2003 Practice Management in Veterans Health Administration

Volume 1

Published by the

Office of Primary & Ambulatory Care

Second Edition - June 2003

Department of Veterans Affairs

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Practice Management in Veterans Health Administration 2003

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2003

Practice Management in Veterans Health Administration

This is not an official VHA Handbook and the content is not meant to be a mandate. It is, however, the synthesis of experienced people who have worked tirelessly on the front lines within and outside VHA in conjunction with the collective knowledge from many authorities and experts, grounded in evidence. This document represents many hours of hard work by these individuals.

Managing in health care is not an easy task. It seems as though there is a ceaseless progression of initiatives, directives and sets of objectives that you must meet in addition to doing what is already on your plate. The reality is that managers in our area often feel they're fire fighting or making unsatisfactory compromises between getting everything done and being able to achieve what they went into health care to accomplish in the first place: effective, compassionate delivery of care to our nation's veterans.

We hope the guide is useful for anyone managing a practice or just practicing within VHA. This version of the guide is therefore designed for three purposes. 1) To be as current a source of information or where to get it as possible. (As such, be sure to use the reference area to its full advantage. The chapters attempt to provide sufficient information of what things are so you can discern what you might need more quickly.) 2) The guide attempts to explain in a straight-forward manner the purpose, issues, and dilemmas associated with a number of initiatives in VHA. Continuity of care, Advanced Access, and the latest regarding process improvement and performance measurement are just some of these types of topics. 3) The guide includes some ideas about how to accomplish a number of the goals discussed in the chapters. Activities, processes, quick tips and tools are interspersed throughout the guide

In order to more fully understand where we're coming from, ***try to make it a point to read the first three chapters.*** They should provide a useful context by which to view your clinic and what's happening in them. In general, our rationale for including more "how to" and "hands on" is that there's no sense in making you reinvent the wheel. Your busy enough moving mountains.

In trying to get this out for the Ambulatory Care Meeting, it was not possible for all chapter editors to review all the material. Therefore, to use a popular Washington term, we claim 'plausible deniability'. We have tried to be sure all the content is consistent with VHA and VA policy. We ask that any errors, inconsistencies, or other problems be brought to our attention for correction. We welcome suggestions for improvement.

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June 2003

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CHAPTER 1

Systems, Processes and Managing

Janice F. Cerveny, Ph.D.

Goals:

To ensure practice managers have a "systems" view of the VA health care delivery system and of their clinics and better understand their managing of those systems and the processes within them.

Objectives:

- To understand in general what a "system" and its goal is, and how to view VA clinics as systems.
- To develop a common understanding of what needs to be managed well to improve the system's flow.
- To learn what processes are and how they are (should be) designed to ensure the system's entities function properly.

Introduction

What is a good practice manager? While there appear to be many answers, the most incontrovertible one is a good practice manager ensures the clinic accomplishes more of what its goal is. And the goal of the practice is essentially *to increase the rate at which your operation successfully treats its veteran patients.*

Attempting to ensure this goal frequently means juggling and firefighting – which is why we believe there are many responses to the question as to what makes a good practice manager. There never seems to be enough time, space, money, providers, etc. to ensure every day operations flow smoothly.

Why is this? This chapter outlines why and how to view the practice as a system. It suggests that in order to engage in activities that significantly improve the practice, the practice manager should focus improvement initiatives on the bottleneck of the system. Finally, it reviews how processes fit into the picture to ensure the improvement efforts should be a process to improve key processes.

Systems Thinking 101

Traditionally, one learns about the "picture" of any organization's structure largely in business school or health administration classes or workshops. That picture often involves the traditional organizational chart with the hierarchy of management and functional

departments. Figure 1–1 shows a typical organizational chart" view (this may be familiar to members of the VA system who've had military experience since the view's roots are from that venue).

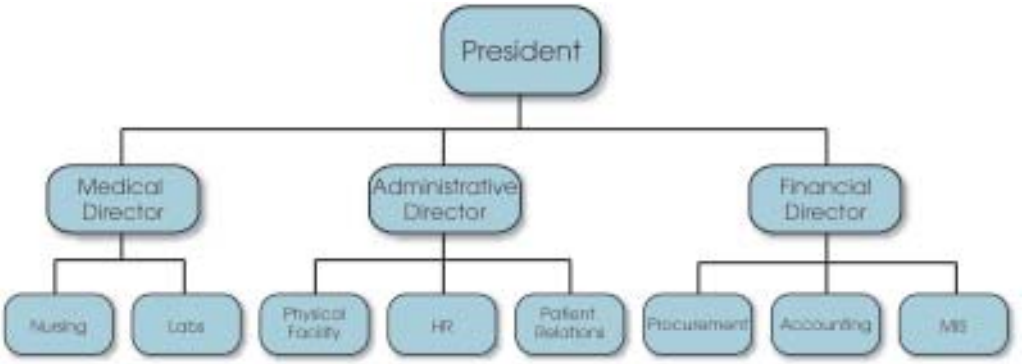

Figure 1-1: Simplified Sample Organizational Chart of a Medical Facility

"The belief is that if every manager pays attention to his or her individual area of responsibility, the organization overall would benefit. The underlying assumption is that the individual links' responsibilities and efforts are aligned toward benefiting the system."

The reasons why this view is taught include:

- To ensure that all individuals understand how the work of the organization is separate yet related.
- So everyone clearly understands their area of responsibility.
- To convey the chain of command (reporting structure) thus ensuring the important principle of "one man/one boss" is not violated (to minimize the confusion of having many masters)

The hierarchical structure inevitably leads many of the individual managers (whether they are in for profit firms, banks, hospitals or health care clinics) to focus on ensuring their area was managed well. This in turn boils down to two objectives: being effective at doing what you are responsible for doing, and being efficient by minimizing resource waste and utilizing them fully.

The belief is that if every manager pays attention to his or her individual area of responsibility, the organization overall would benefit. The underlying assumption is that the individual links' responsibilities and efforts are aligned toward benefiting the system.

Recently, however, more and more managers and health care practitioners have come to realize that the underlying assumption is frequently not correct. Being an excellent procurement manager may entail departmental savings on bulk supply purchases. However, if it means providers do not have what they need to deliver quality care the system's goal is not well served. Staying within budget on support staff may enable you to meet your department's budgetary goals but if this means critical provider's time must be spent on non-patient related activities thus reducing the total number of patients the facility is able to service, then the result is not in keeping with the system's purpose.

The true bottom line is that the (health care) organization must be viewed from a *systems perspective*.

So, what IS a system?

A system is a collection of entities or parts that work together to accomplish its goal. Health care professionals intuitively and readily understand systems thinking simply because their training inculcates this perspective in looking at a patient as a system.

"A system is a collection of entities or parts that work together to accomplish its goal."

Systems are comprised of components or entities for inputs, others responsible for processing, still others for handling outputs and feedback. Figure 1-2 below shows the generic system's view.

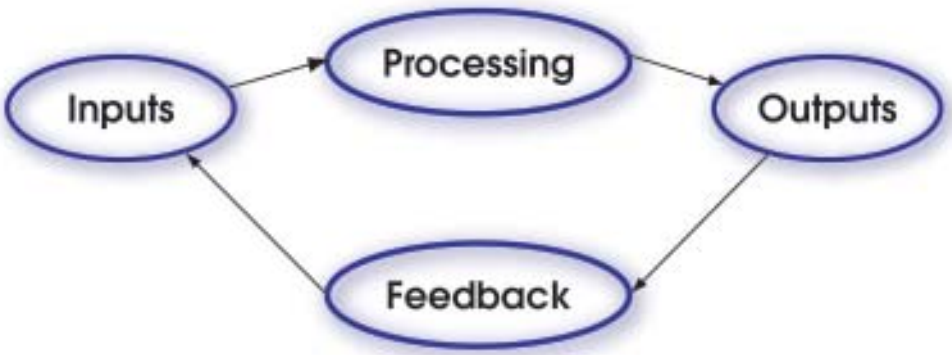

Figure 1-2: Generic "systems" model

The systems view helps managers in any organization, especially in clinical practices, view their efforts as links in a chain.

To translate the generic view to one that is more relevant and important for practice managers to have, it is important to first recognize that there is a core system. The core system is comprised of those links in the chain that are directly involved in generating the system's throughput. In practices, there are links that handle system inputs (i.e. check-in) to the system. There are other entities or links whose responsibility it is to transform or alter the inputs (i.e. provider time and or actions such as patient education, injections, treatments, etc.). Finally, there are other links responsible for the outputs (i.e. checkout).

"The core system is comprised of those links in the chain that are directly involved in generating the system's throughput."

A likely system view of a clinical practice is shown in Figure 1-3.

Figure 1-3: Systems View of the Clinic

But what about all the other "pieces" you're managing now? You know: units such as reception, labs, pharmacy, specialty clinics, maintenance, security, etc.? Surely they're part of the system?

"A quick rule of thumb to identify which units are support links is that a support unit does not directly work on the patients. Instead its work is focused on ensuring the key throughput-generating links that are involved with direct patient care perform well."

Yes – and, in terms of a currently-popular car rental company commercial, not exactly.

Many (if not most) of the remaining entities or units are part of the system – they are support links. A quick rule of thumb to identify which units are support links is that a support unit does not directly work on the patients. Instead its work is focused on ensuring the key throughput-generating links that are involved with direct patient care perform well.

If the clinic is working well, the system's feedback loop provides measures and indicators of the system's performance. Typical measures of good performance are patient satisfaction (with wait times, appointment times, provider capability), staff retention, good patient outcomes (fewer unnecessary returns), The issues and some ideas as to how to ensure good measures and performance evaluation systems are provided in *Chapter 11, Measuring & Monitoring Performance and Clinic Improvement*.

A critical first step in managing the practice successfully, therefore, entails quickly creating a clear picture of your system. Activity 1-A is one way to achieve this.

The critical need is that *this picture must be clearly understood by all individuals in your clinical practice.* Thus, ideally, the activity outlined on the next page (in worksheet form) should be done by a small, representative group of key individuals in the clinic. However, it can by done by you then explained ("sold") to the providers and staff.

ACTIVITY 1-A

Simple System Diagramming

Purpose: To ensure you have created a simple, clear picture of your practice's primary throughput links and support entities.

Time Frame: 30 minutes

(Invest the 30 minutes in order to begin to manage better now and in the future.)

Steps:

1. Spend 5 minutes crafting a single sentence statement of your clinic's purpose. (Many may have and use their own mission statement or that of the VA system overall. Or, you might want to use or modify the one presented in the Introduction to this chapter.)

   - If you're doing this in a group, it's probably easier to create a "straw man" statement prefaced by a simple explanation of why it's important to verbalize.
   - If you're doing this on your end and will be communicating the purpose and system diagram to everyone, at least prepare the simple explanation of why it's important to verbalize.

2. Review Figure 1-3 in light of your clinic or practice.

   - If you feel that it is sufficiently descriptive of your throughput-generating system, simply reproduce it for further use in managing your system as outlined in this guide. Or,
   - If you feel that the figure is not, modify it to better reflect your practice configuration. This may entail renaming links, removing one or two and/or substituting others.

3. Brainstorm a list of the *key remaining* units or entities in your clinic or practice that are not part of your direct throughput-generating chain.

   - Place, as bullet points underneath the links of the core throughput-generating chain, approximately where these support units primarily operate. Some examples: "Reception" and "Records" might be underneath your Check-in (or equivalent) link; "Supply" or "Housekeeping" units might be positioned underneath the "Provider" link; "Pharmacy" might be positioned near "Actions".

4. Prepare a brief description in your own words of what a system is and why it's important to understand for use in conjunction with the core system and its support entities in educating your providers and staff.

5. **When you plan and launch your next several improvement initiatives, use this description and the figure.**

What is the goal of the clinical practice system?

As stated at the outset of this chapter, the goal of the practice is *to increase the rate at which the operation successfully treats its veteran patients. The job and responsibility of the practice manager is to manage the system to ensure it achieves more of its purpose at higher levels of performance.*

"The job and responsibility of the practice manager is to manage the system to ensure it achieves more of its purpose at higher levels of performance."

Systems theory has brought a new perspective for addressing the observed phenomenon that many organizations have wonderful departments that operate well if looked at individually but, because their efforts are not well-integrated, the organization did not perform as well as it could.

The challenge is how to manage the system.

"The challenge is how to manage the system."

Practice managers have a difficult job that tends to pull them in many conflicting directions. On what should they concentrate first? How do they prioritize what should be addressed? The reason these questions are so difficult to answer is because all systems, by definition, are comprised of interdependent links. Further, activity at each of the links will experience variability.

Interdependency means that many times actions taken in one link will affect the other links. If the assumption that the work of the links is aligned is invalid – some actions that benefit one or two links CAN adversely affect the others. Variability means simply that no matter how well planned your efforts might be, "Murphy" can strike and disrupt the flow of patients through the practice.

The systems view helps one focus on that which will most improve the rate at which you achieve more of the goal of the system in the following way.

Envision that the links in your chain have different levels of capacity: using Figure 1-4 as an example, each link illustrates this fact.

Figure 1-4: Capability of the Clinic's Links

Which link will dictate the rate of flow through the system? In the hypothetical example provided in Figure 1-4, it's the provider link. If you want the system's flow overall to improve –you, the practice manager, should focus your improvement efforts on the bottleneck of the system. Activity 1-B is a simple activity to help you identify your practice's physical bottleneck area.

ACTIVITY 1-B

The Bottleneck Hunt

Purpose: To identify the likely physical bottleneck in the current core throughput-flow of the practice.

Time Frame: 30 minutes

Steps:

1. Reproduce and display your throughput -generating system view of the practice prominently with a work team representing each of the links.

2. *Write the major responsibility* of each of the links underneath the link. Try to the start the descriptive sentence or phrase with a verb, such as "sort", "check", "process", etc. Ignore all the "exceptions" and variations that might exist. Your goal is to simply clarify the links' key areas of responsibility.

3. List the major tasks that are *essential* for that responsibility to be completed successfully. Once again, be sure the use a verb such as "open", "copy", "attach", "obtain", etc. Do not include any steps that are done occasionally or for special situations.

4. For each task listed, provide an estimate of the time that task on average, requires for one patient. If there seems to be disagreement as to what this average time is provide the "best case" and "worst case" times and split the difference. For now, do not include waiting time (you'll eventually be guided on how to manage the system to reduce that waiting time).

5. Given these average time estimates, the number of resources (can be clerical staff, technicians, nurses, physicians, etc.) available and volumes of patients through each link, which link seems the most likely candidate for your bottleneck? Check this with what you've intuitively observed or experienced as follows:

   - Is this the link where patients frequently seem to get "jammed up"?
   - Is this where you or your supervisors seem to have to intervene to expedite activity?
   - Does this link's resource seem to be the one that gets interrupted frequently? If the responses here are generally, yes, it's the likely bottleneck in your physical flow.

6. What if you STILL can't decide? This generally occurs if your clinic's system is fairly balanced in its capability to deliver care. Any given day or week's "glitches" can make bottlenecks seem to appear at random.

   - Solution: Think about the GOAL of the system – and select the link that you believe is most closely tied to its successful achievement.
   - While not scientific, you have located the likely bottleneck in physical flow.

Why is "systems thinking" so important in health care delivery?

"having a clear system's view helps ensure that you know who matters the most – the customers of the system – the patients."

There are several reasons why "systems thinking" is vital to all managers of clinical practices.

First, having a clear system's view helps ensure that you, the clinic providers, and staff know who matters the most – the customers of the system – the patients. It becomes the common denominator that increases the likelihood that the efforts of everyone in the system are focused on satisfying the patients' needs.

Second, because each link clearly understands the interdependencies, there should be greater awareness on each link doing its part for the system. This is particularly the case when one looks at the core throughput-generating and support entities. Each core system link knows its immediate customer and can better focus and prioritize its efforts in meeting that next critical link's needs well. Each support link has the same understanding.

" there should be greater awareness on each link doing its part for the system."

The overall picture therefore should reinforce that the objective is that system's entities or links are focused more on subsequent links and system outcomes and not on its own concerns or needs.

While this intuitively feels right to many clinical practice managers, our reality is somewhat different. The reasons for this – and what you can do to mitigate its effects are raised in *Chapter 11, Measuring & Monitoring Clinic Performance & Process Improvement*.

"If you don't have a basis on which to prioritize the problems on which you are working – solving ANY problem is rational. Using the system's constraint or bottleneck as the prioritizing entity is more rational."

Third, it is only when managers have a systems-based view of their clinics and practices that the physical bottleneck or constraint area can be found. The roots of what is now known as the Theory of Constraints (TOC) are a way of managing and ensuring continuous improvement of your system by the identification and improvement of the system's constraint.

If you don't have a basis on which to prioritize the problems on which you are working – solving ANY problem is rational. Using the system's constraint or bottleneck as the prioritizing entity is more rational.

How and where do Processes and Process Improvement fit?

"processes are used by each of the links in the throughput chain or system to convert its inputs into required output for the next link. "

All of the links in the system's chain use processes by which to accomplish required work. One way to understand processes are as sets of inter-related activities to do just that. In other words, processes are used by each of the links in the throughput chain or system to convert its inputs into required output for the next link. Just as there's a core throughput-generating set of links in the system, there's a core process or set of steps that is required for each link to process or convert its inputs into output that is required by its key customer link.

Recall, the most effective and efficient area to improve is the constraint… increasing the rate at which it operates, increases system throughput. This establishes one important criterion for selecting which processes to target for improvement. However, reality also dictates another important criterion for selecting improvement opportunities: it cannot

cause negative effects on other important areas. This particularly means the improvement shouldn't significantly increase work flow or expenses.

"Overall: there should be an overall problem-solving process that is understood and used to select, plan and manage improvement or changes in the clinical practice."

Review the system's goal and what you've defined its throughput to be. Apply the simple "acid test" questions below to the improvement or change you would like to integrate.

Acid Test Questions

- Is the area you are seeking to improve the system's physical constraint?
- WILL the change improve throughput and decrease (or at least not significantly increase) work or patients IN the system and/or will it decrease (or at least not significantly increase) expense?

Use the criteria to help select improvement opportunities.

Frequently, when you receive training in improvement, one of the first points communicated is that you must look at overall processes to help know where to improve. In other words, sound management improves the processes that create measured outcomes. It is not taking actions that simply make a measure look better.

A second important point to learn is that in order to improve successfully, a sound, customer-focused problem-solving process must be followed continuously. Overall: there should be an overall problem-solving process that is understood and used to select, plan and manage improvement or changes in the clinical practice.

The question is – what is a good problem-solving process to use for your improvement efforts? There are many labels for the various improvement programs for managers that have evolved over the past twenty years such as TQI (Total Quality Improvement), CQI (Continuous Quality Improvement), TQM (Total Quality Management), QI (Quality Improvement). There have been an equal number of improvement and problem-solving processes associated with them (Plan-Do-Study-Act (PDSA) or equivalent methodologies). Each, however, carries the essence of the familiar scientific method. The steps summarized in Table 1-1 are an example of a PDSA-based problem-solving methodology.

Plan	1. Identification of a problem (ideally, one that is important to or jeopardizes satisfying the system's customer) 2. Gathering data regarding the extent and causes of the problem (this establishes baseline data by which effectiveness of an adopted solution can be judged) 3. Brainstorming possible root causes to the problem that are used to generate alternatives which are then evaluated in order to select a possible solution.
Do	4. Implementation of the solution - frequently on a "pilot" or small-case basis.
Study	5. Measuring again to determine successfulness of the solution, and
Act	6. Retention and broader application or successful solutions of terminationa nd selection/implementation/evaluation of another alternative. 7. Repetition of the process on a continual basis to ensure increased improvement.

Table 1.1: Sample Plan-Do-Study-Act Problem -Solving Methodology

There is a related continuous improvement, problem-solving process that is used in conjunction with the earlier material regarding constraints or physical bottleneck in systems. Its major components are presented in Table 1.2 System Constraint-Based Process of On-Going Improvement (POOGI).

1. Identify the system's constraint.
2. Act to fully exploit the system's constraint.
3. Subordinate everything to the constraint.
4. Elevate the constraint.
5. Do not allow inertia to become the constraint – repeat the process continually.

Table 1.2: System Constraint-Based Process of On-Going Improvement (POOGI)

This model is being used in numerous industries – including health care settings (for example, see D. Womack and S. Flowers. "Improving System Performance: A Case Study in the Application of the Theory of Constraints." *Journal of HealthCare Management* 44 (September/October 1999): 397-405). Many of its principles are evident in IHI's current Advanced Access initiative as well. A brief explanation of what is involved follows.

If you don't have a basis on which to prioritize the problems on which you are working – solving ANY problem is rational.

The underlying improvement and problem-solving process that is tied to the system's shown in Table 1.2 contains five steps.

"If you don't have a basis on which to prioritize the problems on which you are working – solving ANY problem is rational."

Step 1: Identify the Constraint

It is important to reiterate: enhancing the flow of patients through the clinical practice will only occur if the links in the throughput-generating system and the weak link are identified. Activities 1-A and 1-B were designed to help you do this.

Step 2: Determine how to fully utilize the Constraint

" Do not make the constraint do unnecessary work."

Do not make the constraint do unnecessary work. "Unnecessary" means – don't require that provider or lab or department to work on something that other resources can do. It doesn't matter how busy the other non-constraint resources appear to be now – the point is every minute of time that a constraint is doing non-constraint specific tasks is a reduction of system throughput.

"every minute of time that a constraint is doing non-constraint specific tasks is a reduction of system throughput."

This also has implications for where quality inspections or checkpoints should be positioned. If 5% of provider time is consumed to perform certain procedures, assessments or test on patients who require them, then the same procedures or tests have to be redone, 5% of the throughput of the system is again lost.

"Ensure the constraint is not made unnecessarily idle."

Ensure the constraint is not made unnecessarily idle. Say you have providers available, for example, on two full-days and three half-days in the clinic, while the clinic itself is open 40 hours a week. If your physical constraint is the provider link, do not make them wait while the intake area is collecting or tresting a urine sample because system throughput will be reduced.

Step 3: Subordinate effort to the Constraint

Okay, reading this step's a bit of a puzzle. Essentially, it's stating that once you know what the physical constraint is and have figured out how to fully utilize its unique capability it is important to ensure that all other links keep that constraint area working smoothly at all times.

Do you get it now? It makes some sense doesn't it? The question is getting a better understanding of what's involved to do so.

