-64 years

Name:	DOB:		Record #:	
Home Phone:	Work Phone:	G:	P:	AB:
Allergies:			Pharmacy used:	
Grade/Degree completed:	Occupation: ( ) Current ( ) Retired			
No. of Children at home and birth year(s):				
Nearest relative:	Relationship:	Home Phone:	Work Phone:	
FAMILY HISTORY Mother:	Father:	Brothers/Sisters:		

PHYSICAL & HISTORY	last	2002	2003	2004	2005
Age					
Physical					
Blood pressure					
Breast/testicular exam/DRE (20-35 yrs, hx of undescended testes/testicular atrophy)					
Height (in.)					
Weight (lb.)					
Tobacco status					
TESTS	**last**	**2002**	**2003**	**2004**	**2005**
Cholesterol (every 5 years)					
Mammogram (women ages 50-69 every 1-2 years)					
Pap smear & pelvic exam (every 3 yrs; exception of post hysterectomy with cervix removed, nonmalignant)					
Fecal occult blood (> 50 yrs)					
Flexible sigmoidoscopy (50 yrs as indicated)					
COUNSELING	**last**	**2002**	**2003**	**2004**	**2005**
Tobacco use					
Substance abuse (drug, alcohol)					
Diet					
Injury prevention					
Dental health					
Sexual practices					
Exercise					
Breast/testicular self exam					
Domestic Violence					
Calcium/Vitamin D					
Hormone prophylaxis (peri-and postmenopausal women)					
Durable power	DP Name:				
	DP Phone #:				
Living Will					
IMMUNIZATIONS	**last**	**2002**	**2003**	**2004**	**2005**
Td					
Rubella					

ACTIVE PROBLEMS	ONSET	ACTION	RESOLVED
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			

CONSULTATIONS		
Name	Specialty	Date

SURGERY	DATE

MEDICATIONS					
Name	Strength	Freq.	Orig.	Renew	Dc'd

[4] From the US Preventive Services Task Force *Guide to Clinical Preventive Services*, 2nd ed. Baltimore: Williams & Wilkins, 1996.

- *Rooming criteria*

  Rooming criteria includes having patient ready (e.g. shoes off for patients with diabetes). Standardizing the process for rooming patients by diagnosis increases efficiency and decreases variation in completion of necessary information and steps. Patient's don't necessarily need to be undressed to be ready for the visit, but knowing what would help the patient be ready for a more efficient visit with the provider would lead to smoother flow. (See Rooming Criteria, below)

Rooming Criteria Example

Rooming Criteria

Reason for Visit	Ht.	Wt.	Head Cir.	BP	Temp	Pulse	Resp.	Vision	Gown	Expose Area	Expose Feet	Allergy Check	Phone # Check	Health Maint. Forms	Immun. Forms	Diabetic Flow Sheet	Chaperone
New CPE (includes P/P & Annuals)	X	X		X	X	X	X		after Prov sees			X	X	X	X		X
Est. CPE (includes P/P % Annuals)	X	X		X	X	X	X		X			X	X	X	X		X
Schools/Sports/PE	X	X		X	X	X	X	X	X			X	X	X	X		X
Well Child Check	X	X		X	X	X	X		X			X	X	age specific	X		
Chief Complaint				X	X					X		X	X	X	X		
Adult																	
Pain, any system				X	X					X		X	X	X	X		
Respiratory		X		X	X	X	X					X	X	X	X		
Cardiac		X		X	X	X	X		X			X	X	X	X		
Dermatology				X	X					X		X	X	X	X		
Orthopedic				X	X					X		X	X	X	X		
Diabetic		X		X							X	X	X	X	X	X	
Children	X	X	<18m	3y+	X	X	X	5y+		X		X	X	X	X		
OMT				X								X	X	X	X		
Rechecks (depends on reason for recheck, use above criteria)																	
Repeat Pap		X		X					X				X				X
Breast Check		X		X	X				X				X				X
Follow up <3 weeks				X									X				
Lab Only													X				

When taking a BP, be sure to watch to see if the monometer reading returns to zero.

When weighing a patient, be sure to zero the scale first.

Staff to document reason for visit - providers to obtain history.

From: The Perfect Practice for an Efficient Physician by Sherry Anderson Delio, MPA, HSA, Used with permission

Unplanned Activity Card Example

One way to understand inefficient processes and interrupted flow is by using the Unplanned Activities Card.