"Ensure non-constraint resources work to keep the constraint operating optimally."

Ensure non-constraint resources work to keep the constraint operating optimally. Any department or unit that precedes the physical constraint area must be focused on ensuring that patients (and required intake information, records, results, etc.) show up as and when required. Similarly, departments or units that precede the exit point of the system must be focused on ensuring that the rate of exit is not jeopardized.

This focus should always take precedence in instructions given to individuals in these non-constraint areas. It also has significant ramifications for performance improvement and monitoring (as will be seen in Chapter 11, Measuring & Monitoring Clinic Performance & Process Improvement).

Step 4: Increase throughput by elevating the constraint.

Where are you now? You know where to improve (step 1 ensures you find the system's weak link). You are focusing the alternatives you evaluate and select from to exploit that constraint so it's operating optimally (step 2). And you ensure that all remaining links are focused on keeping the flow of work moving through the constraint.

The question now becomes – what next? Recall that your goal is to increase throughput – the rate at which you provide effective patient care. If you want to increase this flow – who's capacity must you increase? That is the meaning of this step: increase throughput by elevating the constraint.

Once the constraint is fully utilized and efficient, you need to add more to that weak link's capability. The focus of your budget requests can be like the following:

- Invest in training or equipment to help the constraint work better or faster – to make that area more productive.
- Add other resources with that same constraint's capability.

Helpful Hint: It's is probably better to think carefully when you have one or two other key links that have about the same capability levels. If this is the case, consider increasing their capacity somewhat BEFORE you increase the constraint's capability. The reason for this is, that it enables you to more easily increase overall flow without disrupting procedures and processes you've created. In other words, you won't have to change what you're doing because the focus and tasks of all the other links can remain the same.

Step 5: Repeat the above – continuously (Don't allow inertia to become the constraint.)

ALL practice managers should have an improvement (problem-solving) process that is actually used. Fighting today's biggest fire is not a good process. In fact, while it's a default method that is frequently used – an important bit of advice might be in order.

"ALL practice managers should have an improvement (problem-solving) process that is actually used. "

The big "duh": Doing the Same Thing ("problem solving") the same way (i.e. fire fighting) WILL yield the same result.

The moral of the story is, adopt and use an EFFECTIVE problem-solving improvement process. The one bulleted above is certainly a good start and a similar version is a minimum requirement to be an effective clinical practice manager.

CHAPTER 2

Effective Decision Making and Problem-Solving for Clinic Managers

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Goals:

To clarify what effective decision making and problem solving are and how to do them and provide two generic tools for analysis and buy-in that can be used for these purposes.

Objectives:

- To understand the components of effective decision making and problem solving.
- To learn the pitfalls of and criteria for effective decision making and problem solving process.
- To instruct clinical practice managers in the availability and use of two tools to resolve conflict and analyze and improve solutions as well as provide guidance as to how each should be used to increase buy-in of others.

Introduction

Decision making is a process by which a choice is made on a set of alternatives relevant to a current or anticipated situation. Making decisions is an integral part of the managerial process. Managers are expected to render decisions. It is at the core function of the position. (1)

Problem solving is a special case of decision making. The issues addressed are unique and solutions are not readily evident. (2) The decision making process is utilized in solving problems but they are not the same. For example, faced with a particular situation the decision can be made that the issue at hand is not a problem and that it can be safely ignored. In another case the manager may be asked to choose between Product A or B. Neither is a problem but the decision making process needs to be utilized. On the other hand, there could be three viable solutions to a particular problem. The decision making process is then applied by the manager to come up with the best choice.

Many of the chapters in this handbook or guide contain information about topics of importance to many clinic managers. A commonly-heard frustration about guides such as this is that solutions are not always provided. While in several instances some innovative practices by clinics are presented – it is important to understand that the examples serve simply as *ideas that might work* to solve similar problems in your own

practice settings. However, each clinic is unique. Each has different staffing and patient configurations, availability of space, equipment, etc. vary. The point is – do not automatically adopt ideas in the belief that you'll produce the same results. It may not happen.

The ability to generate possible solutions, evaluate and select from alternative courses of action and ensure their successful implementation is still required. If you goal is to improve your system, you will have to make decisions and follow an effective process in order to do so.

This chapter therefore, does several things to assist you. It outlines the different components of effective decision making and problem solving processes. It then familiarizes you with the pitfalls that are common to decision making and problem-solving and a way of understanding the types of problems. This information helps generate some important criteria or characteristics that are probably critical for sound decision making and good problem solving processes. Finally, it presents two tools that are generically useful to resolve problems (and conflicts) as well as to generate and evaluate decision making situations and alternatives that satisfy these criteria. An important piece of the tools is the communication process to increase buy-in.

Decision Making and Problem Solving Processes

Managers essentially have three choices when faced with the need to make a decision: they can stall, temporize with a quick decision, or practice sound decision making processes (3). The most productive choice is to apply an effective decision making approach. It's likely that most managers stall or make the decision on the fly. Stalling may seem rational (this will be discussed a bit later when the negative branch tool is explained) but is costly. Temporizing is expedient but often creates additional problems.

When placed in a decision scenario the first thing a manager must do is to assess the situation. What is the problem? What are the essential issues at hand? What are the desired outcomes? These must be very clearly defined so that the manager can have a solid framework for the application of the critical elements of the decision making process.

The essential components in decision making are:

- A situation is assessed – this implies that underlying assumptions must be identified, and that prioritization occurs;
- Alternatives are considered – this implies that focused deliberation is conducted; and
- A choice is made – this implies a judgment or conclusion.

In Chapter 1 two forms of effective problem-solving processes were presented. The first is essentially the scientific method. The second was suggested as a more focused methodology because the "problem" to solve or the decision to make is always based on the system's constraint.

Part of deriving the important characteristics of effective decision making processes and tools will come from seeing a quick summary of the common pitfalls. The remainder of the characteristics can be gleaned from a way of understanding types of problems and management decision making styles. This information should assist and motivate you to learn effective decision making and problem solving tools such as the two presented at the end of this chapter.

Pitfalls in the decision making process

1. Assumptions

If a problem has no solution, it may not be a problem, but a fact – not to be solved, but to be coped with over time.
Shimon Peres

We view our world through the eyes of our assumptions. They are the filter by which we take in or throw out the input from our external environment. These assumptions affect our determination regarding what courses of action are plausible and which are not. It can be said that from our assumptions flow our decisions.

Assumptions are derived from our value system but experience and observations reinforce and shape them over time (1). We have all been taught a pool of information and beliefs. Our experiences lead us to retain those that are reinforced and discard or modify those that are not. The longer we stay with an organization the more we internalize the organizational assumptions embodied in the organization's culture. They are "the way we do things around here" – the culture. It is this organizational culture that teaches a fixed set of alternatives or solutions that tend to be applied to every situation.

"Awareness of our underlying assumptions, on the other hand, allows us to question the current reality and to call on a different perspective when necessary."

Being unaware of our standard assumptions is a very significant barrier to effective decisions. This is because assumptions can lead to decisions that may be correct but not necessarily the best because it simply maintains the status quo. This is the hallmark of the stagnant organization. Given the rapidity with which change is occurring in the health care environment, this pitfall is now clear.

Awareness of our underlying assumptions, on the other hand, allows us to question the current reality and to call on a different perspective when necessary. More effective decisions are then usually arrived at.

2. Alternatives

One does not plan and then try to make the circumstances fit those plans. One tries to make plans fit circumstances.
Gen. George S. Patton, Jr.

"The number and tenor of the alternatives we generate are a function of how we define the problem or frame the decision that needs to be made. If there is no effort to untangle the problem and its source or the objective and ways to achieve it, the generation and ultimate selection of a good alternative is jeopardized."

A decision always involves a choice between at least two alternatives. The quality of a decision depends on whether the given alternatives are viable or not. Given faulty choices, any decision will be erroneous as well. How do we formulate alternatives? – By analyzing the facts. How do we analyze the facts? – Through our assumptions. How do we obtain these facts? – Based on our opinions.

The number and tenor of the alternatives we generate are a function of how we define the problem or frame the decision that needs to be made. If there is no effort to untangle the problem and its source or the objective and ways to achieve it, the generation and ultimate selection of a good alternative is jeopardized.

An inherent pitfall is that people involved in making a decision (be it individually, as a small group, or a committee) already have preconceptions about a situation or problem and their preferred solutions or course of action. Thus, while we know we should let the facts drive the analysis and decision – the tendency is to find data ("facts") to support preconceived ideas.

One way to guard against this pitfall is an approach suggested by Peter Drucker in his book The Effective Executive. (4) He recommends that individuals first express their *opinions* about why the problem or situation exists *before* data is collected. Each opinion is considered an untested hypothesis that then should be tested against reality (the "facts").

To illustrate, let us say a manager is put in charge of a committee to decide which software to purchase to implement a hospital-wide electronic medical record system (EMR). The group will likely include clinicians, information technology (IT) staff, and finance personnel. The clinicians will want software that is fast and easy to use. The IT folks will want something compatible with software and hardware already in place. The finance people will want the cheapest one. The chairperson, sensing that this is a high-profile assignment, will prefer a system that can be set-up quickly with the least cost. If the group proceeds with gathering data first we can predict what each sub-group will come up with to support their positions. On the other hand, if the opinion of each is elicited prior to data collection the various proposals (untested hypothesis) can be better defined and clarified.

" The best way to assess the adequacy of given alternatives is to look at them from different points of view."

To determine criteria of relevance the committee must focus on its objective: pick the appropriate software for the EMR. It is clear that even if they pick the most compatible or cheapest software, the clinicians will not use it if it is not fast and/or easy to use. The main criteria for the EMR proposals should be one that will allow convenience, reliability, and general acceptance to the clinical staff. The issues of cost, compatibility, and speed of implementation can be applied to the "facts" in a more relevant manner. This approach allows the alternatives to be more objectively evaluated as to exactly how each will impact the situation or problem at hand. Each proposal or opinion (hypothesis) can be tested against reality.

3. Judgment

When a decision has to be made, make it. There is no totally right time for anything. The biggest mistake is to never make a decision.

Gen. George S. Patton, Jr.

Making a choice is an exercise in judgment. The essence of good judgment is the ability to understand the underlying currents of a given situation, and then formulate an opinion as to what is best to do (or not do) about it. Pre-conceived notions and assumptions can easily cloud judgment.

The best way to assess the adequacy of given alternatives is to look at them from different points of view. A good manager fosters disagreement and spirited discussion of alternatives prior to making a decision. She understands that the best decision is often the product of the disagreement between conflicting opinions. The good manager does not decide unless creative dissent has been allowed to occur. This approach safeguards the decision from organizational assumptions and allows innovative possibilities to be brought to light. It also protects the decision-maker from being taken in by the plausible but false or incomplete. (4)

"The manager must use processes and tools that ensure that the situation or problem and desired outcomes are clearly defined as well as the consensus or buy-in of all participants."

4. Consensus

Cooperation isn't the absence of conflict
but a means of managing conflict.
Deborah Tannen

Webster defines consensus as "an opinion held by all or most" (5). It is more appropriate to consider consensus as the agreement by the group to work towards a common purpose. This is one reason why an effective clinic manager should take the time to ensure everyone has the same picture of the organization, its throughput and its purpose.

The issue of consensus is most relevant given the tendency and increasingly required use of committees or multiple parties for making specific decisions. The push toward shared healthcare decision-making is a case in point.

" This is a malignant form of "consensus" against which the competent clinic manager must guard."

The pitfall for the manager is that the committee may "decide" to go along with whichever opinion is forwarded most strongly by its proponents regardless of merit. A more dangerous occurrence is for the group to decide on the proposal that all the members can live with (whereby "consensus' equals the least objectionable action). While such decisions are less disruptive it may not only serve to maintain the status quo but the problem or situation may not be addressed at all.

We have heard the comment that the camel is a horse put together by a committee. The manager must use processes and tools that ensure that the situation or problem and desired outcomes are clearly defined as well as the consensus or buy-in of all participants.

5. Group think

No one is thinking if everyone is thinking alike.
Gen. George S. Patton, Jr.

Group think is defined as the phenomenon wherein the mode of thinking within a group is such that the desire to achieve unanimity overrides the critical appraisal of alternatives

(2). The group as a whole tends to focus on only a few choices, overlooks risks and drawbacks of proposals, and may not evaluate new information for their relevance to the options being considered. This is a malignant form of "consensus" against which the competent clinic manager must guard. Awareness of the various pitfalls in decision making is essential. Consistent application of sound practices is the key to steering away from this dangerous mind set.

6. Action

You miss 100 percent of the shots you never take.
Wayne Gretzky

" The manager must learn to decide, take action, but most of all follow-up and critique the whole process."

Making a decision is a deliberate act. It requires courage and conviction. Courage is needed to face the possibility that the chosen course of action may be wrong or that it may fail. Conviction comes from having faith in the effectiveness and thoroughness of the process that was applied in coming up with the decision.

Ineffective managers frequently fall short in taking the steps necessary to implement the decisions made. They are afraid to make a mistake and do not want to fail. Sometimes they suffer from analysis paralysis. At times, they may actually choose a course but fail to act on it. A good plan that is not executed is no plan at all.

Managers must be allowed to make wrong choices. Dynamic and leading organizations allow their managers the freedom to fail. What every manager should hope for is that they make more good decisions than poor ones. They must also critique their decision making process in detail whenever they find out that a wrong decision was made so as not to repeat the same mistakes. The ability to make good decisions comes from practice and repeated self-appraisal. The manager must learn to decide, take action, but most of all follow-up and critique the whole process.

" One simple rule of thumb regarding most people-oriented decisions is sensitivity is critical in addressing them successfully."

Types of Problems – and Decision Making Styles

Types of Problems: Decision-making and problem-solving are complicated because managers face two broad categories of problems in the workplace: job-oriented and people-oriented (3). The complicating factor depends upon whether the consequences or outcomes of the situation are low vs. high.

It is probably safe to say that a job-oriented, low-consequences type of decision can usually be identified and resolved quickly. A bad decision here will have little impact on productivity or the imge of the manager. For example, the determinants regarding where to position the glove dispenser in an exam room for a provider is a "no-brainer". Job oriented, high consequence problems havea direct impact on the operations of the clinic or department, and decisions can have serious consequences to the effective functioning of the work area concerned. These are situations when it becomes most important for the manager to diligently apply sound decision making concepts and practices. Changes to policy and procedure, alterations in office design, modification in patient care processes, how to implement safety or other regulatory requirements, or introduction of new technology are examples of such decisions.

"Buy-in is equally critical especially with high consequence decisions."

Clinic managers frequently deal with people-oriented, low consequence problems. Their resolutions are important to an individual employee but may have little impact on the

operation of the clinic. Examples are conflicts over break times or scheduling changes. Clinic managers frequently deal with people-oriented, low consequence problems. Their resolutions are important to an individual employee but may have little impact on the operation of the clinic. The manager should be cognizant of the fact that these problems exist inside the employee. These issues must be handled with sensitivity. Nevertheless, the denial of a request is best handled with fairness, firmness, and clear communication with the party(s) involved.

People-oriented, high consequence problems elevate the importance of having a successful resolution since the potential negative effects are much larger.
These problems are very personal and emotionally charged. They usually involve more than one person. The impact on productivity is significant. The manager must aim to arrive at a decision that is as fair as possible. Consideration should be given to policies and procedures that affect the matter, labor union contract provisions, regulatory requirements, safety issues, and other potential ramifications.

One simple rule of thumb regarding most people-oriented decisions is sensitivity is critical in addressing them successfully. Generally, one must always allow individuals to "save face" and maintain a sense of self-respect. Buy-in is equally critical especially with high consequence decisions. Resolutions imposed without recognition and validation of individuals' needs will consistently cause resistance and affect successful implementation.

Managerial Style: Most clinic managers recognize at least three basic styles of decision making: autocratic, consultative, and group process oriented. Many have learned that autocratic managers (who tend to decide with little input from others and expect staff to implement directives) can be effective – as long as they are sufficiently brilliant, innovative, and visionary. If they are not, they find that they must spend a large amount of time and energy ensuring directives are carried out appropriately.

Consultative managers obtain input from others before making a decision. They benefit from having a larger pool of options and information as well as frequently experience greater buy-in from the staff. However, they must guard against compromising so much with the decision that the chosen course of action's effectiveness is lost in the process.

Group process-oriented managers utilize group decision making and tools frequently to the extent that buy-in is consistently achieved. However, if the time factor for decision making is critical this method will most likely not be applicable. Moreover, personality clashes and political agendas can run rampant. The best forum for this approach is when members of the group are knowledgeable about the different aspects of the problem, are motivated to find the best solution, and are committed to rectify the situation.

The competent manager understands that all three styles of decision making can be utilized by the individual. The style is best suited to the demands of the situation. Job-oriented, low-consequence situations are often amenable to autocratic decisions. People-oriented, low consequence scenarios can also be handled through autocratic decisions although a consultative approach is probably more appropriate when such decisions might have deleterious effects on the employees or the workplace. Issues that are of high-consequence, whether job- or people-oriented, are best handled through the consultative or group technique. Since high-consequence decisions have significant

impact on the operations of the clinic or department these two approaches offer the most opportunity to obtain staff buy-in and cooperation.

Organizational politics have a profound influence on how decisions are made within the context of the hierarchical structure. Smith et al stated that this influence is such that the preferences of the powerful are always taken into serious consideration by subordinates when decisions are made. (6) This reiterates the importance of systems thinking and need for the alignment of what individuals in units or departments are expected to do and that which benefits the system. The manager is the one who must ensure that the desired alignment exists in order to ensure creative and innovative inputs are applied in the thinking and execution of needed work.

Characteristics of sound Decision Making and Problem Solving processes

Given the pitfalls and understanding of problem types and managerial styles, the following are the list of criteria or characteristics of good decision-making and problem-solving processes should:

1. Include a way to force us to surface and examine assumptions
2. Incorporate a way of clearly articulating causes, effects and assumptions that withstand logical scrutiny.
3. Integrate the effects on people as well as on operations.
4. Enable managers to see likely negatives and address them ahead of time or sufficiently to ensure they will act to implement the selected alternative.
5. Be easily learned and followed by the decision-maker. This is particularly the case the more visible and pervasive the potential effect on the system and others in the system.
6. Integrate perspectives and opinions via active participation of interested or affected others.
7. Result in choices and/or are communicated in such a way that buy-in can be achieved by all affected parties.
8. Used continuously and focused on increasing system flow

Table 2.1 Features of Effective Decision-Making and Problem-Solving Processes

Tools and Techniques for Decision Making and Problem Solving

Table 2.1 presents the important criteria and characteristics for effective decision making and problem solving processes. The big question that remains however is what tools and techniques are "out there" that fit these criteria or have these characteristics?

In decision making, you essentially evaluate a number of alternatives. The one you select is often the one that ensures you'll get the DESIRED outcomes (usually in terms of effectiveness, efficiency and cost) without causing undesirable NEGATIVE outcomes (usually those that would alienate patients, providers or staff).

What follows are two tools that satisfy the criteria from Table 2.1 and that will enable you to create a robust solution. Each tool also includes instructions (a process) for communicating so that you bring critical other parties to collaborate. (Other explanations of such tools can be found in Lisa Scheinkopf's book "Thinking for a Change" (7) and the VA CMI EEI satellite program tapes from last September and October showing them.) The tools are "negative branches" and "conflict diagrams".

Tips & Tools

Negative Branches

Users of this and other "guide books" on how to manage better are full of suggestions and or actions you should undertake. More frequently, clinic managers are given some fairly comprehensive proposals such as "Implement Advanced Access Care", ""Move to a Patient-Centered approach", "Use Shared Healthcare Decision Making" to meet VHA customer service standards. Each of these ideas is in alignment with the mandated and intuitively-correct philosophy of the VA system being focused on its customers and ensuring that their needs are met on a continuously improving basis. However, busy clinic managers are often torn by what to do – and how to do it.

Experienced managers however, have learned that the implementation of new ideas tends to create one or more of several negatives: staff and provider resistance, undesirable delays, errors in data and record keeping and lower levels of quality of care for some patients are some of the most common.

The first decision making tool explained here helps identify how and why the undesirable negatives might occur and, in doing so, help clarify what enhancements could or should be put into place in order to prevent the negatives. As you review the steps to learn how to use the tool, notice how the tool can be used even in one-on-one situations where there's another individual who comes to you with an idea with which you don't agree. Frequently managers are confronted with such "half-baked ideas" and do not have good tools to bring about a satisfactory resolution with the other party.

From a high level perspective, the negative branch is a cause-effect (if-then) map of how an idea could cause negative effects (see left-hand side of Figure 2.1). The right-hand side of the figure illustrates what such a portion of a completed map might look like in this case using the common practice of overbooking appointments.

The figure is read as an "IF – THEN" structure. Wherever there are two lower entities connected with the ellipse, the figure is read as an "IF-AND-THEN" structure.

Using the right-hand side of Figure 2.1, we can see the logic behind:
IF, (we take the action we're evaluating) we overbook appointments based on historic percentage of No Shows in our clinic, AND (the factor that contributes to the effect we observe) sometimes, with overbooking, 1 of the 2 patients who are in the same time slot will have to wait, THEN (the negative effect) patients are the ones who will "pay" for any miscalculation.

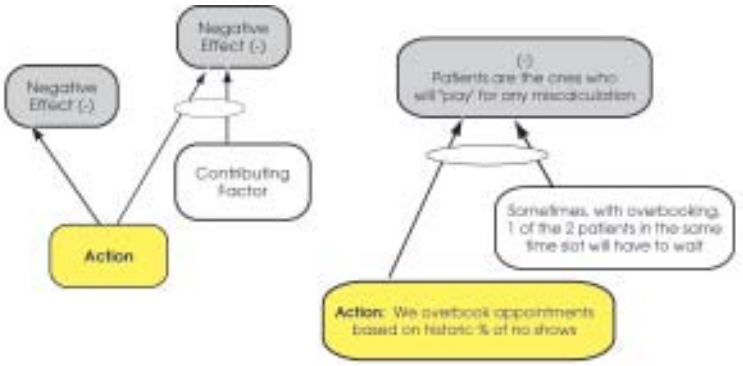

Figure 2.1 - Sample Negative Branch Decision Making Tool

If you re-read the first four criteria and characteristics of effective decision making and problem solving – you can see how the negative branch tool meets these criteria.

Let's see how well characteristic number 5 (ease of learning) is ensured by working through an example using "Clinic Adopts a Patient-Centered Approach".

For this guide, let's use the proposal that the VA "move to a patient-centered approach" as a working example.

Activity 2-A

Constructing a Negative Branch:

Step 1: Write down the Positive Effects of the proposed idea or solution.

This first step is important because as a busy decision-maker it is easy to dismiss proposals, changes or others' ideas – often with disastrous interpersonal relations. All that's required to complete the first step successfully is to take 2-3 minutes to list the positives or purported benefits. Note: The more opposed to the idea you are the shorter the list is likely to be.

Helpful Hint: *If you cannot think of anything positive, try to find and list one or two reasons you have heard or read that others claim is a justification or benefit of the proposed idea.*

Some possible positives of the Patient-Centered Approach might be:

- Greater satisfaction of important system stakeholders
- Improved quality of individual care for many patients
-
-
-

Add any other negatives you might have in the space provided.

Step 2: List the Negative Effects you see with the proposed idea.

The goal of this step is to clearly articulate the negatives you think the proposed change will cause. **Note:** it is generally easy to complete this step – and you'll tend to create a significantly longer list here the more strenuously you dislike the alternative or proposed solution.

Helpful Hint: If you cannot think of many, double check your thinking by going to 1-2 individuals who can find and articulate negatives and get their perspectives (this will actually be useful for subsequent buy-in efforts).

Some possible negatives of the Patient-Centered Approach might be:

- We will have less time for patients
- There will be even MORE delays than we're currently experiencing
-
-
-

Add any other positives you might have in the space provided.

Step 3: Write the "half-baked idea" (state it as a fact in existence) in a box at the bottom of a sheet of paper. Try to connect one of the negative effects you identified to it by using cause-effect as explained.

Review the list of negatives – select the one you see most clearly linked. Say the word **IF** *followed by reading the starting action or idea* followed by stating **THEN** reading *the negative effect.*

For example:

IF "we move the clinic to a patient-centered approach"
THEN "there will be even more delays than we're currently experiencing".

Do you intuitively recognize the need to "fill in some additional explanation"?

Many clinic managers recognize that the effect doesn't automatically derive from ONLY the proposed action – but that there are contributing factors as well.

To create a more completely connected cause-effect diagram – list what those additional pieces of information are. One way to do so is to read the IF-THEN followed by the word "because". The additional explanation constitutes the extra information you will need to incorporate into the negative branch.

In this instance, most clinic managers recognize that

IF "we move the clinic to a patient-centered approach"
THEN "there will be even more delays than we're currently experiencing"
BECAUSE:

- There are limited number of rooms
- The exam rooms will be tied up longer, and
- You can't use occupied rooms

The key to building a more complete, logical branch is to couple those entities that exist currently with the original idea (these are needed for logical "sufficiency"). They are linked visually with an ellipse which represents a logical "AND". (NOTE: To easily understand a logical "AND", think of the three things required for a fire to exist: IF there is oxygen AND there is fuel AND there is a spark THEN there is a fire. The logical AND links all three essential pieces to getting the effect or fire.)

Those entities that might or will probably occur – but do not exist currently (i.e. the exam rooms "WILL" be tied up longer) will often end up as an intervening step or entity between the original action or idea and the effect to which you're trying the link.

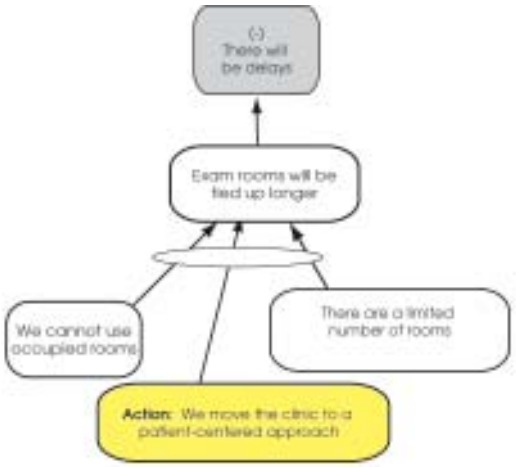

Figure 2.2 - Sample Negative Branch of Patient-Centered Care

Figure 2.2 shows the more complete negative branch incorporating all the additional ideas.

Figure 2.2 is read as follows:

IF "we move the clinic to a patient-centered approach"
AND "there are a limited number of rooms"
AND "we cannot use occupied rooms",

THEN "exam rooms will be tied up longer".

IF "exam rooms are tied up longer"
THEN "there will be even more delays than we're currently experiencing".

Be certain to repeat this process to include all negative effects that were identified in step 2. For effects you end up positioning at the "top of the tree" – check to see if some of the other effects linked in earlier branches don't also connect. This is called "additional causes").

Helpful Hint:
Try to critically examine your work to surface any assumptions. For example, is it true that the exam rooms WILL be tied up longer with just those three entities or does something else have to be present? One other assumption is that all providers and staff using the room work at the same average rate at which they currently work.

It is important to continually identify additional assumptions. They will be the key to finding innovative solutions to problems and assist you in your decision making.

Note: for a more complete tutorial on building negative branches, consider using Scheinkopf's book "Thinking for a Change".

Step 4: Review your completed diagram from the perspective of key individuals' whose buy-in and collaboration are required to successfully execute or implement the proposal. Restate any "inflammatory" or "blaming" type of phrases that will cause defensiveness.

For example, perhaps one of the additional entities you might have put as a contributing factor is a behavior you've noticed in some of your staff such as "staff drag their feet whenever new initiatives are launched". While it may be true – this step in the negative branch tool forces the manager to systematically and objectively pare out or restate such phrases. **This is because achieving the system's objective is the most important – and you have the responsibility of ensuring that that remains your focus as well as that of your providers and staff. Keeping phrasing that is accusatory will derail your efforts.**

One way to restate an entity such as the foot dragging one above might be to tone it down by stating "Staff tends to resist unexplained initiatives they are expected to implement".

The importance of this step cannot be emphasized strongly enough because it will be critical for communicating effectively to achieve buy-in and collaboration.

How the negative branch can be used in decision making and problem solving.

One of the biggest challenges clinic managers face is how to evaluate alternatives so as to make the best decision possible. A tool such as the negative branch enables them to clearly see the concerns they and others will have and how those concerns come to be.

However, you should also see how and what you can do to alter or prevent the negatives as well. In Figure 2.2 and the explanation of step 3, it is clear that if you can change either the number of exam rooms available (see Chapter 5 on Optimizing Resource Use for pointers on how to reexamine and find more physical space) and/or the rate at which staff and/or providers are working in that physical space – you can prevent the use of rooms for longer periods of time.

Important criteria items 1 and 4 from Table 2.1 are clearly satisfied by the use of the negative branch tool for decision-making.

Step 5: Effectively COMMUNICATING your reservations

Frequently managers have excellent ideas that are well-reasoned and likely to be effective that are spectacular failures. Certainly one of the factors that this happens is related to managerial style as discussed earlier in this chapter. This implies that the decision making process must include a more consultative, more group-process oriented flavor without the time consuming or conflict-riddled negatives commonly associated with those methods. **What follows is an easy to use, logical process that enables you to obtain buy-in hence an increased likelihood of necessary collaboration of others.**

5.1 Initiate a meeting with the parties whose input and buy-in you require. Be sure to tell them what the meeting is about and what you hope to achieve as well as set a time frame. As a rule this type of meeting rarely exceeds 30 minutes.

- It's probably a good idea when first using the negative branch tool to explain that's a new one with which you're experimenting as well as how it was constructed. Do not spend more than 2-3 minutes on these prefatory remarks.

5.2 Present the POSITIVE effects to the proposed action or idea. Recall that you generated these in step 1 of the negative branch tool. Ask for and acknowledge (or visibly list on an overhead or flipchart) other positives others might see with the idea.

- Do not engage or encourage significant discussion because you'll increase the likelihood of getting derailed
- If modifications are suggested, visibly acknowledge these as well. This is to lay the groundwork for showing receptiveness to the group's ideas.

5.3 Present and explain the negative branches using the same "if…and…then" logic starting from the bottom of the branch and moving upward. Slow down if you must! – your objective is to communicate your concerns, not try and blast through the logic so the other side gets the feeling you're "pulling a fast one."

5.4 Once you are through the negative branch logic, REFRAIN FROM OFFERING ANY SUGGESTIONS. You want to elicit input from your staff and providers about the logic.

Your goal is to get staff and/or providers to find ways to either strengthen the implementation of the alternative or (if you are using the tool to evaluate someone else's "half-baked" idea) contribute to its improvement or removal from consideration.

- IF you hear plausible solutions that "trim" the negative branches (i.e. that attack or challenge the assumptions you have in the diagram), have some brief discussion to more clearly frame these out and close the meeting out.
- IF you are offered some solutions but the ideas don't have real merit (e.g. don't fully trim the negatives), guide attention to those branches not yet trimmed but, once again, do NOT offer any suggestions.
- IF no one offers any solutions – chances are you'll just have some more discussion about the idea or proposal. Close out the meeting offering to leave a copy of the negative branch with them for future closure.

The positive effects of communicating in this manner should be fairly obvious: you have an efficient way of identifying and communicating "all sides" of the picture that actively encourages focused participation. It is generally recognized that buy-in and required implementation is greatest when people feel they've contributed.

Other Uses of Negative Branches:

- You have issues or concerns about an idea that a staff member or provider has.
- You need to provide feedback into VISN-level decision making.
- You are uncertain about how to successfully implement a new initiative.

Tips & Tools

Conflict Diagrams

One of the most common challenges clinic managers face is dealing with conflicts effectively. Conflicts can be between the manager and an individual (i.e. a patient, provider or staff member), between groups of individuals (nurses vs. providers), or between the manager and a group (i.e. clinic manager and nurses).

The classic sign of a conflict is what one side wants is in opposition to what the other side wants. Its symptoms are that each side views the other side as stubborn and unrealistic as emotions escalate.

Some managers resolve conflict by avoiding it or the making of the decision. Frequently managers (busy practice managers included) compromise when faced with conflicting propositions.

The tool presented in this last section of Chapter 2 is designed to assist you in quickly and more effectively resolving conflicts.

There are four steps in the Conflict Cloud or Conflict Diagram approach. Each is explained in Activity 2-B using the proposal that you implement "Advanced Access" in your clinic as a working example.

Activity 2-B

Step 1 Define the conflict objectively and accurately. Use the template provided in Figure 2.3 Template for Conflict Cloud or Diagram to fill in each of the blocks labeled A, B, D, D and D'.

A. What do I want?
B. What does the other side (O.S.) want?
C. WHY do I want what I want? (I.e. what need is driving your position?)
D. WHY does the other side want what they want? (I.e. what need is driving the other side's position?)
E. What's the common objective? (I.e. why is it important to resolve this conflict?)

***Helpful Hint**: Sometimes it is difficult to pinpoint the REAL needs (for yourself and the other side) to write in blocks B and C. One A way to help find them is to just put something down and, after completing step 3, revisit what you wrote*

Caution & Hint:
Don't ever write (as the "other side's 'need', C ", phrases such as "to be controlling", to "throw their weight around", etc. It's your opinion and need to vent your frustration – not a need. If you can't think of anything to write – simply write what they've stated as a reason for their position or look at an important performance measure they've been told to improve or seem to hold important.

In the case of advanced access the conflict might be the following:

A. What do you or one side want? Probably to "Implement Advanced Access Care".
B. What does the other side (conceivably a portion of your staff) want? Probably to "Not Implement Advanced Access Care".
C. WHY do you want what I want, i.e. what need is driving your position? Probably something along the lines of "be seen as working in alignment with VA initiatives".
D. WHY does the other side want what they want, i.e. what need is driving the other side's position? This could conceivably be something along the lines of "not jeopardize my current productivity requirements".
E. What's the common objective – why it's important to resolve the conflict? "To have a well-run clinic" is probably acceptable.

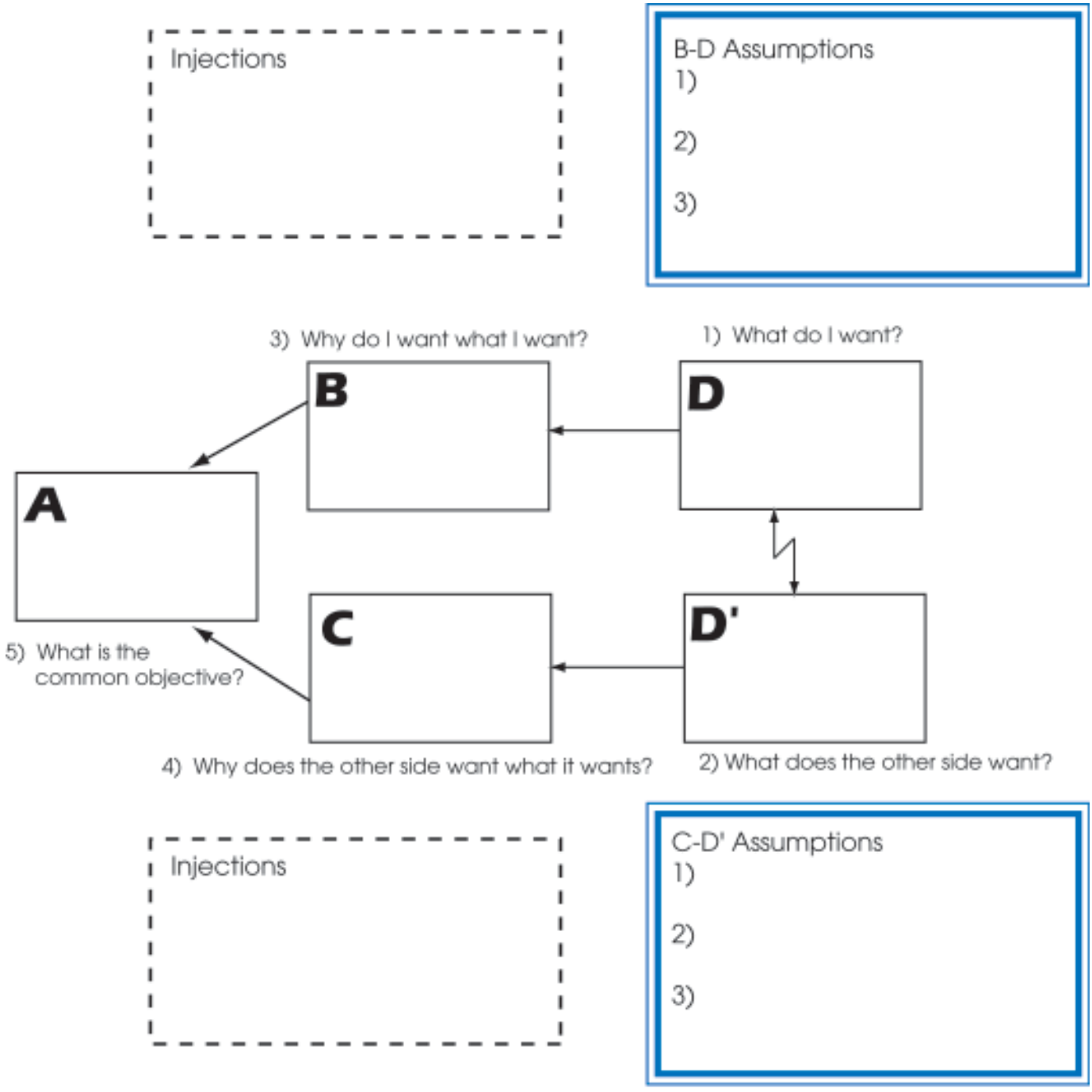

Figure 2.3 - Template for Conflict Cloud or Diagram

Step 2: Check the logic of what you've written for all "horizontal" arrows.

The conflict diagram is based upon the logical construct known as "conditional logic". The negative branch is based upon the rules governing causality. The latter's logic, therefore, is phrased as "IF-THEN". The cloud, on the other hand, is phrased using the following:

"In order to" phrase at the head of the arrow,
"I must (have/do)" phrase at the end of the arrow.

Figure 2.4 contains the completed conflict from step 1 that will be used to illustrate how the logic check has to be completed.

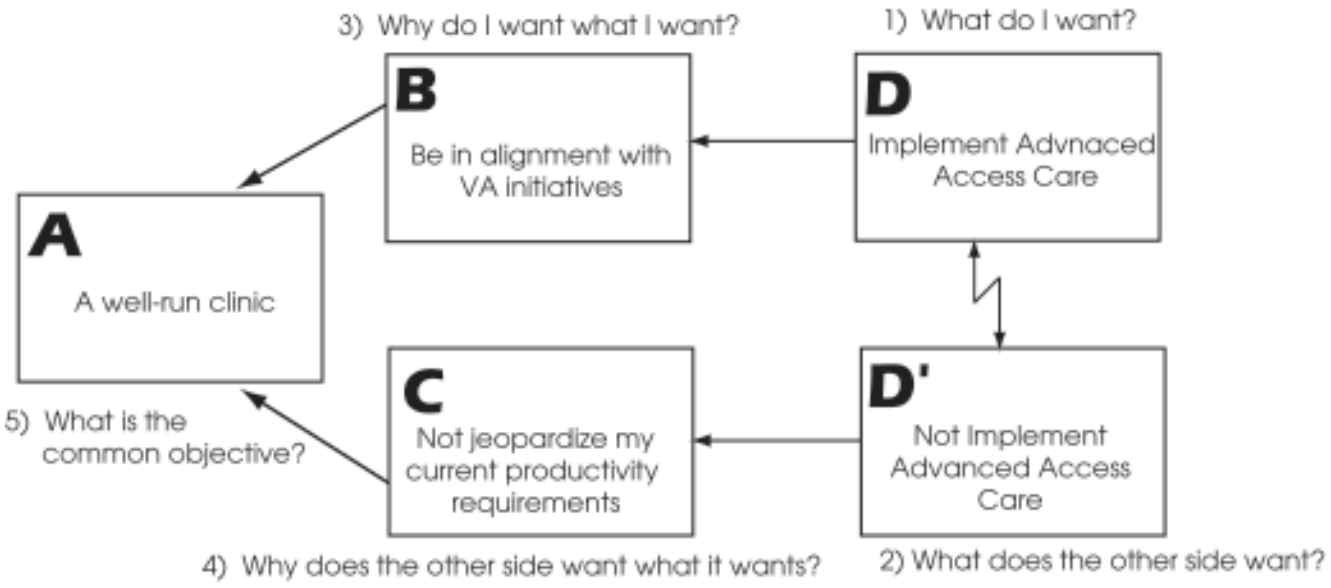

Figure 2.4 - Sample Conflict Diagram for Advanced Access Care

To do the logic check properly, read the diagram out loud to verify that the linkage between the blocks is essentially correct. Using Figure 2.4 it will sound like:

In order to have *(A) A well-run clinic,* I (as clinic manager) must (*B) be in alignment with VA initiatives*. Makes sense, doesn't it? Continuing: In order to *(B) be in alignment with VA initiatives,* I must therefore *(D) implement advanced access care*.

The other side of the conflict is: In order to have *(A) A well-run clinic,* the other side (i.e. a group of staff) must *(C) not jeopardize current productivity requirements*. And, in order to *(C) not jeopardize their current productivity requirements* they must *(D') not implement advanced access care*.

Helpful Hint: Do not simply read what's written without checking that the two entities are linked logically. However, don't split hairs here either. *If what you've written is essentially you and/or the other side's position, leave the blocks as you've written (you may make minor grammatical modifications if necessary).*

If you want to quibble over whether something is logically connected or not – do not make any changes and complete Step 3. In all likelihood you're intuitively already using the process for finding a solution.

Step 3: Construct a SOLUTION

The key to successfully resolving the conflict lies in identifying the various assumptions that exist in the situation and adopting or implementing any required actions that can negate their impact or existence.

For example, say I WANT to go to a conference to learn innovative material at a particular week that conflicts with a family vacation. The assumptions are: the only place to get the material is at the conference, the only time that for the conference is that particular week, and that the only way to learn material is a conference setting.

Frequently, as soon as you take the time to systematically surface the assumptions, the beginnings of a solution can be found.

Therefore, in order to construct a solution, first "surface the assumptions" on the B-D, C-D', and even the D-D' arrows. IF the conflict is between you and another person, try surfacing assumptions on YOUR SIDE (the B-D linkage) only.

> *To surface assumptions, insert the phrase "because" after doing the logic check as shown in Step 2. Many (not necessarily all) of the phrases you insert are assumptions as to why you believe that in order to get your NEED you MUST have the thing your arguing for.*

From our Advanced Access Care Example:

In order to (C) not jeopardize current productivity requirements your staff argue *they must* (D') not implement advanced access care *because*:

Some assumptions are:

- Productivity <u>will</u> be jeopardized with this change.
- There's nothing they can do to mitigate a temporary "hit" on their productivity.
- Productivity will be permanently reduced or reduced such that their jobs are jeopardized.

Develop an "injection"

An "injection" is an action you can take or something that, if it existed or was done, invalidates any assumption. The detailed injection = a solution…. It "evaporates" the conflict.

There are a number of plausible ways to challenge the assumptions surfaced on the C-D' side. Some ideas that come to mind are:

- An agreement is made that during an agreed upon phase-in period, if some of the individual productivity measures decline, your evaluations will include a notation as to why this occurred and removing blame or responsibility from the individuals.
- A negative branch can be drawn to surface assumptions underlying how the implementation might specifically affect productivity so that specific action can be taken to prevent it.

Be sure to surface assumptions and generate possible "injections" at B-D, C-D' and the D-D' links.

Note: For more detail on how to use the conflict diagram, use Lisa Scheinkopf's book.

Step 4: Effectively COMMUNICATE a resolution

As was the case with the negative branch tool for decision making and problem solving, effective conflict resolution requires a consultative, more group oriented process and style. It is important to remind yourself that **your goal is to resolve the conflict in a way that all parties are satisfied.** When the conflict is over a change in procedures, roles or responsibilities of others, it is paramount that the process be fast, easy to use, and logical so that you achieve the critical buy-in and desired collaboration of others.

The following are the steps on how to effectively communicate a resolution to the conflict.

A. Whenever you find yourself in a conflict, immediately STOP the discussion and complete steps 1-3 of mapping it properly, surfacing the assumptions and generating some plausible solutions.

   People who have used this approach a couple times find it can be done in about 10 minutes.