The Unplanned Activity Form assists the team in identifying waits and delays in the process of providing smooth and uninterrupted patient care. Each provider carries the card during a patient session and documents when and why patient care is delayed or interrupted. Put a "tic" mark for each incident of unplanned activity, or Indirect Patient Care "Pulls". This collection tool can be adapted for any role in the practice to discover interruptions in workflow.

Once the interruptions or delays are uncovered, improvement ideas can be generated and tested.

Unplanned Activities/Indirect Patient "Pulls"

Provider Name: _____ Date:_____ Time:_____

Place a "tic" mark for each incident of an unplanned activity.		Total
• Phone Interruptions		
• Support Staff Interruptions		
• RN Interruptions		
• Provider Interruptions		
• Hospital Admissions		
• Patient Phone Calls		
• Pager		
• Missing Equipment		
• Missing Supplies		
• _____		
• _____		
• _____		

5. Evaluate your Key Supporting Processes to Identify Waits, Delays and Inefficiencies.

Improving key supporting processes of your practice will decrease or eliminate waits, delays and waste to improve patient care. Some key supporting processes to consider:

➢ Documentation

Concise and timely Medical Record documentation by providers and RNs through the use of templates, quicknotes, CIS and or consistent dictation is crucial to improving access.

Suggested Process

- Electronic templates decrease the amount of time it takes to enter patient visit information.
- Set the expectation that all providers will dictate, thereby eliminating hand written notes.
- Identify a standard practice outlining when to document within the office visit.

➢ Phone and Message Management

Create, manage and distribute appropriately all messages and communications for the office practice which frequently originate from the receptionists or RNs.

Suggested Process

- Decrease what goes across the provider's desk and increase efficiency through use of electronic systems, such as CIS.
- Eliminate paper messages and communications through the use of an IDX system which has synopsis, which are role specific.
- Design standardized ways for all providers to receive messages in action driven models. For example, 4 boxes in the provider office labeled:
  - Prescriptions
  - Test results
  - ASAP
  - Later"
- Provide template samples of correct message taking to insure completeness, accuracy, and ability to take action from the message.
- Design "rounding" through the practice into the paper flow role to distribute and retrieve messages from providers in a standardized and timely manner.

➢ Prescription Refill

Define an efficient and timely process to address patient needs to obtain prescription refills.

Suggested Process

- Be proactive through the use of standardized visit forms. Include asking patients about their medications and if they need prescription refills written at the time of the visit.
- Request patients bring all of their medications to their office appointments to allow for review of the medications and renewals as identified.
- Create a "Prescription" phone line to take messages from patients that includes all pertinent information.
- Communicate through patient newsletters or posters at the practice the need for patients to receive their renewals at the time of their visit.
- Print appointment reminder cards that include reminders about prescriptions.
- Identify a process to complete the renewal process, obtain provider approval, and communicate with the pharmacy. Include documentation within the medical record reporting prescription being completed.

➢ Diagnostic Test Reporting

➢ Referral Management Process

➢ Coding and Billing Process

➢ Patient Flow/Rooming Patients

See examples of rooming criteria, page 36.

➢ Standardize Stock and Inventories

- Standardizing supplies and inventory leads to decreased re-work, higher predictability of needed supplies being present, and less interruptions to the flow of patient care.
- Utilize the Unplanned Activity Card to determine what interrupts patient flow for your practice.(See the Unplanned Activity Card example, pg 37).
- Use open rooming to maximize flexibility. Providers no longer have only their own exam rooms. Using all exam rooms spread amongst the number of providers present each day maximizes space utilization and increases flow of care.
- Standardize supplies in rooms and have them stocked at all times. Providers need to come to a consensus on what the standardized supplies should be in the exam rooms to increase flexibility of room use. The practice needs to determine what the inventory levels will be in each room and how often they will be stocked and by whom. It is important to track the actual completion of stocking of the rooms to ensure this is being accomplished. See the Standard Room Stocking Checklist and Monthly Calendar examples.