Helpful Hint: *If this is an interpersonal conflict (i.e. between you and one or a couple other individuals) work most aggressively on challenging assumptions on YOUR side, B-D. As a rule, that's what the other side will attempt anyway and your goal is a resolution not necessarily that your perspective prevail.*

B. REVIEW all the remaining steps below, then resume the meeting with the other party. (Essentially, you simply have to say, I've been thinking about that problem we had and I'd like to talk about it if we can…)

C. Present the conflict diagram in REVERSE order from the way you constructed it.

- **First**, present (A) the common goal or objective. (This ensures you're both focused on why the issue needs to be resolved.)

- **Second**, present the OTHER side's need C. The phrasing required is simply "I think that in order for us to have a well-run clinic, you must not have your productivity jeopardized".

  Note: IF the other party suggests changes to the wording for the need you write, make that change on the diagram immediately.

  (This is to show that you're subordinating your needs and perspectives to the other side. This helps keep them listening and participating.)

- **Third**, present the OTHER side's "want" (D') in the same "in order to not jeopardize your productivity performance requirement, you feel you must not support the implementation of advanced access." It usually helps to be accommodating and listen as the person says "well, of course…".

- **Fourth**, you will read your side of the conflict, starting with your need (B) and then stating your want. In essence it needs only to be something to the effect of "well, in order to have a well-run clinic, I must visibly be in alignment with VA initiatives. And, in order to do that, I must implement advanced access."

Frequently what occurs is that both parties calmly commiserate and conclude in effect: "No WONDER we are arguing…"

D. Get agreement on the validity and the importance of the NEEDS and to stop arguing about the WANTS.

   - The simplest way to do this is to physically cover the D and D' entities and point out that your mutual goal is to get A, B and C.

E. Suggest handling the conflict using the process of surfacing assumptions underlying the arrows.

   - Using YOUR side of the cloud (B-D) and surface at least a couple.

   NOTE: the biggest land mine in the communication process is to surface assumptions on the other side's portion of the conflict first – you will undo nearly everything you've achieved.

F. Listen for plausible injections from the other side but ***DO NOT PUSH!***

   - IF the other side suggests injections, help "close a deal". Work out details regarding the solution and actions to be taken.

   - IF the other side does NOT make suggestions, leave the discussion and the cloud with them. Chances are they WILL still come to an acceptable "win".

Summary

The components, pitfalls and individual managers' style all enter into the art of effective decision making and problem solving. These are critical skills for any manager. It should be clear that these have evolved to provide the important criteria and characteristics for sound decision making and good problem solving processes outlined in Table 2.1.

It is for this reason that the "how to" regarding two tools (negative branches and conflict clouds) are provided at the beginning of this managers guide.

It should be clear in revisiting the seven criteria and characteristics of effective decision making from Table 2.1 that the methodology shown here are particularly well-suited to be used no only for clearly defining situations that require sound analysis but in doing so, provide a communication process to increase buy-in and the active collaboration of others.

CHAPTER 3
Advanced Access Care

Janice F. Cerveny, Ph.D.

Goal:

To outline the purpose and methodology for integrating Advanced Access Care into the clinical practice – successfully.

Objectives:

- To explain the sequence of steps required to implement Advanced Access.
- To provide specific actions and examples of each in order to complete each step in the implementation process.
- To identify tips and hints of what to monitor to reduce the likelihood of experiencing problems in implementing Advanced Access.

Introduction

One of the more recent initiatives undertaken by the VA is Advanced Access. Its underlying philosophy is geared toward improving the access of veterans to clinic services at a time when many clinic managers are feeling significant strain to accommodate existing users. Thus, the proposition sounds a bit impossible but though there is general agreement that it needs to be done. The goals of Advanced Access are to increase access and reduce delays – often thought to be conflicting propositions.

As was pointed out in Chapter 2, any manager (busy practice managers included) compromise when faced with conflicting propositions. In the case of advanced access the conflict might be the following: In order to achieve the objective of running the clinic well, they must be seen as successfully working in alignment with VA initiatives (a necessary condition). In order to be in alignment, they must implement Advanced Access. However, the other side of the conflict is essentially as follows: In order to run the clinic well, they must also not jeopardize any existing performance requirements (such as budget compliance, staff, provider or satisfaction, etc.). And, in order to do that, they feel they should not implement Advanced Access.

The typical solution or "compromise" is that the practice manager will take those recommended actions to implement advanced access that s/he feels can that are visible and do-able with existing resources. The negatives associated with this piecemeal approach are pretty predictable.

There are essentially ten steps involved in implementing an access improvement initiative in your clinic. When you look at them – you can actually see the solution to the conflict.

The first two steps are focused on ways to help you find more capacity – without expending significant additional budget dollars. These focus on your backlog (and how to remove it) as well as ways of preventing additional backlog (reduce unnecessary demand). Steps 3-5 are focused on getting your supply and demand aligned with each other. The final five steps (6-10) are focused on actions that can help you increase supply.

This chapter summarizes how this might be achieved as well as some pointers on how material from chapters 1 and 2 "fit".

First, Gain Immediate Capacity

1. Work through the backlog

"Backlog" consists of all of the appointments that are on the future schedule for a particular clinic.

"Good" backlog consists of appointments in the future that are *needed*. These include:

- Providers' discretionary return appointments
- Patient preferences (patients call and want to come in tomorrow)
- Automatic appointments at certain intervals to manage specific types of patients

"Bad" backlog is appointments for anyone who was deflected into the future who could have been seen today. Your goal at this stage is to **avoid bad backlog.** It encumbers clinic schedules by taking up slots that could be used for patients who need appointments with their providers. A clinic cannot successfully improve access without working down the backlog.

There are several actions clinic managers can consider and adopt in order to address bad backlog. One set has to do with ways to work the backlog down. Another set has to do with ways to reduce demand (thus preventing the creation of backlog).

Though there are several alternatives do NOT feel restricted to these. You may see that some of the other ideas on how to do Advanced Access scheduling that apply to this step.

Action 1.1 Eliminate duplicate appointments that are not clinically appropriate.

This item makes sense. Essentially it's suggesting that you cull existing of appointments in the system that shouldn't be there.

Use the VISTA scheduling system to generate a list of patients with multiple future appointments and eliminate duplicate appointments that are not clinically appropriate. Some pointers by which to accomplish this are shown for question 1 on **Figure 3.1 Check Sheet for Backlog Reduction.**

Action 1.2 Temporarily add appointment slots

Sometimes additional staff is needed and should be used on a temporary basis to help reduce existing backlog. This helps prevent future backlog from being created.

The most common way to address the backlog is to temporarily add appointment slots to the schedule. Consider adding weekend or evening appointments or extra appointments during the day.

Remember: your goal is to improve the system's performance for good. Yes, your budget or some performance targets may not look good in the short term but flow will improve in a sustainable fashion.

2. Reduce the creation of additional, unnecessary demand

This sounds like an absurd idea – who would create additional unnecessary demand? It happens – more frequently that many managers are aware. What follows are some explanations of how to achieve this.

Action 2.1 Maximize activity at an appointment.

Maximizing activity at appointments ("max-packing") essentially means doing as much as you can for patients while they are in the office for any given visit, in order to reduce future work thus frequently eliminating the need for extra appointments. Checklist item 2 can help "flag" those that apply. Use a providers' meeting to help quickly (15 minutes) brainstorm items for a checklist of preventive care. This can help to anticipate a patient's future needs and ensure successful "max-packing".

A good example of how to maximize activity was done at the Washington VA Medical Center (Dr. Lee Ferguson, Lee.Ferguson@med.va.gov) via its including a feature in the CPRS note template to automatically show a list of each primary care patient's future appointments at the bottom of the note template. The Primary care providers use this list of future patient appointments to see what a patient's "future" schedule is while they are writing the visit note and/or making clinical decisions. The provider can then cancel the future appointment if it isn't necessary, take care of additional patient needs right away, or leave the future appointment as scheduled. The provider can also check to make sure that the patient is scheduled to come back to the "correct" provider by matching the clinic name on the CPRS note template with the patient.

Instructions for use: place patient's names as column headings and place an "X" for the sentence(s) that apply to the patient. Samples of suggested solutions are shown in the right-hand column. Clinic managers can generate other ideas via brainstorming and evaluate them via negative branches.

Goal: Work through and prevent Patient Backlog	Patient 1	Patient 2	Patient 3			Suggested solutions for discussion/ evaluation
1. Does this patient really need an appointment? Check for each patient if s/he has:						
Just been seen recently						Investigate: visit may no longer be necessary (call/cancel)
Only needs refill of meds						
Patient is in hospital						
2. Patient is scheduled for subsequent visit(s).						"Max-pack" and/or checklist of preventive care
Can I take car of all that patient's needs (so that the next month's appointment is not needed?)						
3. Does this patient need MY personal attention?						
Patient has chronic condition that requires monitoring						Consider use of nurse clinics
Can this patient's needs be met via another form of care?						Use e-mail, phone
Can/should another provider take care of the patient?						etc.

Figure 3.1 - Checksheet for Backlog Reduction

Action 2.2 Reduce variation in scheduled return visit intervals

Some providers require a one-month interval before a scheduled return, others require a three-month interval for similar patients. This action suggests that you evaluate providers' variation here. You can use a histogram for past data to accomplish this.

Ask the providers to discuss the discrepancy and think of what makes sense. You can have them generate some assumptions (see the Chapter 2's pointers on surfacing assumptions) and find one or two they are willing to challenge in order to try and reduce demand. Some commonly-held assumptions are that "patients won't be able to get an appointment if they need one", or that my "productivity evaluations will suffer if I see patients less frequently". Having physicians and care teams responsible for a group or panel of patients, rather than the number of visits generated or individual patient appointments provided, eliminates such concerns about productivity.

" **unclear patient expectations can generate unnecessary demand.**"

REMINDER: *Don't forget to explain the reasons for the return interval or any changes to practice to the patients.* Some patients may not understand why they aren't coming in on the usual schedule and will call to make an appointment. This would simply shift work unnecessarily onto another link in your chain – and put you back into the backlog hole you're trying to eliminate. Some may be given an appointment and won't keep it because they don't understand the clinical importance of the visit. In either case, **unclear patient expectations can generate unnecessary demand.**

Action 2.3 Stop automatically booking no-shows.

Do an analysis of the reasons for "no shows" (use the "check sheet" and "Pareto chart" tools as per Figures 3-1 and 3-2). Data can be grouped to look at different types of patients, the appointment time intervals, etc.). Agree on the criteria that should be used in rebooking no-shows (e.g., have missed only once; have been seen in the clinic within the last year, etc.).

Reason for No Show	Week of 2/15
A Admitted to hospital for another reason	𝍸 𝍸 𝍸 //
B Forgot appointment	𝍸 𝍸 𝍸 𝍸 𝍸 𝍸 𝍸 𝍸 //
C Deceased	///
D Family Emergency	𝍸 ///
E Ended up in hospital on other business and got inserted into schedule to save a trip	𝍸 𝍸 𝍸 𝍸 /
F Was delayed elsewhere so skipped	𝍸 𝍸 ///

Figure 3.2 - Sample Check Sheet for No Shows

" One of the biggest contributors in creating unnecessary demand is the practice of automatic scheduling of patients for return visits."

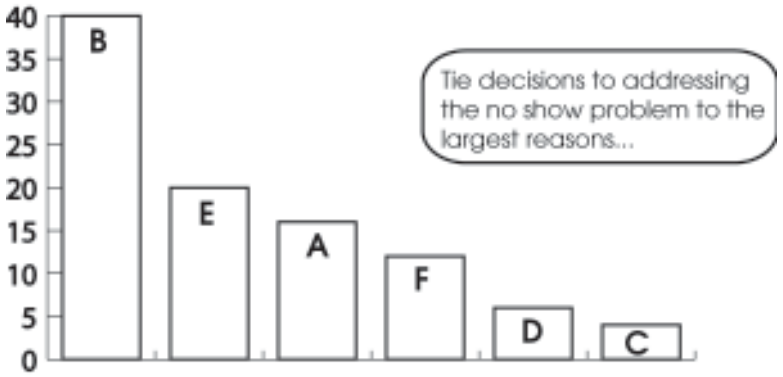

Figure 3.3 - Sample Pareto Diagram for Reasons for No Shows

Action 2.4 Stop <u>automatically</u> scheduling patients for return appointments.

One of the biggest contributors in creating unnecessary demand is the practice of automatic scheduling of patients for return visits. One of the most frequent reasons for this practice is to check lab results.

Alternative practice: at the initial visit with the patient (for which lab or similar procedures are required), do two things. First, schedule the procedures to be done within a week. Second, at that same <u>initial</u> visit, patient should be advised that s/he will be called *only if there are abnormal results or those that will require* a scheduled visit. Create a tickler file (can be as simple as a dry-erase board with each provider's name and spaces for patient's name and procedure and date to serve as a provider reminder) so that those results are easily checked by the provider about 8-9 days from the initial visit date.

Action 2.5 Create alternatives to traditional face-to-face interactions

This action systematically challenges the assumption that "the provider must have a face-to-face visit in order to ensure good patient outcomes". Intuitively, clinic managers and providers have generated ways to challenge this assumption.

- Provider can have telephone consults
- Nurses can staff telephone advice lines.
- E-mail, Tele-medicine, and Internet communication between physicians or nurses and patients (this option is useful to manage care of patients with chronic conditions).
- Care teams (i.e. nurse clinics) can perform for certain procedures such as sigmoidoscopies, stress tests and/or monitor patients with chronic conditions.
- Use of group visits where several patients meet together with a provider and/or the care team. (In a group visit, the provider might meet briefly with the group, but the services of a traditional visit might be performed by a combination of nurse practitioner and an educator.

Action 2.6 Optimize patient involvement in care

Patients who are involved in their care and educated on self-management, particularly for chronic diseases, have been shown to reduce unnecessary demand for visits. An additional benefit is that there is better overall management of the patient's condition.

Consider an education program that at least assists receptive patients on how to manage their medications, the indications of when provider intervention might be necessary and what to do in an emergency. Such programs have yielded outcomes of patients who are less likely to utilize the emergency or urgent care clinic for a preventable exacerbation and reduction in office visits.

Overall: Make a plan for reducing your backlog and reduce demand.

Agree on a starting and ending date for working down the backlog. The start date should be as soon as possible (the longer you wait, the more your backlog will grow). The end date depends on your current delay for appointments and how much additional capacity everyone agrees can be added to the system. It is important to set realistic dates.
Consider having physicians contribute ideas or commit to actions they plan on taking to work down their own backlog (where and when to add appointments) and commit to a plan for adding capacity. Written commitments from physicians are helpful in reducing the backlog.

Align Supply and Demand

3. Address Supply and Demand

Many health care practitioners, whether they're in clinic or hospital-based settings, feel buffeted by the whims of patient demand. However, in a number of settings, patterns can be discerned regarding demand for services or appointments, calls for advice, messages for providers when one looks at the population, the clinic's provider mix and provider practices.

The following are actions that can help address supply and demand issues.

Action 3.1 Measure demand

Demand is the total number of patient requests on any given day. Counts of return visits generated today, phone calls (from patients plus consults from other providers), walk-ins, faxes, e-mails and transfers from urgent care need to be made for a representative time period. Weekly and monthly demand averages can then be generated.

Helpful Hint: Multiply each type of demand for service times its average length (in minutes) and divide by 60 minutes to compute the total hours of demand per day. The overall figure will tell you total daily clinic demand.

Action 3.2 Measure supply

"In addition to provider time for appointments, be sure to also calculate and check the supply of major pieces of equipment, nursing staff, technicians, etc. involved with the direct throughput chain."

Supply is the total availability of people (providers, nurses, etc.), equipment, offices and exam rooms available to a clinic. Capacity is clinic's availability for appointments (services) to patients. At the very least, capacity is the total hours of clinician time devoted to appointments. However, given Chapter 1's discussion about a system-wide process of on-going improvement, think carefully as to whether the clinician is indeed the bottleneck to the clinic.

In general, supply is most easily calculated by recording the total hours of time for appointments and services. **In addition to provider time for appointments, be sure to also calculate and check the supply of major pieces of equipment, nursing staff, technicians, etc. involved with the direct throughput chain.**

> **Helpful Hint:**In all likelihood, providers or exam rooms is the constraint point or weakest link. This is particularly the case in some clinics with part-time providers. The point is: CHECK.

" Plot each demand and supply (can be done by day, week or month) to see patterns of alignment or misalignment of demand and supply."

Action 3.3 Compare supply and demand

Your goal here is to see the potential misalignments in your clinic's supply and demand. An approximate percent of each type of demand (phone call, walk-in, etc.) serviced by say nurses vs. physician providers vs. a particular lab or piece of equipment can be compared to each one's total availability to give a rough comparison of demand vs. supply.

Plot each demand and supply (can be done by day, week or month) to see patterns of alignment or misalignment of demand and supply. If you align these data on the same graph, supply and demand are aligned if they follow the same basic patterns.

> **Helpful Hint:** Another indicator of whether your demand and supply are in alignment is to examine waiting time. If the average wait time is essentially flat (i.e. has been 2.5 months out for a year or so), it means that there is a steady pool of demand. Demand in other words presents for service and an equal amount of service is supplied – it's just that it's 2.5 months too late.

"Do not group data improperly."

> **Watch Out: Do not group data improperly.** Calculating demand can be done for just about any representative time period – however, if an eligibility change is implemented (as happened for example with Audiology), you'll see a temporary bump in demand.

Action 3.4 Make panel size equitable and base it on clinical FTEs

Your clinic's current panel size is essentially the total number of patients divided by the number of providers (in FTE terms). There's no ideal panel size per se. However, equitable panel size is probably most critical for the clinic's providers to overall provide good quality care in a timely manner. This means not only in terms of overall panel size per provider – but also number of new patients per provider.

> **Helpful Hint:**As a rule, do not try and adjust panel size for practice variations that exist among providers. (Do a "negative branch" on this following the steps described in Chapter 2.)

"**times for longer appointments should not be predetermined for certain days, but should be applied as needed**."

Note: If, when you examine what is happening to clinic panel size over time you see that is increasing while patient satisfaction is decreasing (and if you can illustrate that provider time is your system's constraint), the request for budget dollars for staff can be made very powerfully.

4. Reduce Appointment Types

Having a lot of appointment types increases total delay in the system because each appointment type creates its own pattern of delays and queues. For example, if a provider only provides physicals on Thursday afternoons, a patient needing a one physical may have to wait several weeks until such a slot is available. Further, scheduling staff frequently have spend more time determining who gets which slots the more appointment types you have.

Action 4.1 Use only a small number of appointment types

As a rule, Advanced Clinic systems do not distinguish between urgent and routine appointments. For primary care, the only distinctions are whether the provider is "present" or "absent" and if the appointment is short vs. long. For specialty clinics, appointment can boil down to Type (1) – Consults, routines and returns, and Type (2) – Procedures (requiring special room set-up or equipment).

Action 4.2 Standardize appointment lengths

The most flexibility for scheduling is one that has only one or two basic appointment lengths (e.g., 15 minutes or 20 minutes) that can be utilized either as a single unit or grouped together for a longer appointment as needed. Unlike many current clinic practices, **times for longer appointments should not be predetermined for certain days, but should be applied as needed**.

A nice example of a clinic that reduced appointment types was in the Oklahoma City VA comprised of 20 primary care providers (both physicians and mid-level providers). Initially, there were 2-4 provider clinics (i.e. PM urgent care) and numerous nurse clinics as well (i.e. anti-coagulation, blood pressure management, etc.) – nearly 80 clinics in all. Freeze outs in which schedulers could not find open slots for a patient were common. Instead, the clinic was restructured into five teams with 4 providers and clinic RNs, patient care coordinators, LPNs, etc. assigned per team. There were only two types of appointments: new patients and existing patients.

The first two appointments in the morning and the first appointment after lunch are held for new patients, although schedulers have some discretion to use other times as well for new patients and to fit other patients into these slots as needed. New patients appointments are 30 minutes long, returns are 15 minutes. Providers are only scheduled 3 slots per hour.

Longer than normal variation can therefore be absorbed and shorter appointment durations that open up time for providers enable them to continue documentation, return phone calls, etc.

Clinic Name: Primary Care - Oklahoma City

Contact Name: Boyd Shook, MD, Associate Chief of Staff for Ambulatory Care (Boyd.Shook@med.va.gov)

Recall, if you implement steps 1 and 2 you've already worked through your backlog. Implementing steps 3 and 4 help match the average supply and demand via reducing appointment types and lengths. Notice from the Oklahoma City VA example how demand peaks can be absorbed and demand valleys can enable greater provider (constraint) utilization.

5. Plan for Contingencies

No matter how well you seem to have balanced supply and demand, there will be times when there is a demand surge. This is sometimes expected (e.g., flu season) but can be unexpected (e.g., a lot of walk-ins on a rainy day in golf country). Similarly, expected and unexpected variations in supply can also occur (e.g., bad weather, vacations or emergency sick leaves.) The following actions help you manage the clinic more proactively.

"NOTE: It is probably a good idea to evaluate these using the negative branch and/or the conflict cloud to gain the active collaboration of others.

No one idea is necessarily right for you given you clinic's staff, its patient mix and composition, the culture that has evolved, and its demand and supply patterns."

Action 5.1 Manage demand variation proactively

When you measure demand, patterns can be discerned. This will enable you to plan to add temporary capacity when predictable peaks are expected. Flu season creates a familiar bump in requests for appointments in January and February. For days when there is excess supply, clinics have agreed-upon assignments for staff to "max-packing visits" to help prevent creation of backlog or to have scheduled team meetings.

Action 5.2 Develop flexible, multi-skilled staff

The ability of a clinic to respond to expected or unexpected surges in demand depends to a large extent on the flexibility of the staff to adjust their responsibilities during these periods. A procedural change to temporarily remove as much load as possible from a provider who is a constraint can help increase flow during those surges.

Action 5.3 Anticipate unusual but expected events

By creating a check sheet of past incidents or situations that have disrupted flow, staff teams can quickly create an agreed upon protocol to use. Thus, if a patient must be admitted from the EKG clinic to the hospital directly – relatively little disruption occurs.

The pointers below is a summary of a number of clinic initiatives to manage variation and unexpected events.

> ***NOTE:*** *It is probably a good idea to evaluate these using the negative branch and/or the conflict cloud to gain the active collaboration of others.*
>
> *No one idea is necessarily right for you given you clinic's staf, its patient mix and composition, the culture that has evolved, and its demand and supply patterns.*

Some pointers to manage variation in demand more proactively:

- Agree ahead of time who will cover for a planned and unplanned absence; have a call-in list to cover provider cancellations.
- Hold Friday afternoon flu shot clinic during September, October, and November, with physicians rotating coverage of the flu shot clinic.
- Establish policies governing provider leaves or absences from the clinic (e.g., with 60-day notice, will cancel and reschedule patients; for less than 60-day notice, the provider must see the patients).
    - Put leave policies on-line so that physicians know and can check them as needed.
    - Make the leave policy a standard for all team members.
    - Ensure that patients have enough medications prior to a planned leave by a provider.
- Have primary care providers use "curbside" consults with specialists (i.e., direct phone access to specialists by primary care providers), rather than making the referral, when the supply of specialists is lower than normal.

Some pointers to anticipate unusual but expected events:

- Have a simple protocol (flow chart) for all staff to use for unusual events.
- Use "walk-arounds" to rehearse everyone's role.
- Take the following steps in anticipation of each of these unusual but expected events:
    - Admission of a clinic patient to the hospital:
        - Predict the volume and frequency of such events and create a direct admission process so that the admission can be completed within 30 minutes (e.g., notify the in-patient unit of a possible admission prior to the patient's arrival in the clinic, based on patient symptoms and clinical history, etc.).
    - Change in VHA eligibility rules (which often leads to a surge in demand for specific procedures, tests, and devices):
        - Set up special processes to answer veterans' questions and assess their eligibility (e.g., temporarily assign clinic staff to answer phone calls about the new ruling).
        - Train staff to provide services related to that procedure (e.g., techs to do hearing aid or eye glass fittings).
        - Add appointment slots during the initial weeks of the eligibly rule change.

- Unplanned provider absences:
  - Discourage unplanned absences by making other providers responsible to cover missing providers' appointments (which creates peer pressure to be there).
  - Notify patients with already scheduled appointments and give them the choice to see someone else or to reschedule.
- Staff departures:
  - Plan additional appointments (or other forms of contact and support) for patients who may be expected to need extra support once their regular provider leaves.

Redesign to Improve Supply Capability

" Managing the constraint increases the flow of patients through the clinic."

Thus far, steps 1-5 in implementing Advanced Access enable clinic managers to first, gain immediate capacity easily (which enables you to work through your backlog and correct its creation) and second, to begin to match supply capability with demand. The final phase of Advanced Access is focused on ways to increase capability of your system. There are five steps in accomplishing this goal.

6. Manage the Constraint

" Though it may be likely, do not assume the primary provider to be the constraint."

As stated in Chapter 1, one characteristic of systems is that there is always a constraint on the flow. A constraint, or bottleneck, is the thing that restricts the throughput of patients into and through the clinic system. This occurs when the demand for a particular resource (e.g., rooms, providers, tests) is greater than its available supply. **Managing the constraint increases the flow of patients through the clinic.** Other than the ideas provided in Chapter 1, some additional steps to take in managing the constraint in the clinic include the following:

Action 6.1 Identify the constraint

It is often difficult to identify a constraint by evaluating the demand and the capacity for each resource because of the interdependencies with the various entities in the system.

Use Activity 1-B from Chapter 1 as one way to find the constraint. Or, look carefully at the work you did to complete Step 3 in this chapter. Both should help you identify the constraint area. **Though it may be likely, do not assume the primary provider to be the constraint.**

Action 6.2 Drive unnecessary work away from the constraint

As outlined in Chapter 1, there is a link in your throughput chain that is the rate-limiting step. Do not assume that this is the most expensive resource.

Chapter 1 also pointed out some basic rules regarding this constraint in the process of on-going improvement (POOGI) that was described. Generally, the constraint area should rarely/never be idle unnecessarily. Ensure that there will be steady stream of work (patients) flowing smoothly toward it. The focus should be on

optimizing the capacity of the rate-limiting step, not on optimizing every resource in the system.

Some pointers to exploit and subordinate to the constraint

- Have all clinic personnel but especially the constraint resource work to the highest level of their training and expertise.
- Make sure all tests have been completed and all necessary information is in the patient record prior to the consult.
- Check what formal and informal measures are used to evaluate non-constraint resources. Consider removing any that don't encourage the resource to assist the constraint (to ensure it doesn't go idle) or increasing emphasis on those performance measures on resources behaviors that do assist the constraint.
- To ensure that all tests are completed prior to the consult appointment, consider electronic prompts for the referring physician that specified the required tests. A health summary form can also serve as a method for gathering all pertinent information about the patient so that the specialty doesn't have to spend time searching for the information needed for the consult.

One example of managing a constraint well was done in the Central Texas Veterans Health Care System. For Audiology, the greatest constraint in the system is the audiologists' time. Prior to redesign, it was estimated that the audiologists spent one third of their time doing clerical/technician level duties.

To free up the audiologists time, Audiology Assistants now do the following: place orders for hearing aids; take ear molds; address problems related to assistive devices, repairs and accessories; verify adequacy of ordered items; manage repairs and factory returns; make phone calls to patients and respond to incoming calls; and handle equipment set up, and calibration and repair coordination. In addition, the department Secretary is trained to review referrals to verify eligibility and redirect inappropriate referrals.

Source: Robert J. Dunlop, PhD, Chief, Audiology Section (robert.dunlop@med.va.gov)

"The care team's composition is based upon how the clinic manager decides to ensure its supply meets its demand."

7. Optimize the Care Team

The specific mix of staff (number of physicians, nurses, assistants, technicians, clerks, etc.) varies from clinic to clinic. The mix determines the extent and type of work that can be driven away from the constraint and is, therefore, key to maximizing the capacity of the clinic.

The care team's composition is based upon how the clinic manager decides to ensure its supply meets its demand. To do this, look at the nature and pattern of your clinic's demand. Identify the throughput-generating link that is most critical to meet this demand (within the limits of clinic resources).

Essentially, following the process of identifying the constraint, exploiting its capacity and ensuring all resources subordinate to it as summarized in Table 1.1 from Chapter 1 will dictate the optimal care team's composition. In other words – what staff resources or skills (and how many of each) are required to ensure the constraint works optimally?

The following additional actions will help ensure a well-functioning care team.

Action 7.1 Use standard protocols to optimize the use of other providers

Establishing protocols for conditions and processes that can be clearly delineated is an easy way to optimize use of other providers. A standard process for flu vaccinations can ensure that a nurse or other appropriate provider can administer shots consistently.

Action 7.2 Separate responsibilities for phone triage, patient flow, and paper flow

Clinic systems often work best when the work for triaging patient requests for care, the patient flow through the office, providing the medical record or paper work for the visit, etc. *is clearly assigned to particular individuals*. This provides fewer opportunities for delays to build in the system overall

"The system's constraint link is the synchronization point for managing the clinic's flow."

8. Synchronize Patient, Provider, and Information

As was established in Chapter 1, clinics are interdependent links of a chain. Much time can be spent waiting for another stage in the chain to be completed. In a clinic, the major links are probably much as you identified (some may have modified) Figure 1.3. Activity A-1 should help position critical support entities and information (medical record, chart, etc.) needed for the patient visit.

The system's constraint link is the synchronization point for managing the clinic's flow. Remember that while this point is often physician or primary provider time, it is vital that you determine this for your system.

Steps to help staff synchronize clinic processes include the following:

Action 8.1 Start the first morning and afternoon appointments on time

Agree on what a specific clinic appointment time means in terms of the constraint. If the constraint is the provider and the first a.m. appointment is at 0800, all links prior to provider time (registration desk, intake tasks, etc.) must be synchronized around that point.

Action 8.2 Obtain patient information by alternative means prior to the visit.

This action is a clear example of the constraint-based process of on-going improvement step of subordination of non-constraint resources to the constraint. **Given that your goal is to synchronize provider time with patient needs and information, the more patient-specific information you can obtain will enable your staff to complete forms, flag noteworthy items and/or prepare special resources that are needed for the provider to work optimally.**

"Given that your goal is to synchronize provider time with patient needs and information, the more patient-specific information you can obtain will enable your staff to complete forms, flag noteworthy items and/or prepare special resources that are needed for the provider to work optimally."

Techniques to accomplish this step include:

"**Use a "chart-check" as a quality control inspection step prior to the synchronization point (physician entering exam room).**"

- Whenever possible obtain patient information prior to the day of an appointment. Think about using the appointment confirmation call to do so.
- Use group visits (or other methods) for new patients to obtain patient information prior to the actual initial visit.
- Develop and use a health history form for patients to fill at home and bring with them to the visit.

Action 8.3 Check the chart to make sure it is available as well as complete and accurate

Use a "chart-check" as a quality control inspection step prior to the synchronization point (physician entering exam room). The logic is fairly straightforward. Say, for example, there is on average a 10% incidence of charts that are missing necessary information (such as lab results or other diagnostic tests). The chart check should catch these prior to the constraint (provider) being unnecessarily idle or having to do rework. The result is you increase the flow or supply capability to the system by that 10%.

Action 8.4 Use health prompts to anticipate the full potential of today's need

"**ensure the clinic staff has the right supplies, equipment and/or procedures**"

There are a number of prompts (e.g. the preventive medicine guidelines) that can be embedded electronically in CPRS or used manually to generate information that the care team needs on the day of the clinic visit. Your goal is to use prompts to tell the care team that the patient may be due for a sigmoidoscopy, flu shot and pneumococcal vaccine, or a HbA1c test for diabetes. Learning to use these efficiently is another way of increasing supply or capacity.

Action 8.5 Make sure that rooming criteria include having the patient ready

Rooming criteria check sheets should be used to ensure that the patient is ready for the physician. Check sheets typically include such items as shoes off for a diabetes patient.

9. Predict and Anticipate Patient's Needs

Anticipating patient needs is crucial for help increase clinic capability or flow. Most of the actions below are pointers and ideas that **ensure the clinic staff has the right supplies, equipment and/or procedures** completed prior to or at the appointment time.

- The care team can use a 15-minute huddle to review the coming or the next day's patients. Contingencies can be put into place to ensure the patient's needs are met while maintaining clinic flow. The check-off in the notes sections of CPRS' clinical reminders can be used to look at what is due for each patient in the near future so it can be done today

Helpful Hint:*To conduct a "huddle," the care team gets together at a pre-determined time each day to look ahead on the schedule and anticipate the needs of the patients coming that today. For example, a physician may see that a patient will need a potassium test. Staff can have the patient go to the lab immediately after checking in at the clinic while others can adjust the schedule (or move an early-arriving patient with a slightly later appointment into that slot so the first patient can be absorbed into the flow 30 to 45 minutes later.)*

- Consider using visual tools to communicate. Clinics have creatively used white boards to flag special needs appointments, contingencies (such as what the rerouted patient above), as well as provider and staff assignments for the day.
- Effective use of clinic reminders in CPRS can help generate lists of immunizations, tests or check-ups.
- Use the notes section of the package to enter special comments about patient needs; post this information as well as room location in a central place in the clinic workroom.

"**rethink the use of rooms and equipment.**"

10. Optimize Rooms and Equipment

A final way to increase the clinic's capability is to **rethink the use of rooms and equipment.** Traditional practices regarding assigning rooms to specific physicians and layouts of equipment and supplies are being modified to increase flow through clinics.

Examples of two easy to use changes are open rooming and standardizing supplies and layouts in exam rooms.

Open rooming means that any provider can use any exam room. If, for example a clinic has 8 exam rooms with two assigned to each of the 4 clinic providers, on days where only 3 providers are available, only 6 rooms were utilized – even though this meant delays and increased patient wait time. A simple policy change whereby the 3 providers move through the 8 rooms (usually this means 1 room more than normally used).

Clearly, this change suggests that equipment and supplies that are stocked in the rooms need to be standardized – and continually replenished. This enables any provider to know precisely what's available and where it's located in the room thus increasing efficiency. If the clinic couples this with contingency planned as per step 9 explained above, specific equipment or supply needs can easily be moved into position on mobile carts or special supply trays for those patients that require them.

Summary

"**Thus, phase in the ten steps of Advanced Access in stages.**"

The goals of the Advanced Access initiative in the VA are to increase access and reduce delays often with little additional resources. Because many managers know they should comply but assume that implementation requires additional resources – they may be tempted to implement only those pieces they feel they can implement. The resulting "patchwork quilt", will probably create frustration and not yield the level of improved clinic performance desired.

Thus, phase in the ten steps of Advanced Access in stages. Recall that the first two steps are designed ***to help you find more capacity – without expending significant additional budget dollars and to prevent the creation of additional backlog.*** Steps 3-5 are focused on ***getting your supply and demand aligned*** with each other. The final five steps (6-10) are more proactive process and layout redesign focused on helping you ***increase your supply capability.***

CHAPTER 4

Chapter 4: BUDGET AND FINANCE

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Goals:

To present both an up-to-date and comprehensive summary of what clinical practice budget planning involves as well as a proposed process for doing so successfully.

Objectives:

1. To summarize how the VA funding process works
2. To orient practice managers with the different types of funds available, and
3. To provide detail as to how to calculate nurse staffing requirements as well as tips to successfully procure resources.

Introduction

A practice manager faces a number of challenges in planning a program budget. These challenges can vary from operating within a given FTEE, space, and equipment budget to being fully responsible for the much larger scale activities of budget analysis, planning, and implementation. The challenges frequently come from the apparent lack of sufficient resources to effectively meet patient demand. This in turn creates the biggest challenge of how to prioritize facility needs and translating them into successful budget requests.

This chapter is designed to help you improve budget planning and development capability. It therefore is designed to first provide an understanding of the likely approach you have acquired to perform your budgeting responsibility. It is contrasted with what your process needs to move to in order to be more "client-centered". Next the known intricacies of the VHAs funding allocation system (VERA) and the general funding process are presented. Finally, some specific details regarding the "what and how" of budgeting for staff (numbers of and salary and benefits), equipment, and space tied to the clinic's patients and programs.

The Budget Nightmare

For reasons of simplicity, let's delineate two methods of managing: the conventional way which is more "clinic-centered" versus the more recently-adopted and advocated "patient-centered" methodology. The key difference is that in the former, the patient moves to the different work centers and stages of service. In the latter, the work essentially moves to the patient.

"The process of budgeting all comes down to determining "what do we need in order to operate well"?"

The thinking and behavior engaged in doing budgeting under the more widely-used and familiar clinic-centered approach differs from that which is engaged in under the client-centered approach. The differences can probably be condensed as follows.

The process of budgeting all comes down to determining "what do we need in order to operate well"?

Under the more widely-used, clinic-based approach this is determined by essentially looking for capacity "gaps". In other words, managers are taught to (and will, therefore):

1. Calculate the current load on each category of staff (i.e. nurses, assistants, providers, etc.), the major pieces of equipment and different units of space (i.e. per exam room, per lab, etc.). This means looking at output rate compared to standard measures of capacity or levels of performance.

2. Gather or guess at data regarding projected demand, i.e. how many of what kind of patients will be generating requests for services for the next year.

3. Compare the two sets of data:

    a. Any entity that appears "stretched" becomes ammunition in the budget wars as a justified request for more dollars.

    b. If it looks like another resource (such as an assistant, a piece of equipment, an extra exam room, etc.) might assuage the situation from (a) above, you have even more ammunition in the budget wars as a justifiable request for dollars.

    c. Any that is underutilized is technically an area for savings.

4. Prepare the budget with supporting documentation bearing in mind that the more you can tie that documentation to the VHA's high priority initiatives the better.

" The major assumption underlying this process is that an over-utilized resource anywhere is as important as any other. "

The major assumption underlying this process is that an over-utilized resource anywhere is as important as any other.

And what are the effects of budgeting in this way?

- Clinic managers all learn to build very solid, legitimate cases and justifications – and will spend a tremendous amount of time to generate and gather the required data to do so.

- The "spend down" at the end of the year (after all, you can legitimately plead need/poverty) is endemic.

There are several problems. One, clinic managers are frequently unable to clearly prioritize who needs more of what… i.e. "where to allocate scarce resources". This same

fundamental problem faces the overall VHA system's executive decision-makers as well. This becomes a major issue is *because ALL other clinic and facilities managers are doing the same thing.*

"Unfortunately, neither of these situations exists in today's VHA health care delivery setting."

The effects are relatively predictable. No one gets everything or more than they ask for rather they get some proportion. The "squeaky wheels" and/or "more system savvy" seem to be the ones who get more of what they request. Everyone learns to "pad" their requests – only to have the same nightmare repeated the following year. And everyone want to figure out how the VERA determinations are made.

The Point: In general, the clinic-centered budget process that emerged was and is probably fine as long as: (a) patient satisfaction is not relevant to what you do and/or (b) if there are sufficient resources (or you can get them) to provide the type and quantity of care to meet patient demand.

Unfortunately, neither of these situations exists in today's VHA health care delivery setting.

What should the budget process be under the patient-centered, Advanced Access Care-based approach that is systems-based and to which the VHA is moving?

1. Identify the system's (i.e. clinic's) constraint or bottleneck link. Calculate the load on the key resource for that link in exactly the same way as you would for the conventional approach. So, for example, if the "provider" link is the weak link, you'd want to examine utilization rate per provider over time.

2. Gather data regarding projected demand, i.e. how many of what kind of patients will be generating requests for services for the next year and define how this will impact the constraint.

3. Compare the two sets of data:

    a. If the clinic's bottleneck is "stretched" (nearly 100% efficient and highly or over-utilized consistently), this becomes the basis for requesting more dollars to either acquire more of that capacity, and/or

    b. If it has been determined that another resource (such as an assistant, a piece of equipment, an extra exam room, etc.) is best suited to help the constraint operate at a higher level of efficiency or increased capacity, you have another viable request for dollars.

    For example, if you identify that the provider is the bottleneck and choose to reconfigure staff roles so that a provider assistant can take on about 30% of what the provider currently does (hence can make the provider – and the system's flow 30% more productive) you can build a logical and defendable request for the salary to do so.

    c. Any resource that appears underutilized but feeds or supports the constraint area or the final exit point of the system needs to have at least some "excess" capability because there is variability in the system. In other words, if the provider has an emergency that

precludes their seeing patients for the day – resources on the patient care team have to have some capability to "catch the system back up". Thus, some of what appears to be surplus can and should be defended in the budget process.

4. Prepare the budget with supporting documentation.

The principle benefit of the latter approach is the focus it gives to the clinic manager for his/her budget requests as well as the simplification of the data gathering and documentation portion of the process. The benefits for the VHA executive levels of decision-makers are that they also have a basis for making the apportionment decision that is in alignment with its patient-centered policy.

"**The intent of the VERA system is to distribute appropriated money among the VISNs based predominantly on healthcare services delivered by each VISN.**"

The VERA Funding Model

The Veterans Health Administration (VHA) instituted the Veterans Equitable Resource Allocation (VERA) system in April 1997 to allocate funds to the Veteran Integrated Service Networks (VISNs). VERA ensures that appropriated funds are distributed based on use of the VA health care system by eligible veterans rather than on historic funding patterns. The intent of the VERA system is to distribute appropriated money among the VISNs based predominantly on healthcare services delivered by each VISN.

Under VERA, each network receives a "tailored" price that reflects the unique characteristics (e.g., cost of labor) for that network. This price is comprised of three pricing groups based on patient classifications. The patient classifications are Basic Care Non-Vested, Basic Care Vested, and Complex Care. A description of each classification and the reimbursement amounts for Fiscal Year 2001 is provided in Table 4.1 below.

During the course of a given fiscal year, *a patient may qualify for multiple patient classes*. To determine reimbursement, a patient is placed in their final patient class on the VERA Hierarchy Chart at the end of a fiscal year. A majority of the patients cared for in a general medicine Primary Care setting will qualify for Basic Vested Care reimbursement under the VERA funding model.

"**specific information about what factors are used to allocate funds and how much weight each receives in the formula are not shared. (Given the explanation in the prior section, now you know why.)** "

One of the reasons why facility and clinic managers want to know about how VERA works is to guide them in budget preparation and planning with the unstated goal of maximizing budget dollars each receives. However, specific information about what factors are used to allocate funds and how much weight each receives in the formula are not shared. (Given the explanation in the prior section, now you know why.)

Patient Classification	DESCRIPTION	ANNUAL FUNDING
Basic Care Non-Vested	These patients have not had a thorough medical evaluation (defined by certain CPT codes) or an inpatient admission in the last three years.	$121.00
Basic Care Vested	These patients have received one appropriate, thorough medical evaluation (defined by certain CPT codes, and requiring at least a disease specific history and physical examination), or an inpatient admission in the past three years.	$3,126.00
Complex	These patients had a qualifying inpatient stay or special emphasis care. There are 26 Patient Classes that currently qualify for Complex Care reimbursement, listed in the VERA Handbook (available through the VA Intranet or your Fiscal Officer)	$42,765.00

Table 4.1 FY2001 VERA patient classification and reimbursements

"The amount of money available for distribution may vary each year and is not directly dependent on the numbers of patients VHA treats."

There are, however, several general pieces of information that are known regarding VERA.

First, VERA distributes only the Medical Care budget appropriated by Congress not monies recovered from patients' private insurance, sharing agreements, or other sources.

Second, while VERA methodology is used to distribute money among the VISNs, VERA is not universally used to distribute money within every VISN or site.

The amount of money available for distribution may vary each year and is not directly dependent on the numbers of patients VHA treats. Thus, a VISN which increases the number of treated patients is not guaranteed to receive a larger total allocation. In other words, if the VHA appropriated budget is unchanged and all VISNs increase the number of patients eligible for a VERA reimbursement, then the "per patient" amount that is allocated will be less. Further, the dollar amounts listed in Table 1 are for FY2001 only thus, you cannot assume that these will reflect any future fiscal years.

"distribution is not based on the total number of all veterans receiving care. Priority Level 7 veterans do not qualify for VERA reimbursement."

Third, distribution is not based on the total number of all veterans receiving care. Priority Level 7 veterans do not qualify for VERA reimbursement. Only some higher priority level patients (generally those previously known as "Category A" veterans) count in the VERA distribution model. Currently the VERA model includes veterans with service-connected disabilities; veterans with incomes below a specified limit; World War I veterans; ex-prisoners of war; veterans with special statutory eligibility (such as exposure to Agent

Orange in Vietnam, radiation from a nuclear detonation, an environmental hazard, or a toxic substance in the Persian Gulf); and domiciliary patients.