Standard Room Stocking Checklist

Internal Medicine
Exam Room Checklist

Qty	Item	Qty	Item
3 boxes	Gloves	6	Stool cards & Developer
4 rolls	Gauze	2 boxes	Tongue Depressors
12	3 ml Syringe	2 pkgs	Cotton Balls
4 each	Blades, 10, 11, 15	2 bottles	Alcohol
4 pkg	4-0 Ethilon suture	1 bottles	Peroxide
10	20 Gauge needle	3 bottles	Sterile water
10	26 Gauge needle	24	Ear tips
1 vial each	1% & 2% lidocaine	2 tubes	K-Y Jelly
2 boxes	7 ½ Surgical gloves	2 rolls	Table paper
4	Sterile field	12	KOH slides
20 pkg	Iodine swab	4	Flow meters
2 boxes each	All size Band Aids	10	Capes
4 tubes	Bacitracin	12	Drapes
3	Surgical scrub brush	12	Gowns
4	Razors	2 vials	Saline
2 rolls each	All size tape	5	Ammonium chloride
12	Viral cultures (green)	12	Urine cups
12	BSS cultures (red)	12	Pap packs
12	Gen-probes (blue)	6	Speculums
2 boxes	Cotton tip applicators	1 tube each	Xylocaine gel (red & blue)

Daily Restocking Monthly Tracking Example

Placement of a calendar on the inside of a cabinet door of an exam room can help track restocking. Each day the exam room is restocked, the staff member signs off on the calendar.

Restocking Calendar

Month:_____Year:_____

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

➢ Receptionist Script for Improved Access and Scheduling

Providing a script standardizes a way for receptionists to interact and communicate with the patients to help meet their needs.

Suggested Process

- Provide receptionist with a collection of scripts they can reference to support their effective and informed communication with patients.
- An appointment "script" which asks the questions of the patient:
  - Would you like an appointment today?
  - Would you like advice from the RN?
  - Would you like to leave a message?
- A script describing "open access" for patients.
- A script that provides appointment booking guidelines can decrease variation in appointment usage.
- A script that describes how the clinical team functions and has details of the individual providers for patients looking for new primary care physicians.

8. MEASURES AND MONITORS (SEE MEASURING ACCESS IMPROVEMENT WORKBOOK)

"How will we know if our efforts to improve patient access to care is making a difference?"

As you work to improve your practice's access to care, you will want to know if the changes you are making are, in fact, making a difference!

The best way to know if your efforts are succeeding or failing is to have data over time showing trends on key access measures such as:

- Panel size
- Backlog
- 3rd available appointment
- Under and over counts
- Total daily visits
- Number of times contingency plan implemented
- Patient satisfaction
- Same day appointments daily/pre-books or future capacity
- No show data

Make a data plan to collect the essential data, to analyze it, to display it, and to feed the data back to users. A data management plan specifies who would collect what data, when, from what source, and specifies the methods for analyzing and displaying the data.

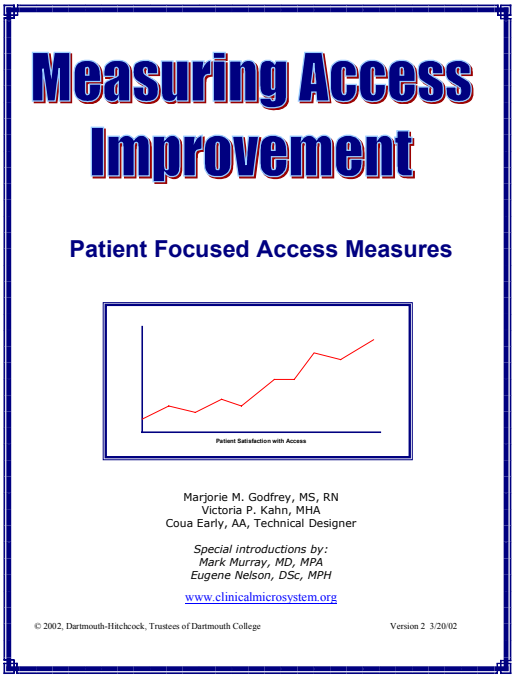
Measuring Access Improvement Workbook

The Measuring Access Improvement Workbook has been developed to help clinical practices measure and monitor their efforts in improving patient access to care.

It is designed to be used either as a hard copy notebook, or in an electronic format.