Additional information related to the VERA funding model is available through local and VISN Fiscal Officers. A list of current vesting codes is available on the VHA Intranet.

The Current Reality of Budgeting and Finance

Many clinic managers are interested in finding out how can they get the most budget dollars they can.

The first critical element to know is that there are different pots or buckets of money that are restricted to certain categories for spending. This is unlikely to change whether the conventional way or the more client/system-based method of budgeting is used.

One bucket of dollars is for staffing. A second one is for equipment. The final category essentially deals with physical facility or "space ". While some details regarding considerations within each category are provided below, the local fiscal officer can be of invaluable assistance in outlining the parameters for specifics and providing individual guidance for managing one's budget.

"So the question becomes – what information can and should be used to properly budget?"

Generally, salary dollars can only be used for salary. Equipment and construction money cannot be used for salary purposes or vice versa. It has been said that one can build a new clinic, supply it with new equipment, but not be able to operate it because it doesn't have the salary dollars to staff it.

So the question becomes – what information can and should be used to properly budget?

Staffing and salary dollars:

Available salary money is generally the main factor cited as limiting the total staff. However, do not assume that the solution to your clinic management problems is the addition of staff. The key is tied to the constraint.

> **Note:** If you have taken the time to complete Activities 1-A and 1-B from Chapter 1, you should have a clear picture of your system's core throughput-generating chain and the current weakest link that most dictates the rate at which you can service your patients. (If you haven't done so, take the time to read through the instructions and do those activities now.)

"The processes of service delivery should determine the particular staff mix and the number of each profession."

The processes of service delivery should determine the particular staff mix and the number of each profession. For example, the patient-centered model, with services such as sign in, sign out, and electrocardiography delivered in the examining room, uses a different staff mix than the traditional VHA 'bus stop' model. Practices with only one examining room per clinician will of necessity have a different patient flow, and hence are likely to have different staffing needs. The approach outlined below generally works for each type of staff (clerical, nursing, blended, or clinician) utilized in the practice.

In general, the goal is to ensure that the constraint experiences as little non-productive time as possible, even if that means other staff are not always 'busy.' Thus, if the provider is the constraint link the staff assigned to the team needs to be focused on ways of ensuring this goal. Decisions about the layout or additions to space and the availability and positioning of equipment are subordinated to this same goal. Stated another way, the clinician should spend all their in-clinic time performing those activities which only they can perform. Any time spent on activities which another team member can perform is not recoverable, and is time not spent on activities which require a clinician.

Within that context, you can begin by utilizing a nurse staffing methodology. Based on the number of appointments scheduled each day, the complex needs of each patient, and the functions expected of each team member, you can calculate the daily number of nursing staff needed on each team. Adjustments must be made for required absences, among other items. It is important to account for "productive" (direct and indirect productive hours) and "non-productive" (benefit) hours of work. "Non-productive" hours are the vacation time and sick leave that employees receive.

Process Steps for Determining Staffing:

"The amount of indirect nursing care time may vary by nursing team member but the overall time should be added to the FTEE calculated for the team."

First, determine how many of each type of personnel must be on duty at all times given the patient care team and number of teams in full time equivalents.

Second, adjust the FTEE to allow for "non-productive time". Most nurse staffing methodologies multiply by 1.2 FTEE for each 1.0 FTEE needed on duty to do so. In other words, a 20% increase to the productive time is factored in for vacation, leave, sick time, etc. Productive hours include direct care hours (actual time spent with patients) and indirect hours (time spent in committee assignments, training, performance improvement, research, etc.). The amount of indirect nursing care time may vary by nursing team member but the overall time should be added to the FTEE calculated for the team.

Third, add the benefit or non-productive time to the above.

Fourth, multiply the resulting figure by the average hourly salary (including benefits).

For example, *if 4.0 nursing staff were needed to handle daily patient workload, 4.8 would be needed to handle patient workload and non-productive time (4*1.2=4.8). If non-direct care time were 0.5 FTEE, then 5.3 FTEE are needed (4.8+0.5=5.3). A formula for the components of the salary hours budget is found in Figure 4-1.*

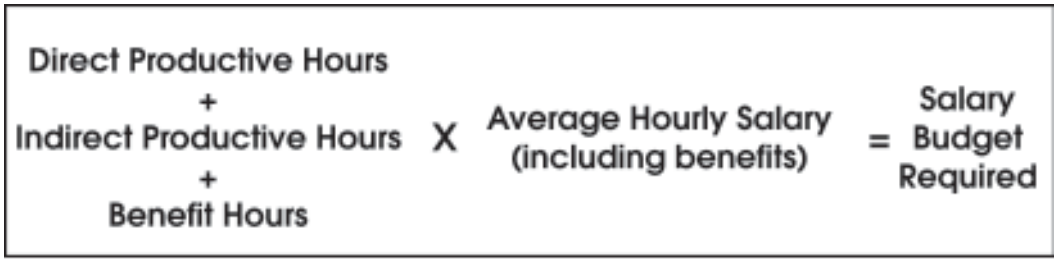

Figure 4-1: Salary calculation formula to adjust FTEE

The same process applies to evaluating other support staffing needs.

This kind of calculation should be part of planning for staffing whether one has total budgetary control or not.

"**The important addition that is not shown as part of the calculation formula is the annual salary adjustment.**"

The important addition that is not shown as part of the calculation formula is the annual salary adjustment. In general, salaries and benefits increase each year usually by 2% to 4%. These additional costs are not always completely covered by increased Congressional appropriations, so be prepared to build these elements into the budget each year. For more in-depth training and guidance regarding how this is best done, consult your education department and your fiscal officer.

The American Nursing Association has staffing recommendations and guides that should be useful (see references section). Utilizing benchmarks can be helpful when planning for staffing, including for other team members, such as social workers. Surveys, such as those done by the VHA National Social Work Resource Planning and Utilization Committee, can provide guidelines for social work staffing in a primary care model. Elements to consider relative to staffing are caseload size, number of visits, clinical documentation requirements, and task allocation. Some challenges in this area are the lack of uniformity in job roles and functions among social workers and lack of availability of current national data.

" **An enhancement that should be incorporated into the criteria for prioritization should be whether the piece of equipment will enable the clinic to increase the rate at which the constraint can operate. Thus equipment that will enable the constraint to work more efficiently or effectively specifically or serve to remove some proportion of work currently having to be done by the constraint or enabling a key resource to better provide work smoothly to the constraint.**"

Equipment

Equipment dollars come from another "pot" (funding appropriation) in your facility budget. As such, these funds are restricted to equipment purchases only.

Budgeting for equipment conventionally starts by the clinic manager identifying equipment needs early each fiscal year through a staff survey, followed by a rigorous prioritization process based on criteria developed by the team. An enhancement that should be incorporated into the criteria for prioritization should be whether the piece of equipment will enable the clinic to increase the rate at which the constraint can operate. Thus equipment that will enable the constraint to work more efficiently or effectively or serve to remove some proportion of work currently having to be done by the constraint or enabling a key resource to better provide work smoothly to the constraint should receive high priority.

Once that prioritization is done, there are several important issues to consider when planning for equipment purchases. These factors are: (1) comparisons of costs to purchase versus lease that equipment, (2) expected maintenance and repair costs, and (3) the effect of having the equipment out of service. The latter can be done more cleanly if the equipment is clearly tied to the clinic's constraint. *An hour of constraint time that is lost is equivalent to an hour of whatever the throughput is to the system.*

A cost comparison, which includes the actual equipment cost, maintenance costs, repair costs, and the life of the equipment should be considered in the analysis.

Equipment requests will compete with the other departments' requests, and perhaps even compete within your own department. It is now clear why "The Budget Nightmare" section at the beginning of this chapter exists.

Under the conventional "rules of engagement" the key is to provide solid justification. Historically, under the clinic-based approach, equipment vital to patient safety or patient

care generally 'competes' well, and these needs are usually the first to get attention in a facility.

> **Handy Tip:** For those equipment needs that are not funded in the initial allocations, ***keep the information available and check with the fiscal or budgeting office periodically.*** This is because budgets are based upon forecasts (estimates). Inevitably, some initiatives that were funded do not get launched, contracts don't get cut in time, etc. thus money may come available. Some of this excess may enable you to obtain an equipment purchase. Always having your requests ready, prioritized and up to date will enable you to take advantage of this opportunity. If you have tied the equipment prioritization to your constraint you will be investing dollars to best ensure optimal operation of your constraint.

Space

Space is an important resource for any practice because it often impacts the efficiency of the providers and the flow of patients through your clinic. *As a rule, any space changes must be cleared through the Chief Operations Officer.* Many facilities have Space Committees which must weigh all requests and will consider whether each is congruent with the master space plan for the facility.

Space is probably the most coveted and jealously guarded of all resources, thus it is essential to get input from all involved parties (including current occupants) at the outset. It is sometimes surprising to find large numbers of programs or people affected by seemingly minor space plans. Moving to a more patient-centered, advanced access approach means your responsibilities regarding space will involved not only determining what changes or additions should be made to existing space but an effective "buy-in" process as well. Tool 1 from Chapter 2 was incorporated for the latter purpose as well. Following its "communication process" is focused specifically on the latter need for "buy-in". Chapter 5 provides some other detail regarding space and layout that may be of additional assistance.

The significance of the physical space issue in this chapter however, lies in that fact that making changes to physical space always requires dollars in some form even if it is only a move from one office to another.

A quick process to help create complete budget requests includes:

1. Is the change regarding space focused on improving the flow of patients through the constraint (or shifting some of the flow from the constraint)? *Select those that are for further consideration on this basis.*

2. Characterize the type of space change required. Is the request for:

    a. An addition or expansion?

    b. A renovation of existing space? Or

    c. Moving/shifting existing space?

3. List all of the issues that must be resolved (or develop a negative branch – see Tool 1 from Chapter 2) in order to successfully accomplish the change. Typically, these will include items such as the following:

    a. Moving often requires telephone and computer hook ups, painting, carpeting and signage.

    b. Renovations include not only actual construction cost but also the requirement of ensuring access for the disabled as well as moving costs as per above.

    c. New or renovated space often leasing of temporary space to locate exam rooms, check-in space, etc. and also requires furnishings or new equipment.

    Be sure to include requests for these needs as separate items as some must be funded from different sources.

4. Quantify the actual cost estimates (use comparisons such as lease vs. construction) associated with all of the items developed in item 3 above.

5. Prepare a statement that identifies how the change fits with the strategic goals for the practice and the facility, and details efficiencies that can be achieved through the plan. **You can probably strengthen your case if it is tied to system flow and the clinic's constraint area as per item 1 above.**

Some additional pointers about what seems to have worked in the "space wars":

- Multi-purpose flexible space is generally favored over single use space, as conversion costs at later times are generally lower. The *Ambulatory Care Infrastructure Assessment* released in 2000 is a very useful tool to help define space needs for the delivery of clinical care.

- Take the time to actively research the furniture types and costs for your space. Do not assume anyone understands the specifications and functional requirements of a healthcare practice. When all is said and done, they are not the ones who must work daily in the space with the equipment and furniture. VHA Facilities Management has developed standard room packages in different styles that may reduce costs and help prevent overlooking an aspect of preparing space for use. Check with the facility or VISN Interior Designer for assistance and information on approved sources of furniture.

- For maximum efficiency, be sure to orchestrate the move with the environmental management services and information management.

- Plan to suspend or reduce in-clinic operations to allow dry-run and reduced-volume beak-in periods.

- There are specific guidelines for occupying space that was previously a bed section. Check with senior management regarding proposals for conversion of such space.

- Contracting (leasing) clinic space is best accomplished as a team with the contracting officer and engineering staff, and perhaps even legal review. Numerous guidelines surround the contracting process, covering everything from square footage, doorway size needed to accommodate those with physical disabilities, to bidding policy. **VA Handbook 7610.3(265)** Chapter 2, 10/29/96 and Chapter 6 in this guide provide additional information regarding contracting.

Summary

Sound budget and financial management is an important skill for the practice manager. It requires a solid understanding of the VERA funding model, which determines the contribution of ambulatory care to the network and facility budget. It also requires a sound understanding of three major resource areas important to the practice: staffing, equipment and space. This chapter briefly outlines the parameters within which the practice manager and team can operate. An understanding of these areas can make the practice manager an owner instead of the victim of the budget.

CHAPTER 5

Optimizing Resource Use

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Goals:

To provide details and best practices concerning how to use the resources of staff and physical space optimally while balancing important considerations to ensure efficient, effective patient flow.

Objectives:

1. To clearly communicate why the optimization of resources is important and challenging
2. To identify the approaches that are used and how to improve them to optimize the allocation and use of staff and space
3. To summarize factors that must be integrated in resource utilization decisions and to provide tips and suggestions as to how these can be balanced.
4. To provide specific resources (people, published materials and offices) to which practice managers can refer.

Introduction

Each hospital and health care system does strategic planning to define the types of programs to provide and how best to provide the service. Primary care, mental health, geriatric, or specialty practice managers are all involved in or affected by strategic planning. This is the driver for all future decisions. Practice managers are responsible for translating the facility and VISN strategic plans into reality. This means they must make decisions as to how to use the available resources to provide the defined spectrum of patient care to the greatest population of veterans.

Clinical practices have essentially three types of resources: human resources, physical space and equipment. While you could argue that there are monetary resources as well – they're essentially used to procure or improve the three primary resources needed to run the operation.

The focal point of optimizing resource use has traditionally emphasized the optimal use of staff. Frequently, it is assumed that this would be the most "expensive" resource.

"You should now understand that the most "expensive" resource for the system is not necessarily the one who is paid or costs the most. Rather ***it is the one with the scarcest level of critical capabilities that are necessary for the flow of throughput in the system.***"

You should now understand that the most "expensive" resource for the system is not necessarily the one who is paid or costs the most. Rather it is the one with the scarcest level of critical capabilities that are necessary for the flow of throughput in the system. Every minute of that resource' capability that is wasted is a minute of throughput lost to the system.

That's pretty expensive.

The decision regarding how to optimally use resources should be examined in this light.

That being said, the reality is most workers don't pay much attention to their assigned responsibilities or the physical plant within which they work – until something goes wrong, they're asked to "do more" or a planned change takes something they perceive they need. Then, they come to you, the practice manager, to "fix it". The point remains the same: if you're going to fix something, make sure the solution is tied directly to increasing throughput (hence the constraint link) in some way. Thus, any solution you put into place should be scrutinized and communicated carefully. The tools presented in Chapter 2 are a way to do so systematically.

"the reality is most workers don't pay much attention to their assigned responsibilities or the physical plant within which they work – until something goes wrong, they're asked to "do more" or a planned change takes something they perceive they need. Then, they come to you, the practice manager, to "fix it"."

This chapter will move you through four sections. The first section presents a generic process (which is frequently done in piecemeal and informal fashion) as to how resource utilization decisions should be made. The next section presents a way to quickly and systematically evaluate existing use of staff and space. The third section then provides a concise summary and explanation of considerations that must be factored into your decisions about what changes to make to improve resource use. Finally, it provides a set of resources to go to for additional details, information and ideas about each.

The Need for a Process

Intuitively and logically, practice managers know they need to examine the staffing and skill mix and define staff responsibilities that will best utilize the most appropriate level of personnel. For example, the role of providers should be to do those things that only they can do.

The challenge in the optimal use of staff is untangling the myriad of tasks that must be performed to ensure system flow. Frequently, the processes (hence tasks) that exist in many facilities are ones that have evolved over time through a combination of trial and error and the mix of staff available at any point in time. Additions to staff usually result in their being assigned the overload of responsibilities others in their position – as well as the overload of other resources whose work they are deemed capable or qualified to handle. Additions to responsibilities of existing staff frequently involved negotiation or conflict.

Thus, the tendency is to list the host of roles to define by making a list. Typically such a list would include:

- Who will answer the telephones?
- Who will receive messages?
- Who will return messages to patients?

- Who will return messages to other clinicians?
- Who will triage the patients and communicate patient readiness?
- Who will be responsible for the tickler process for reminders about patient appointments, prescription renewals, test results, consults?
- Who will make appointments and referrals?
- Who will be involved in various aspects of patient education?
- Who will do the patient review at check out?
- How will this be documented in the medical record and by whom?

"In short, to optimize resource use, the process should identify activities that MUST be performed to ensure the system's goal: patient flow. This ensures effectiveness. The process should also ensure removal of those activities that are unnecessary or that block patient flow. This ensures efficiency."

The reason a generic process to help you optimize resource use is critical is to ensure there is an alignment and efficiency of effort from each key link in the clinical practice' throughput-generating as well as from each area or function that supports those links.

In short, to optimize resource use, the process should identify activities that MUST be performed to ensure the system's goal: patient flow. This ensures effectiveness. The process should also ensure removal of those activities that are unnecessary or that block patient flow. This ensures efficiency.

Below is a summary of a simple, generic process that clinic managers should (and may, intuitively) follow in order to better make these types of decisions regarding how staff and space are utilized.

Each step in the process is stated and its rationale explained below.

A Generic Process and "How To" Details to Optimize Resource Use

1. ***Create a Master List of Functions and Tasks that each link in the Core Throughput-Generating Chain requires from its predecessor link.***

An often over-looked step in determining how to use resources properly is taking the time to summarize this list of tasks that are required to ensure the system performs well.

Overall, for the clinic to operate well, there are a host of tasks that must be performed in an integrated fashion. An often over-looked step in determining how to use resources properly is taking the time to summarize this list of tasks that are required to ensure the system performs well.

Each link in the core throughput-generating chain is a customer of its predecessor. You're trying to ensure the critical tasks that MUST be performed to ensure patient flow through the system. Optimizing resource use means that each link performs its required tasks.

> **Note:** There is a difference in doing what "must be done" with a list of tasks or responsibilities that have evolved over time and what "must be done" that are tasks that a customer link REQUIRES in order to function.

Activity 5-A is designed to enable you to systematically and quickly complete this first step.

Activity 5-A is designed to enable you to systematically and quickly complete this first step. The steps explained in Activity 5-A are designed to coincide with the numbered instructions on Figure 5.1 Sample "Required Functions and Tasks" Worksheet. It ties directly with Activity 1-A from Chapter 1 so you might have to complete that activity prior to this one if you've not already done so. Blank templates of Figure 5.1 for your own use are available at the end of this chapter.

ACTIVITY 5-A

Goal: To quickly capture the list of tasks that are required to ensure the throughput-generating links in the clinic chain perform well.

Steps:

1. Write each link in your throughput-generating chain (as you're generated them in Chapter 1, Activity 1-A) as a separate entity along the left-hand side of a flip chart, piece of paper of use the Figure 5.2 Template for Throughput-Chain Required Tasks.
   An example is provided in the spaces in the left-hand column of Figure 5.1 Sample "Required Functions and Tasks" Worksheet.

2. Highlight the link that is the constraint area or weakest link in your system.
   For the sample shown in Figure 5.1, the "provider" was the constraint area.

3. Extract those activities that each link requires from its earlier or "feeding" link. Use a logical construct called "necessity" to do so systematically.

   The generic form is essentially "In order to" _____, "we must have/do" _____. (This is identical to Tool 2 from Chapter 2.)

   a. Start with the constraint link.

   > **For example:** If your clinic's constraint is "Providers", you would surface that which is required by providers by stating:
   >
   > "In order for ***Providers*** (to have or do their job),
   > ***Intake*** (the link that directly feeds them) must … then fill in the blanks.
   >
   > As shown in the example Figure 5.1, this might be "measure vitals of blood pressure, weight, etc."
   >
   > ***Note:*** *try to put ONLY a verb and a noun – no descriptors at this time.*

   b. Repeat the same process for any and all earlier links, until you reach the first link.

   c. Once all required actions that each link that feeds the constraint area are defined, focus you attention on the last link of the entire chain. Repeat the same type of verbalization upward through all links until you hit the constraint.

Handy Tip: Emphasizing the word "MUST" will force you to keep that list of tasks pared to those that are absolutely required. If you have some uncertainty – ask yourself either of the following:

- "Is it absolutely required that the link being fed have the bullet item in question"?
- "Will throughput (patient flow) stop if this is not present or done?"
- *KEEP TRACK OF ANY TASKS YOU DISCARD FOR USE IN STEP 2 AND FIGURE 5.2.*

Deliverable: **You have a list of all activities that each link in the core throughput-generating chain is required to provide for its "customer" link to perform properly and well.**

Recall: **An important part of optimizing resource use is when each link performs tasks as defined or determined by the throughput-generating chain's requirements.**

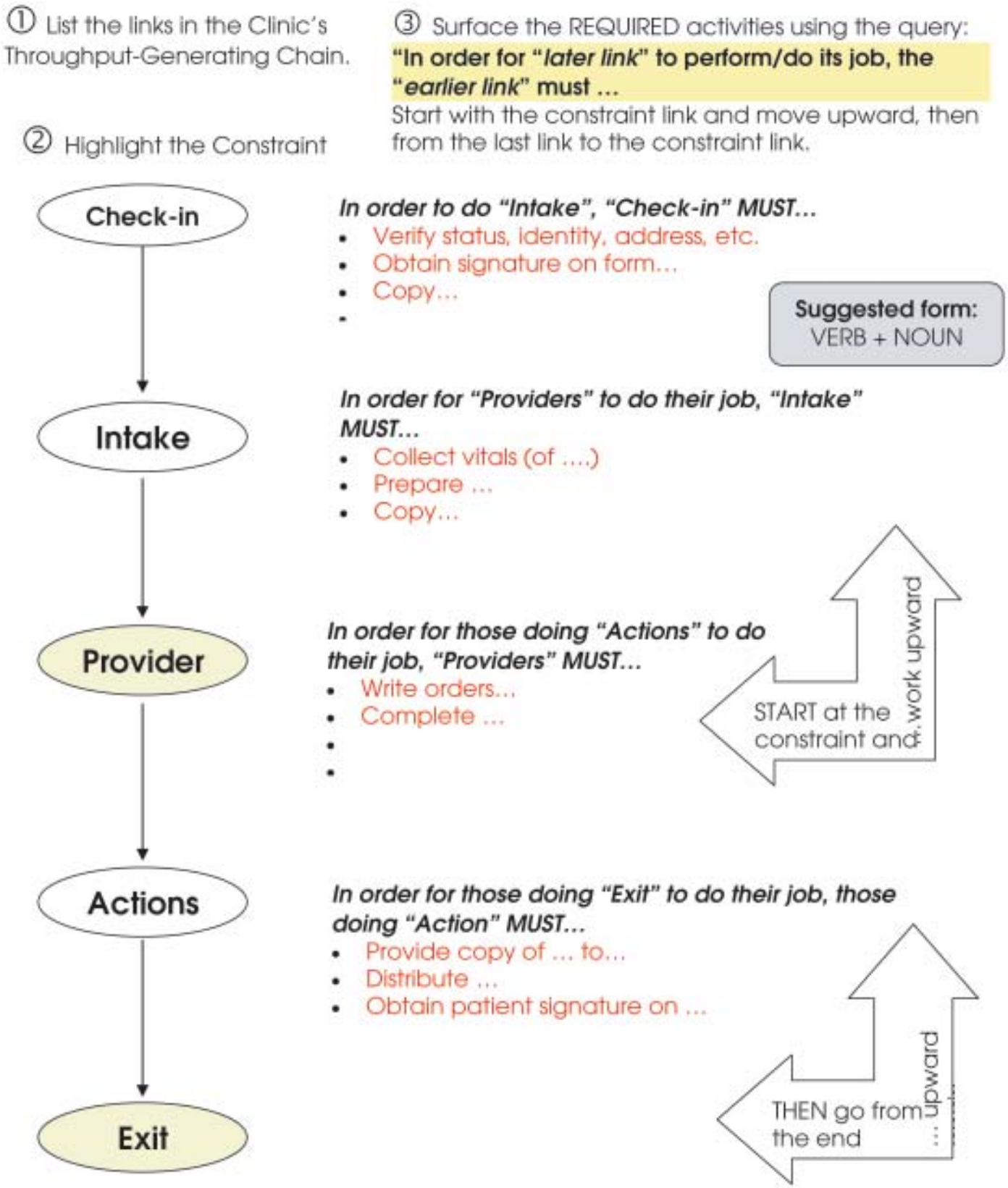


Figure 5.1 Sample "Required Functions and Tasks" Worksheet for Activity 5-A

2. ***Clarify functions and tasks that are necessary for other entities to perform based upon required inputs to complete each thoughput-generating task.***

Each support area has as its customer, one or more links in the core throughput-generating chain. It is conceivable if not likely that the constraint or weakest link in your system is not operating well because its support areas' actions are contributing to the problem, causing errors, rework, unnecessary stoppage, etc. Optimizing resource use therefore also means that critical work of support areas for throughput-generating chain flow.

Activity 5-B is designed to enable you to quickly identify what each throughput-link requires and from whom.

Activity 5-A generated a list of tasks that must be performed by the links in the throughput-generating chain. **Activity 5-B is designed to enable you to quickly identify what each throughput-link requires and from whom.** Figure 5.2 Sample "Support" Entities' Required Activities Worksheet for Activity 5-B.

ACTIVITY 5-B

Goal: To identify tasks required from the key support areas for each link in the throughput-generating chain.

Steps:

1. Copy the required tasks for each of your throughput-generating chain's links from your completed Activity 5-A.

   For example: Perhaps you identified that the "check-in" link's tasks were
   - Update demographics
   - Obtain signature on form…
   - Copy insurance card
   - Copy referral paperwork

2. Identify the input(s) required for each task.

   For example: "Intake" link's key required inputs might be"
   - The EMR
   - Admission face sheet
   - Lab Report

3. Identify the source of each type of required input. Input may come from the patient, another link in the throughput-generating chain, or a support entity in the clinic. Use your list from Step 3 Activity 1-A, in order to identify the latter.

Deliverable: You have a list of all required inputs and the source for each for each activity the links in your core throughput-generating chain must perform.

Recall: An important part of optimizing resource use is when each link performs tasks as defined or determined by the support units truly "support" the achievement of throughput-generating link's activities.

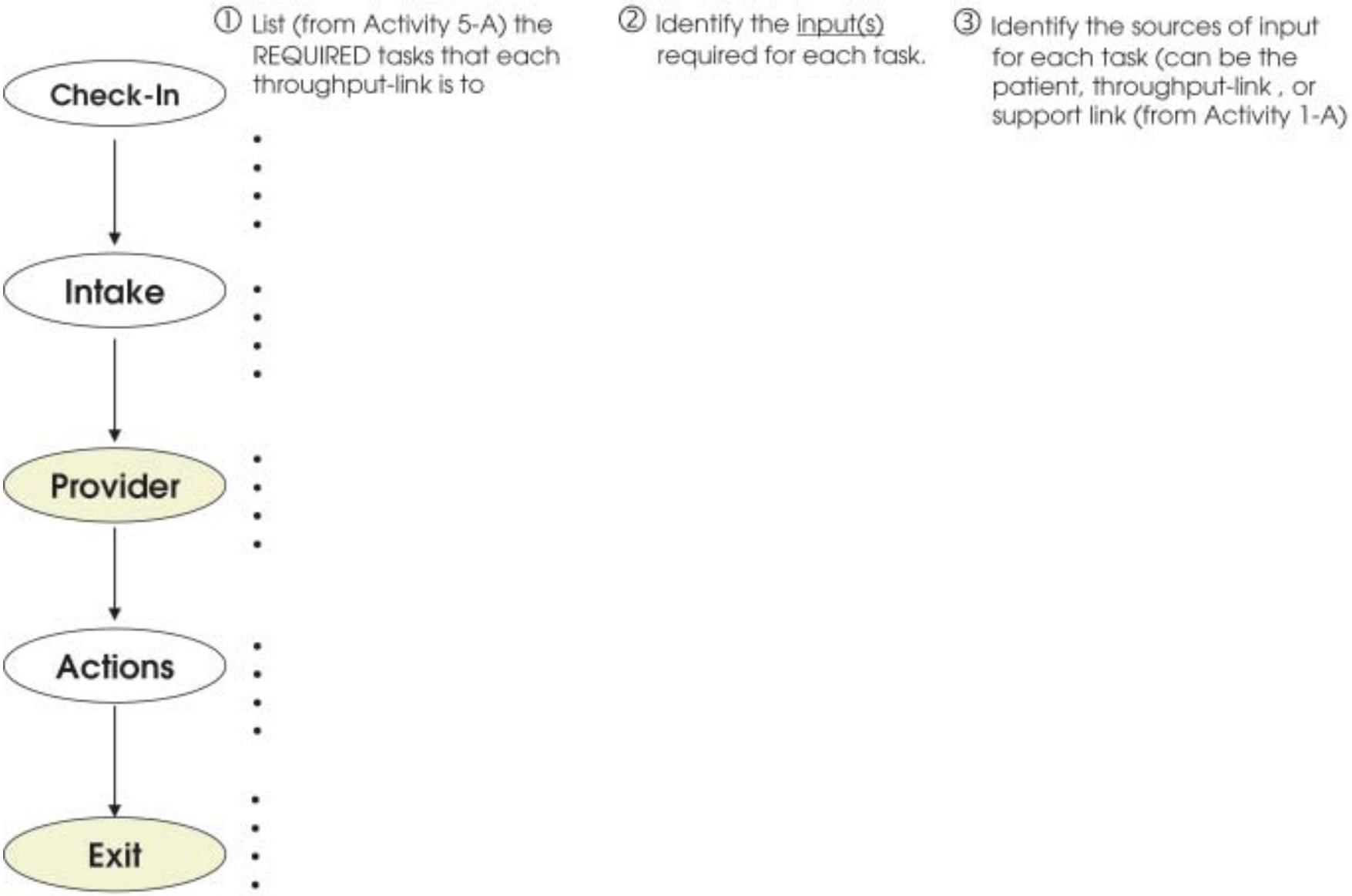


Figure 5.2 Sample "Support" Entities' Required Activities Worksheet for Activity 5-B

3. Generate a list of other tasks that staff may be doing that aren't on the above list.
An often-overlooked part of achieving your goal of optimizing resource use is to ensure unnecessary work is NOT being performed.

However, you also want to obtain additions to this list. Is there staff that still take an action that simply goes to an internal report that no one uses? Sometimes there are steps that are routinely done that are repeated at two other points of time. Think about those things "we've always done" but no one knows for sure why.

> **Example:** A telling non-health care example is what was done at a tire company. There was a problem with a paint striping machine that left blemishes on in-transit tires that a process improvement team was attempting to address. They tried different paints, temperatures, racking systems for drying – all to no avail. A maintenance man, in one of the team meetings quietly asked: Why are we putting the stripe on the tires anyway? He query was met with silence. The machine was removed shortly thereafter.

Tool Tip: In order to complete this step fairly easily, use your just completed results from Activities 5-A and 5-B (use worksheets from Figures 5.1 and 5.2). Don't neglect items you may have produced as a result of the "handy tip" in Activity 5-A.

Conduct a brief (15 minute) brainstorming exercise with the following objective:

Goal: Identifying things we're doing that we should not or might not have to be doing…

Material: Post (on a flipchart or overhead, or make copies) the goal and some of the items you may have produced as a result of the "handy tip" in Activity 5-A as well of what has been identified as REQUIRED activities.

- Elicit inputs – your objective is quantity.
- Enforce the rules of brainstorming: NO discussion or debate, anyone and everyone may offer ideas, record everyone's comments.
- If the group slows down, ask the questions above to help re-prime the pump.

> **Note:** This can even be performed via e-mail. To increase participation, consider a small incentive such as all those who submit ideas will get entered into a lottery for a coveted parking spot for the week…

4. Conduct a "gap" analysis or "needs assessment".

Now that you know what each throughput-generating link and support area links <u>should</u> be doing, it is important to find the gaps. What of that which is required, <u>isn't</u> being done at all versus done poorly?

Optimizing resource utilization entails that required activities of first, the throughput-generating chain and second, by the areas that are to support the flow of patients through the system that are NOT being done or done properly be mobilized there.

This is why the material in Chapters 11 and 12 are so critical. Ideally, you would base the identification of gaps on actual clinic data. Ideally, given the push toward being patient-driven and systems focused, this assessment should be driven by the system's constraint. Additional information on how to incorporate this is provided in Chapter 11.

Thus, performance "gaps" or "needs" should be quantifiable. This is why the material in Chapters 11 and 12 are so critical. Ideally, you would base the identification of gaps on actual clinic data. Ideally, given the push toward being patient-driven and systems focused, this assessment should be driven by the system's constraint. Additional information on how to incorporate this is provided in Chapter 11. In the absence of hard data at the outset, consider the following quick tip for a way to conduct this assessment:

Tool Tip: Conduct a brief (15 minute) **Nominal Group Technique** exercise with the following goal:

Goal: Quick and informal assessment of how we're doing on required tasks and activities.

> **Note:** Participants should represent the group performing the task, the a representative of the link receiving or using the output, a supervisor or each unit and any other individual who is in a position to be evaluate the performance on the tasks being evaluated.

Materials: Use your completed results from Activities 5-A and 5-B (worksheets from Figures 5.1 and 5.2) along with a flip chart or overhead transparency of Figure 5.3 Template for Nominal Group Technique.

Complete the four steps shown on the Template.

Results: You have an initial idea of where your "gaps" and needs are to help make decisions where to deploy effort and resources.

1. List REQUIRED tasks that a throughput-generating link is to complete.

NOTE: do each link's tasks separately.

2. Identify the people (representative group of individuals who are providing feedback or assessment input..

1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						

3. Have each participant individually and silently "score" how well the task is currently being performed on a scale of 1to n (where n = the total number of ideas. A score of "1" is ideal/excellent and "n" equals not done or done really poorly) on a piece of scrap paper. Record each participant's perceptions on the grid below their name.

4. Calculate row totals in the last column. If there is an "outlier" score - be sure to take a couple minutes to find out the person who gave the score's reasoning but do not get into a conflict with them - see the caution below.

Re-iterate that this is informal, not scientific nor intended to "assign blame". Rather, in the absence of a more systematic performance evaluation methodology, the information will be used in the interim as a basis for developing ways of optimizing resource utilization.

Figure 5.3 Template for Nominal Group Technique.

So where are you now?

- You determined what is required for throughput (patient flow) in step 1.
- You clearly articulated required tasks by support resources in step 2.
- You have an idea of some tasks you are currently performing that could be dropped or discontinued (this will free up capacity) in step 3.
- You know where your performance gaps, hence needs are in your system in step 4.

5. ***Make Appropriate Decisions and Changes:*** Figure 5.4 Visualizing What To Do and How to Gain Time and Capacity To Do It is a way to conceptualize what you have done. Think of all the tasks and levels of effectiveness as being able to be positioned in each of the four quadrants shown on Figure 5.4.

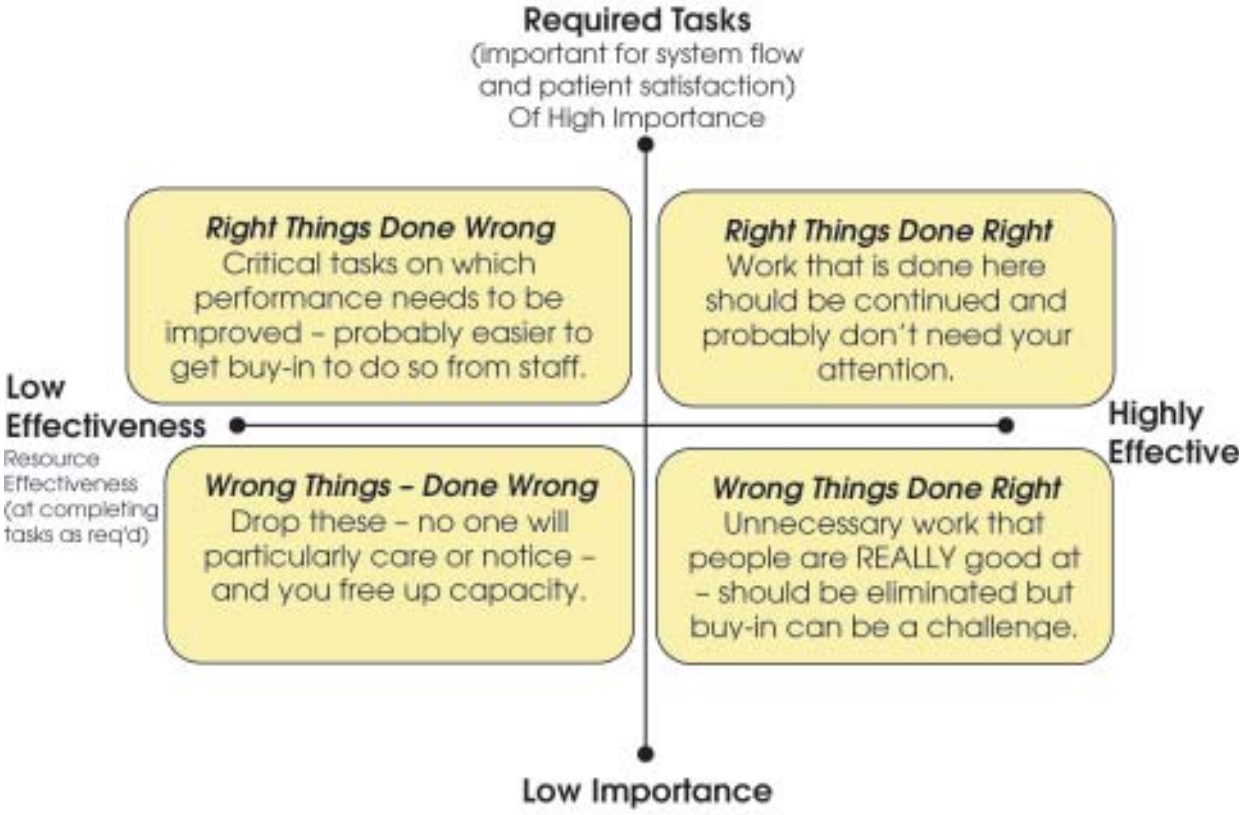


Figure 5.4 Visualizing What To Do and How to Gain Time and Capacity To Do It

You did not go through this analysis to wring your hands. But how do you make appropriate level changes – especially when you know that changing roles and responsibilities is frequently a source of conflict and resistance to change?

Gain time (capacity) by eliminating any tasks in the lower left-hand quadrant.

A potential source of conflict lies with tasks in the lower right-hand quadrant of Figure 5.4.

Focus your immediate decision-making on resource utilization on those activities in the upper left-hand quadrant – especially those "feeding" or supporting the the constraint.

Resist the urge to tinker with those activities in the upper right-hand quadrant except if it improves the rate at which the constraint can perform.

Your primary goal is to move (more and more) toward patient-centered care. This means that optimizing resource utilization must be focused on optimizing patient flow within the clinic.

Figure 4 has a high-level picture of how to tackle this. In general:

1. *Gain time (capacity) by eliminating any tasks in the lower left-hand quadrant.* These are things that you have staff currently doing that aren't on the required list. They will probably thank you and the system wins immediately.

2. *A potential source of conflict lies with tasks in the lower right-hand quadrant of Figure 5.4.* Tasks positioned here are probably not necessary for optimal flow or patient satisfaction – but people have gotten very good (comfortable) and probably rewarded for doing them. Telling them to stop doing them can create resistance.

   Tip: Use the conflict cloud or negative branch tools outlined in Chapter 2 to communicate the problem and bring them to a useful solution.

3. *Focus your immediate decision-making on resource utilization on those activities in the upper left-hand quadrant – especially those "feeding" or supporting the the constraint.* This is because these tasks are critical to system flow and patient satisfaction. Improving effectiveness in terms of how consistently or correctly they are performed is an optimal use of your time and that of your resources.

4. *Resist the urge to tinker with those activities in the upper right-hand quadrant except if it improves the rate at which the constraint can perform.* Yes, they're important but generally, they are performed well. You've got other priorities than to get wrapped around the axle here.

Some ideas on optimizing the use of personnel could include any of the following but will be even more effective if priority is placed upon employing these on the constraint link in the throughput-generating links in your chain and or entities that support that constraint link.

- Using cross trained staff for specific roles and responsibilities, i.e. health technicians.
- Maximize ancillary staff for appropriate functions.
- Automate as many functions as possible.
- Schedule maximum staffing levels for high volume periods.
- Use staff at the highest level of their capacity and training, such as registered nurses performing telephone care and triage, LPNs/Health Technicians for EKGs, vital signs, etc.

Your primary goal is to move (more and more) toward patient-centered care. This means that optimizing resource utilization must be focused on optimizing patient flow within the clinic.

This means taking the patient to an available exam room and then bringing services to that patient. Initial interviews, vital signs, and preparation for examination, patient education, procedures not requiring specialized equipment, and discharge instruction can occur in a single examination room.

In many cases, the patient can be discharged from the exam room ready to leave the clinic, preventing multiple stops and waiting lines. This may mean a goal of 3 examination rooms per provider: one would be used by the clinician seeing the patient, one would be used by the staff person discharging or educating the patient, and one with the next patient getting ready for the clinician.

The alternatives you evaluate and eventually implement to make resource decisions will need to challenge long-held assumptions about how to accomplish this goal.

Delivery of services in the examining room has been successful with only 2 examining rooms per clinician available. If fewer examination rooms are available, then some services may need to be provided separately. Meetings with the pharmacist or social worker, for example, would need to occur outside the examining room.

The alternatives you evaluate and eventually implement to make resource decisions will need to challenge long-held assumptions about how to accomplish this goal.

Some examples of ways to challenge assumptions about how to optimize resource utilization can be seen by some of the "Best Practices regarding Tools of the Trade" as summarized below.

Room supplies: A minimum amount of supplies should be maintained, based on volume of patient visits and procedures performed. Stock all rooms the same to minimize wasted clinician time searching for items. A room check list is helpful to maintain consistent supplies. A specific staff member should be assigned the routine audit and restocking procedure, which should occur on a regular (at least daily) basis. Use *mobile carts for specialty supplies (dermatology, gynecology, etc.)*. Any specialty clinics can be supplied by mobile carts stocked with special equipment or supplies as defined by the clinicians. These carts also should be checked and restocked on a regular basis.

Patient education materials: Patient education is a critical piece of the emerging emphasis on shared healthcare decision making (Chapter 14). In addition, use of "distractors" (see the discussion on the Psychology of Waiting Lines in Chapter 9) is important in reducing perceived waiting times and ultimately patient satisfaction. Placing "patient education materials" prominently in waiting areas and examination rooms enable you to accomplish these goals. As with supplies, material depletion needs to be audited and restocked on a regular basis.

Hardware/software: A commitment to the electronic medical record means each examination room should have the necessary computers, hardware and software to allow prompt and convenient entry into the electronic medical record. Options include desktop PCs, wireless technology, Palm/similar technology, mobile PCs, or others as options multiply.

Telephone/communication devices: A clinician must have a telephone in the room, and if dictation is required, either adequate lines on the telephone, or a separate dictation system in each room. When it comes to Paging Systems some other considerations may come into play. Clinicians should have a minimum set of distractions <u>during</u> patient care episodes. Not only could it impact patient quality but lack of provider attention even more than time spent seem correlated to poor patient satisfaction scores. Overhead intercom systems should not be present in examination rooms. Direct telephone calls into examination rooms should be avoided, unless specific to clinician request. Pagers and cell phones should be avoided as well. Mechanisms should be in place to receive, convey and respond to messages during patient care times.

Optimizing Use of Space

Although the space may actually be adequate for the activities conducted in the area, a variety of factors may cause a *perceived* lack of space.

What are appropriate decisions with respect to space? Space always seems to be an issue and seem always to be a premium – even in relatively new clinics. The need for patient privacy, optimal patient flow, patient and staff safety, patient education, and support for the academic teaching mission of the VHA must be considered when assessing space usage.

Although the space may actually be adequate for the activities conducted in the area, a variety of factors may cause a *perceived* lack of space.

Clinic space is generally required for reception, exams, treatment, consultation, office space, restrooms, equipment and supplies (clean/sterile supplies) location and storage, staff breaks and personal effects, medications, as well as hazardous material, waste, dirty linen, etc.

The key to optimizing space utilization will be to identify that which is required, the considerations or objectives that each must hit – and identifying assumptions that should be surfaced and creatively challenged. Table 5.1 is designed to help illustrate each of these.