It is available as an Adobe Acrobat PDF file in the Special Topics section of the website:

www.clinicalmicrosystem.org



9. COMMUNICATION: PATIENT AND PRACTICE

How will our patients know their role in this new system? Some will argue not to tell the patients anything and allow them to learn through experience. Others will argue the importance of educating patients and helping them learn their new role and the new process of scheduling. Some teams have created materials to be shared with patients at the time they enroll in the practice which sets expectations for the patient and the practice in meeting patient access needs.

How will we communicate within our practice, local site, and larger organization? Communication through the effective use of team meetings, newsletters, flyers, and attendance at meetings throughout the organization are ways some teams have found to spread the news of progress, accomplishments, lessons learned, and data based reports. Communication fosters team building, improved levels of awareness, and a sense of being part of decision making. Identifying members of teams to present to organizational meetings helps to recognize the hard work of the teams and increases individual morale.

Patient Communication

Patients have been accustomed to established patterns of the practice. It is important to help them learn the new "way" of doing things.

Suggested Process

- Always try to give patients what they want.
- Give patients lots of alternatives: today with primary care physician, today with an associate provider, or other members of the team
- Develop scripts for secretaries to use in talking with patients.
- Develop scripts to use in talking with patients.
  - "Good morning, General Internal Medicine, this is Marcy, how can I help you?"
  - "We are in the process of trying to improve how we do scheduling here in General Internal Medicine. Would you like to be seen today, talk with a nurse, or leave a message?"
  - "Your doctor can see you at 3:00 pm today, or the nurse practitioner who works with him can see you any time this morning."
  - "If you would prefer tomorrow, your provider can see you anytime in the afternoon."
- Be careful when patients call for yearly exams, be sure 12 months have expired!

Practice and Organization Communications

It is essential for communication to take place within the practice and the organization.

Suggested Process

- Daily AM huddles to review patient schedules in the same day/coming week to gain insight into scheduling issues and opportunities. Use a cheat sheet to keep AM huddles on track. (See Huddle Sheet examples, pg. 30-31).
- Regular departmental meetings to keep team on track and provide opportunities to discuss issues/brainstorm/provide feedback.
- Organizational publications and newsletters.
- Attend other department meetings to share information and to encourage collaboration.

SPECIAL CONSIDERATIONS

Specialties

"What are the similar and unique aspects of improving patient access to specialty care?"

Organizations need to optimize the system in its entirety.

It is essential to view access to care as a systems issue. There is no value for an organization to improve access to either primary care or specialty care and neglect improvement in the other realm, or worse yet, to improve one to the detriment of the other. This is just optimizing a sub-system.

Access to specialty care may be an even more crucial determinant of success than access to primary care. It is at the point where our patients are referred from their primary care providers (where they have developed an ongoing relationship) to the Specialist, where they feel the most vulnerable and anxious. This is a key place to reduce all delay.

In Specialty care, while the same general access improvement principles apply, the implementation of improvement may differ. "Good access" is still the opportunity for our patients to get an appointment when they choose. In Specialty care, where often a previously established relationship does not exist, access to a specific provider is less important than the delay in accessing the care. At the same time, exemplary access still requires capacity and flexibility either in the Specialty department or with the individual specialists. The principles of matching supply to demand apply as well. The demand for specialty care differs from the demand for primary care in that demand comes both from the population and from referring primary care. The same principles are used in determining demand and supply in specialty care. However, it is important to break out specialty practice and measure subspecialty groups separately.

The supply process includes an investigation of office efficiency using very similar principles and investigative approaches as in primary care. Components include the variable visit rates amongst Specialists both pre and post procedure, the rate of "graduation" of patients back to the referring providers, the efficiency in other non-office based venues that effect the office attendance and finally, an investigation of leverage possibilities for the Specialty providers.

Apply the Change Concepts for Access Improvement

1. Pre-work Review
2. Know Your Demand
3. Know Your Practice Capacity
4. Shape and Reduce Your Demand
5. Increase Your Supply Capacity
5. Work Down the Backlog
6. Plan for Contingencies
7. Redesign Your System

READINGS AND RESOURCES

Resources used in this Guide

Case studies and helpful tools can be found in the IDCOP FieldGuide. A Guide to Idealized Design of Clinical Office Practices.

"Idealized Design of Clinical Office Practices: Themes, Measures and Processes," Donald Berwick, MD, Institute for Healthcare Improvement, Prototype Session 4, Lisle, IL, September 27, 1999. Video

Reducing Delays and Waiting Times Throughout the Healthcare System. Boston, MA. Institute for Healthcare Improvement, 1996.

Books

Anderson Delio, S. The Perfect Practice for an Efficient Physician. Englewood, CO. Medical Group Management Association, 1999.

Kotter, JP. Leading Change. Boston, MA. Harvard Business School Press, 1996.

Langley GJ, Nolan KW, Nolan TW, et al. *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance*. San Francisco, CA. Jossey-Bass, 1996.

Nelson EC, Batalden PB, Ryer J. *Clinical Improvement Action Guide*. Oak Brook Terrace, Illinois: Joint Commission on Accreditation of Healthcare Organizations, 1998.

Nolan T and Schall M. Guide to Reducing Delays and Waiting Times. Breakthrough Series Guides. Boston, MA. Institute for Healthcare Improvement, 1996.

Womack JP, Jones DT. *Lean Thinking: Banish Waste and Create Wealth in Your Corporation*. New York, NY: Simon and Schuster; 1996.

Womack JP, Jones DT, Roos D. *The Machine that Changed the World: The Story of Lean Production*. New York, NY: Harper Collins; 1990.

Recent Publications

Access Improvement

Murray M, Tantau C. Same-Day Appointments: Exploding the Access Paradigm. *Family Practice Management*. 2000, September.

Murray. M. Modernizing the NHS. Patient Care: Access. *British Medical Journal*. 2000, 320: 1594-6.

Buffalo News Editorial. You can see the doctor now. April 4, 2000 (Section B-2).

Grandinetti D. You mean I can see the doctor today. *Medical Economics*, March 20, 2000 (*pp. 102-114).*

Chesanow N. Pick the team, and write the game plan. *Medical Economics*. February 21, 2000. (pp. 75-84).

Lippman H. Same-day scheduling. *Hippocrates*. February 2000 (pp 49-53).

Terry K. Re-engineer your practice – starting today. *Medical Economics.* January 24, 2000 (pp. 175-188).

Lippman H. Practice in the twenty-first century. *Hippocrates.* January 2000 (pp.38-43).

Berwick DM, Kilo CM. Idealized Design of Clinical Office Practices: An interview with Donald Berwick and Charles Kilo of the Institute for Healthcare Improvement. *Managed Care Quarterly*. 1999; 7(3):1-8.

Murray M, Tantau C. Redefining Open Access to Primary. *Managed Care Quarterly*, August 1999.

Murray M, Tantau C. Same-Day Appointments Create Capacity, Increase Access. *Executive Solutions for Healthcare Management.* February 1999.

Murray M, Tantau C. Must Patients Wait*? Journal on Quality Improvement.* 1998, 24(8), August.

Boelke C, Boushon B, Isensee S. Achieving open access: The road to improved service and satisfaction. *MGM Journal,* September-October 2000 (pp58-68).

Measurement

Nelson EC, Splaine ME, Godfrey MM, Kahn V, Hess AR, Batalden PB, Plume SK: Using Data to Improve Medical Practice by Measuring Processes and Outcomes of Care. *Joint Commission Journal on Quality Improvement,* 26(12)667-685, December 2000.

Weinstein JN, Brown PW, Hanscom B, Walsh T, Nelson EC: Designing an Ambulatory Clinical Practice for Outcomes Improvement: From Vision to Reality - The Spine Center at Dartmouth-Hitchcock, Year One. *Quality Management in Health Care,* 8(2):1-20, Winter 2000.

Donaldson MS, Mohr JJ. Exploring Innovation and Quality Improvement in Health Care Micro-systems: A Cross-Case Analysis. Washington, DC: Institute of Medicine; 2000. A technical report for the Institute of Medicine Committee on the Quality of Health Care in America.

Arrow H, McGrath JE, Berdahl JL. *Small Groups as Complex Systems*. Sage Publications, 2000.

Nelson EC, Batalden PB. Knowledge for Improvement: Improving Quality in the Micro-systems of Care. In: Goldfield N , Nash DB, eds. *Managing Quality of Care in Cost-Focused Environment*. Tampa FL: Aspen Publishers; 1999:75-87.

Nelson EC, Batalden PB, Mohr JJ, Plume SK: Building A Quality Future. *Frontiers of Health Services Management,* 15(1):3-32, Fall 1998.

Batalden PB, Mohr JJ, Nelson EC, et al.: Continually Improving the Health and Value of Healthcare for a Population of Patients: The Panel Management Process. *Quality Management in Healthcare,* 5(3):41-51, Spring 1997.

Marrin CAS, Johnson LC, Beggs VL, Batalden PB. Clinical Process Cost Analysis. *Ann Thorac Surg*, 1997;64;690-4.

Nelson EC, Mohr JJ, Batalden PB, Plume SK: Improving Health Care, Part 1: The Clinical Value Compass. *The Joint Commission Journal on Quality Improvement*, 22(4):243-258, April 1996.

Nelson EC, Batalden PB, Plume SK, Mihevc NT, Swartz WG: Report Cards or Instrument Panels: Who Needs What? *The Joint Commission Journal on Quality Improvement*, 21(4):155-166, April 1995.

Kaplan RS, Norton DP. Putting the Balanced Scorecard to Work. *Harvard Business Review*. Sept-Oct 1993; 134-137.

Kaplan RS, Norton DP. The Balanced Scorecard – Measures that Drive Performance. *Harvard Business Review*. Jan-Feb 1992; 71-79.

Websites:

www.ihi.org

APPENDIX

Leadership

"What leadership actions are needed at every level from Senior Leaders to Practice Leadership?"

Leadership is an essential component when considering, supporting, providing guidance, and resources for busy clinical teams to embark on improving access. Leadership begins with the Senior leaders who determine the vision of the organization and then bridge the business imperatives of the organization to clinical action and improvements to better meet the needs of patients and families. Leadership should understand the general intent and goal of improving access through "patient focused access" models to be able to introduce and support the clinical team improvements. Leadership at all levels should offer visible support and demonstrate support of planned changes.

Leadership is responsible for "creating the tension" and sense of urgency for change and action based on vision, current reality of practice, and the health care environment. Clear targets and goals should be outlined. Setting clear expectations of reporting relationships, data based measurement progress reports, and a timeline with expected reports help to keep teams accountable to patients and the organization. Leadership should consider which high level organizational leadership meetings progress reports should be presented. Access improvement should be included in the agendas of the Board of Trustees meetings and other senior leader meetings. This action will communicate the interest of senior leaders and importance of access improvement to teams engaged in improving patient access to care.

Leadership should also be prepared to intervene when barriers and obstacles arise in the process of improvement. Failure to confront obstacles often leads to disempowered clinical teams and failure to progress and achieve goals. Encouraging risk taking and "out of the box" thinking offers encouragement to be creative to the improvement teams.

Rounding on units, asking team members how they are doing, and what they are learning are examples of how leadership at all levels can engage with teams working to improve access.

Perseverance and constancy of purpose is key. This work takes time! The day to day reality of providing patient care in a changing health care environment can distract healthcare providers. Leaders who remind team members of the goals and can keep teams focused on the aim of improving access will help to keep team members on the track to success.

Reinforcement and communication of progress is important along with setting the expectation of team reports of progress. Finding opportunities to recognize and celebrate small successes will help the team sustain their momentum and reinforce the message that this is important work for our patients and our organization.

Teams

"What is the essential preparation work and team discussions that will prepare practices for improving access?"

The clinical teams are at the core of the improvement activities and planning to improve access to care. The teams we define here are the "natural work groups" within a practice. Our experience has revealed many practices have individuals who work independently within a practice and frequently do not appreciate the power of thinking and working like a team in collaboration with set goals and vision. Often, teams cite rare meetings when the entire membership of the team is present and often report on provider

meetings, but not multidisciplinary meetings within the practice. Once regular team meetings are scheduled and conducted, individuals cite improved working relationships, better understanding of each role within the practice, and often, clearer understanding of processes within the practice and each individuals contribution to the process. Successful teams schedule in advance weekly or bi-monthly meetings to convene as a team using effective meeting skills and set agendas. These meetings are often time for workgroup report outs to the team specific to an improvement project within the teams, time for feedback around ideas, review of performance data, and frequently a time for leadership to celebrate everyone's efforts and encourage the team to stay focused. Brainstorming and problem solving often fill the meetings. The continuous attention to communication is carried out through this meeting structure.

Team meeting roles and agendas, and other helpful tools can be found in the Improvement Tools section of the Clinical Microsystem Action Guide which can be downloaded in Adobe Acrobat PDF format from the website:

www.clinicalmicrosystem.org