Required Clinic Space	Considerations for the Required Space	Possible assumptions to challenge that may affect perceived need for space
Reception	• Adequate seating for patients and families • Privacy/confidentiality at check-in area	• Are separate waiting/ reception areas necessary? • Does check-in have to occur in reception? • Will the volume you have now remain in the future if you adopt Advanced Access?
Exam Rooms	• Adequate number for each provider (2.5) • Minimum "down time" • Consistent and appropriately secured supplies & equipment (BP monitor, otoscopes, etc.) • Controlled access	• Are you currently using exam rooms as office space as well? • Do you have half-time clinicians but a dedicated room? • Can check-in/check-out and some procedures (EKG, phlebotomy, etc.) be done in the room? • Does everyone who currently uses the exam room NEED such a room?
Designated Offices	• Privacy (for patients and families being counseled) • Proximity (for users) without impeding patient and staff flow.	• Who can share? • Does the current location have to remain where it is?
Treatment Rooms	• Sufficient for procedures and "peak" demands (including ill patients) • Large enough to hold medical equipment that will be used • Privacy if used by > 1 patient • Conveniently located	• Can more than one patient receive treatment at a time? • Is this desirable? • Does medical equipment used in the facility have to be configured as it is?
Conference Rooms	• Inter-staff consultation • Equipped with required reference, communication and computing capability	• Can space be shared? • Can rules and restrictions on usage be changed?
Restrooms	• Located in waiting and exam areas • Enable any required specimen collection • Staff usage	• Who can share? • Do we need all we have? • Can there be separation?

Table 5.1 Considerations & Ways to Challenge Space Requirements

The fundamental conflict that exists for medications, clean/sterile supplies, dirty linen/equipment/waste, and staff space is essentially as follows:

The fundamental conflict that exists for medications, clean/sterile supplies, dirty linen/equipment/waste, and staff space is essentially as follows:

The objective is to have a well-run clinic. In order to do so, you must properly locate each of the above. Frequently, in order to properly locate them, we want to make changes (such as doubling up on space, moving things around, etc.)

Many times, however, staff (especially those who feel they will be affected by any changes to allocated space) also want to have a well-run clinic. In order to have such a clinic, they feel that there must not have disruptions to the flow of required operations. In order to not have disruptions, they feel they should NOT make changes (such as doubling up on space, moving things around, etc.)

Improve Signage and directions

The questions in the last column of Table 5.1 are designed to surface assumptions that must be challenged in order to successfully resolve this conflict.

Ideas for how to Challenge Assumptions about Use of Existing Space

Improve Signage and directions: When it is necessary to refer a patient out of the clinic for services, maps that clearly reflect patient friendly routes to other sites of service (such as pharmacy or x-ray) and/or interior "landmarks" should be available. Check the clarity (of print size, color and meaning) of signs. Future construction plans should be drawn with optimal patient flow in mind, minimizing the distances patients must walk or be escorted for common services.

Look for Physical Bottlenecks in Flow:

Look for Physical Bottlenecks in Flow: Frequently staff and patients complain of crowding – when simply changes to furniture placement (especially in relation to unchangeable architectural features such as beam) or room placement can actual resolve the problem. Just because a particular area has been somewhere for a long time does not mean it should remain there forever.

Remove unnecessary or excess furniture, equipment and supplies.

Remove unnecessary or excess furniture, equipment and supplies. Hoarding is a grand tradition in many organizations, whether due to the personality traits of the hoarders ("You never know when we might need that again.") or their past experience ("I'm not going to run out of that again" or "We can use end-of-year money to stock up").

Regardless of cause, clinics may have an excess of furniture, equipment and supplies taking up space that could be used for other purposes. Sometimes clinics are thought by management to have sufficient examination rooms when in actuality the rooms are being used for storage.

Get "another (fresh) set of eyes" to look at you space and flow.

Get "another (fresh) set of eyes" to look at you space and flow.

Things You Need to Know About and Resources to Help You

Logical and well-constructed space criteria will not solve all the space problems that practice managers encounter. In 2000, an external evaluation of VHA ambulatory care infrastructure resulted in a short, concise tool that managers can use to help evaluate the adequacy of their existing space and other factors, such as patient flow, that influence the functionality of the space.

Some other sources of information and ideas are identified in this last section of this chapter. What each is and what it contains are summarized.

Some other sources of information and ideas

- The ***Ambulatory Care Infrastructure Space and Patient Flow Assessment Guide*** is available on the VA Intranet site of the Office of Primary and Ambulatory Care at http://vaww.va.gov/med/patientcare/primary/index.cfm.
- ***Appendix B of the VISN 7 Primary Care Space Utilization Policy*****,** is a good example of a policy that gives the details of optimal space configuration. Additional information is also referenced in the *Ambulatory Care Infrastructure Assessment Guide*.
- The "***Customer Focused Checklist***" in the *Ambulatory Care Infrastructure Space and Patient Assessment Guide* provides tools managers can use to:
  - Assess the ambiance and comfort of both an individual clinic and the entire facility.
  - Addresses signage and other design features which help patients find their way to and from the clinic with respect to access for disabled persons, reception and registration areas, waiting areas, and amenities.
  - Offers other suggestion that may improve working conditions for staff.
- The Picker Institute offers a film titled "Through the Patient's Eyes: Ambulatory Care" that demonstrates how a patient sees the environment. Unfortunately, this Institute has ceased operations, but the video may be available through interlibrary loan.

There are also many resources within the Medical Center that can help you in your work.

There are also many resources within the Medical Center that can help you in your work. Find out who represents ambulatory care on Medical Center committees such as the Safety or Environment of Care Committee, the Infection Control Committee, the Quality Management Committee and the Space Committee. They need to know your concerns in order to represent you. You may also have service committees that address these issues.

Some of these other resources and what each is responsible for are listed below:

- *Fire and Safety:* the designated **Fire and Safety Officer** can help with safety issues by telling you what rules you must follow about things such as::
  - storage (how far do shelves have to be from the sprinklers);
  - traffic flow (how much stuff can you have in the hallways, what is considered adequate space for emergency egress);
  - required training and fire drills;
  - How the facility manages Material Safety Data Sheets (must copies be kept in the clinic or can they be on-line, for example).
  - Find out the facility's Safety manual or if the policies and procedures related to safety are organized in some other manner. Read pertinent policies so you know what's expected of you. Most Medical Centers also have a team that conducts

periodic environmental rounds. Many JCAHO environmental issues are picked up during these inspections, so it is important to know when they will be in your area so you may accompany the team.

- *Infection Control.* Your facility has an **Infection Control Practitioner** who can help you evaluate compliance with infection control policies and procedures, such as precautions for patients with multi-drug resistant organisms or managing patients with suspected tuberculosis. They also provide required training. Ask what policies and/or guidelines apply to your clinic. If you are responsible for disinfection and/or sterilization of any re-useable items in your clinic, those procedures must be approved by infection control. The Infection Control Practitioner should be involved in evaluating new equipment/furniture to ensure it can be adequately cleaned/ decontaminated.

- Your point person for **Biomedical Engineering/Preventive Maintenance** deals with equipment in the clinic that requires routine preventive maintenance. Find out what those items are and the frequency for inspection/maintenance. Find out who fixes what and how to reach them

- While titles vary from clinic to clinic, there is an **Engineering (or equivalent) Service** responsible for heating, cooling, and plumbing. Keep a list of how to reach them before there's a problem and incorporate them in some of your efforts to make decisions about optimizing space.

- The **Quality Manager** (or equivalent title) is usually the person who coordinates JCAHO accreditation visits. This individual or his/her office will know of any deficiencies noted in your area (or clinics in general) on the last survey. Invite them to help you do a mock survey.

- Whether your unit is called **Housekeeping, Building Management, Environmental Management** or some other name, these folks are crucial. And an invaluable source of ideas on ways to rearrange procedures, furniture or equipment positions, etc.

- VHA employs **Facility Designers** who can assist in evaluating space needs and furniture layout to develop efficient work-flow designs. They can also assist with signage and decor issues. If there are any plans to remodel or build new facilities, you will need to work closely with your designer. If your facility does not have a designer on site, contact your VISN office to locate one in your area

- The **Employee Health office** can provide information on accident rates in your clinic or service and can help you evaluate work areas and work practices in order to prevent injuries. They also offer preventive health for employees

- Know how to call for help if needed. If you have specific security concerns in your clinic, contact the **Chief of the Police/Security Service** to discuss them.

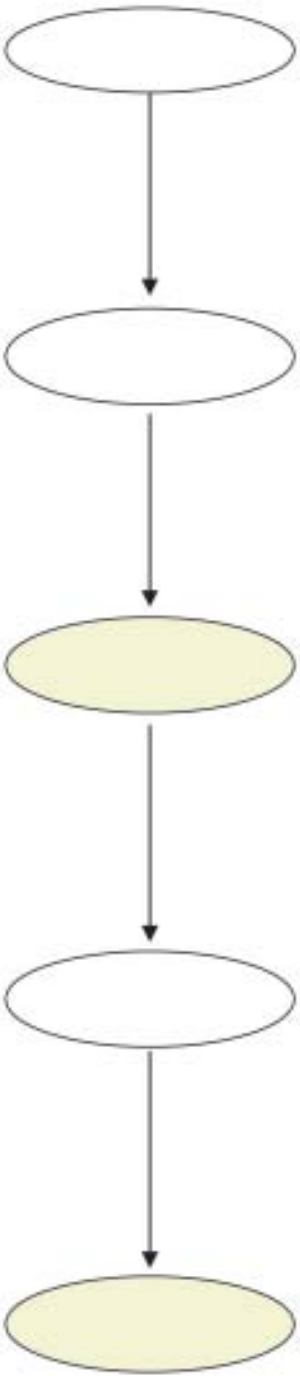
Summary

The facility and VISN strategic plans determine the clinical services to be provided. Staff should be used appropriately with the objective of optimizing the flow of patients through the system. Space should be used to optimize patient centered care. Space is always a challenge, but a manageable one if you identify needs based on patient care services, examine your clinic processes and work flow, utilize the expertise present in your facility, and get ongoing feedback from staff and patients to drive future refinements.

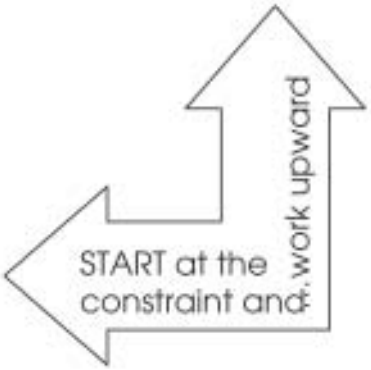
① List the links in the Clinic's Throughput-Generating Chain.

② Highlight the Constraint

③ Surface the REQUIRED activities using the query:
"In order for "*later link*" to perform/do its job, the "*earlier link*" must …
Start with the constraint link and move upward, then from the last link to the constraint link.



Suggested form:
VERB + NOUN



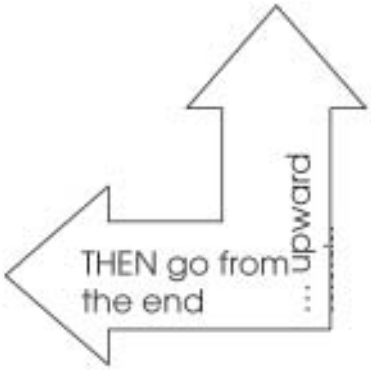


Figure 5.1A Blank Template for Throughput-Chain Required Tasks to Accompany Activity 5-A

CHAPTER 6
Contracting for the Practice Manager

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Goals:

To explore the parameters of the contracting process and the practice managers' role in that process given that s/he cannot negotiate nor enter into the contract directly.

Objectives:

1. Review the major steps in contracting
2. Examine tips and strategies to improve inputs and outcomes at each step.
3. Explore specific restrictions and sources of additional information (and what they can do and how they can best be utilized)

Introduction

The practice manager is often faced with the need to consider contracting for clinical services. There are at least three circumstances when this alternative should be analyzed as described in the chapter.

The first instance is when you are engaged in the first steps of implementing Advanced Access Care as described in Chapter 3. Recall that in doing so your emphasis early on is to reduce backlog. One of the ways to do so may involve temporarily extending hours which could entail the bringing on of contract staff for the period during which this is to occur.

Another instance where contracting might have to be pursued is when there is a need for a one-time set of services that is not available in normal clinic operations. Special post-construction clean-up, preparation of special and ad hoc studies or analyses, etc. might be the types of services the clinic manager may need to contract rather than staff.

Occasionally, there are required services but not at sufficient levels to justify the purchase of required equipment or commitment to full-time staff. Contracting is an option that is required here.

At least another instance is when it is vital to increase the system's throughput. Specifically, this is when you reach the fourth step in the constraint-based decision-

making method of improving your clinic called POOGI shown in Table 1.2 and explained in Chapter 1. Elevating or increasing the capacity of the "weak link" is part of that process. However, there may be a delay in approval of a permanent budget line that will enable you to do so. Contracting for a period to fill the gap would be logical.

The balance of this chapter reviews the major steps involved, provides tips and strategies to improve your contribution to the process,

> **A Bit of Advice:**Contracting can appear to be a daunting task but the steps and tips summarized here should help you accomplish it successfully.

Some Background Regarding Contracts – and the Essence of Your Role

Contracts can range from ones with individual providers ("sole source" contracts that do not require going through the bidding process) to more extensive, "open-market" ones for certain types of services or a complete medical practice. There are distinctions between contracting for an individual clinician's services and contracting for more extensive services, such as for the complete medical practice, as would occur with a community clinic contract. Contracts for Community Based Outpatient Clinics must go through a bid process. Your contracting office should be able to provide more in-depth information.

"The first and most important thing to remember is that YOU CANNOT negotiate a contract, but you are a vital component of the team. "

The first and most important thing to remember is that YOU CANNOT negotiate a contract, but you are a vital component of the team. What this means is that you are not to convey that you are, nor act, as the point person for the negotiation. Even though you are part of the VA system, you cannot act as its agent.

However, you are critical to the process. Remember, the contract is to help improve **your** clinic's operation – so performing what appears to be your limited role is vital.

That role will entail any of the following.

- You will frequently be expected to provide input for the contracting officer at a variety of points in the process. As your contracting officer is assembling the proposal for example, s/he requires information regarding the types of services needed, details about what that might entail such as hours of work, required coverage and procedures. These are usually part of the Statement of Work outlined in the next section.
- Doing some of the "leg work" and fact finding for various stages of the contracting process. For example, you may be the individual who identifies and may even engage in initial discussions with prospective clinical service providers. This is where the caution emphasized at the outset is particularly important. You cannot make commitments or convey verbal agreements at any stage. The contracting officer is the only one empowered to negotiate the contract price and terms.

"The contracting officer is the only one empowered to negotiate the contract price and terms."

Within this general background, more specific details regarding the process and what you can do to ensure it works well for all involved are provided next.

The Contracting Process – and Some Do's and Don'ts

" **Any contract in VHA must deal with the need to provide services that the VA Medical Center or the VISN cannot provide internally.** "

There are nine steps in the contracting process. Who does what and why for each is delineated below.

1. **Statement of Work.**

Any contract in VHA must deal with the need to provide services that the VA Medical Center or the VISN cannot provide internally. Either facility's management or the caregivers at the facility declare that they have an **unmet need** such as for a community clinic or for EEG, Radiation Oncology, GYN or other services.

- Once the decision is made to seek these services via a contract, you first need to determine who serves as the Contracting Officer. This is a key person who can explain the process and the information needed.

- Next, a draft of the Statement of Work must be prepared. The Statement of Work is the description of the services needed. A likely candidate is someone who understands the clinical need

  Helpful Hint: Frequently, the person who understands this need may dislike writing or would probably have to put it on the back burner because they tend to be overloaded with work. People procrastinate most on things they dislike doing or do infrequently. An easy solution is to ask them to record it and then have it transcribed.

The draft is to be submitted to the contracting officer who will refine it as you proceed through the development of the contract. As such the draft should be stated initially with sufficient information so that the contracting officer can begin to work with it.

> **A Heads Up:**Frequently sole source, non-open market bid contracts are made with individuals such as a physician. Bear in mind that s/he and anyone else involved in the contracting process, must have no **conflicts of interest**. If contracts are contemplated with an affiliated medical school then the VHA General Counsel has to assert that any involved physicians have no income from the affiliated institution or otherwise stand to gain in doing such contracts.

2. **Refining the Scope of Work**.

Any practice manager involved in the contracting process works with the contracting officer to further define and refine the scope of work. The operating attitude here should be cooperation and the process a full dialogue between initiator, contracting officer, and pertinent clinical staff.

The goal at this stage is to take the original, rough concept of the statement of unmet need and turn it into the form that the contracting officer must use. Usually, your contracting officer will be able to explain all the contracting jargon and contracting requirements. However, it is essential that the Statement of Work clearly and completely describe the services to be rendered and VHA's quality and performance requirements.

"If it's not in the Statement of Work when the contract is signed, you can't require it later without a formal amendment to the contract. "

If it's not in the Statement of Work when the contract is signed, you can't require it later without a formal amendment to the contract.

Several meetings and negotiations are often needed in this step. Some pointers to complete this step efficiently and successfully are:

- Conduct an internal, all-parties, face-to-face meeting where the issues and actions that are required are surfaced and/or presented.

  At all meetings regarding contracts attendance must be recorded for the contract file so everyone knows how the process was conducted and who was involved. This will be needed if there are any internal or external reviews, or if there are any challenges to the contracting decisions or process.

"At all meetings regarding contracts attendance must be recorded for the contract file so everyone knows how the process was conducted and who was involved. "

- Determine at the outset whether this is to be a sole source or an open-market solicitation. This will focus what needs to be done and the extent to which information is required.

- Quickly brainstorm all issues interested parties involved in the meeting feel should be resolved. For example, sometimes a market survey, such as has happened with real estate contracts for community clinics, will be important. One can also do market surveys to find out who might be interested in (i.e. make an offer on) a contract, to get an idea of prices, etc. Get input from the contracting officer regarding any technical issues, how quickly you need the contract, and setting timelines for getting drafts and redrafts done.

"Get input from the contracting officer regarding any technical issues, how quickly you need the contract, and setting timelines for getting drafts and redrafts done. "

- Assign a subset of those tasks to each of the individuals involved and have each person provide input regarding "actual completion time" that reflects the total amount of time that the task is likely to require. A worksheet such as that shown in Figure 6.1 Contracting Meeting Worksheet can help streamline this task.

  By defining the deliverable, the person assigned to complete the task knows the "end point" – and may be less likely to procrastinate on completing the task if they see that over the next two weeks (the scheduled date for the next meeting), s/he will have to spend only x hours to complete it.

Meeting Date: _____
Location: _____

Individuals Attending:

-
-
-
-

Purpose of Meeting: To identify all tasks required to complete Statement of Work.

List of Required Contract Tasks	Deliverable (what is achieved) when the tasks is completed	Point Person	Estimated Actual Time
1. Obtain information about possible vendors and their availability.	A list of vendors denoting level of interest and approximate amount of availability.		6 hours
2. Conduct price comparisons for the area.	A comparison chart of prices on different contract offerings for similar services.		2 hours
: .			
n. Write final Statement of Work		Contracting Officer	

Figure 6.1 Contract Meeting Worksheet

3. Writing the Request for Proposal (RFP).

The contracting officer now has to put together a document. This document is called a "Request for Proposal" (RFP) which becomes the Contract once it is awarded and signed. The RFP will go through several iterations for concept, language, punctuation, etc.

Note: There may need to be a designated liaison between the service requesting the RFP and the contracting officer, in part because the interested service may have a conflict of interest.

"this is a document that is going to go out on the street for a solicitation and becomes the Contract."

You should be very precise with the RFP. Make sure that all "T's" are crossed and "I's" dotted because ultimately this is a document that is going to go out on the street for a solicitation and becomes the Contract. The heart of the RFP is the Scope of Work statement. Other details frequently include work and reimbursement schedules,

professional credentials, and sites of work. The rest is generally federal government boilerplate – sources for which are summarized in the last section of this chapter.

4. Criteria for Award and Selection Committee.

" add the criteria that are going to be used to award the contract and who will be on the selection committee for the award."

The contract is now almost ready to go out for solicitation.

At this point you need to add the criteria that are going to be used to award the contract and who will be on the selection committee for the award. This is very important because it is possible to inadvertently craft criteria that may favor one offerer (e.g. vendor or bidder) over another. It is also possible to inadvertently set criteria which result in the contract award going to an otherwise unacceptable vendor.

> **Example:** If you make cost the primary consideration, the contract award will go to the lowest offerer, even if their quality of care is inferior. In this case, it is better to make cost one of the evaluation factors counting for perhaps 25% of the weighted values but not 80 or 90%. On the other hand if money is an issue, then you would weight money at a higher value, let's say 70 or 80% of the weighted values.

This is what will govern, in large part, who offers as well as whom you select because once you have the criteria you will have to apply those strictly and evenly. When they are applied fairly, one offerer may come out better than another. Evaluation criteria must include an evaluation of the offer's past performance including pertinent quality of care measurements.

5. Approval by Medical Executive Council.

The contracting officer must then obtain local institutional approval for clinical contracts. The RFP usually goes to the Medical Executive Council (or similar body) for approval. Essentially this group verifies that there are unmet needs (and its magnitude) as well as what criteria will be used to make the selection of the successful offerer.

This ensures that the scope of work or contract contains requirements that the services meet all applicable standards of is accrediting bodies, such as JCAHO or CAP (College of American Pathologists)

6. Soliciting for the RFP.

The RFP is then announced ("advertised") via various sources. The contracting officer has rules governing how to do this. As the clinic manager, you obviously don't want to make the offering process overly long – the contract is for an unmet need after all. However, you must give prospective bidders a fair chance to develop and submit their offers.

"You should not have any contact with potential bidders and must refer all questions to the contracting officer."

Usually the solicitations are open for 30 days.

The offerers (i.e. bidders) should have access to the contracting officer who handles everything at this point. As a rule, the contracting officer shouldn't be doing anything except waiting to get the answers back. You should not have any contact with potential bidders and must refer all questions to the contracting officer.

7. Selection of Successful Offerer.

" a selection committee meets to make a selection based on the criteria in the RFP."

Once the offerers have submitted their responses ("offers") on the RFP, a selection committee meets to make a selection based on the criteria in the RFP. The contracting officer participates in order to make sure all of the rules were followed, attendance is taken, and there is no conflict of interest.

After the selection committee makes its recommendation, the RFP goes to the Medical Executive Council (or equivalent) for approval by your clinical staff representatives. The approval of clinical contracts by clinical leadership is a JCAHO requirement.

Finally, the hospital CEO or equivalent signs the contract it before it goes back to contracting officer for final signature. ***Notice that you do NOT sign this document.***

At this point the RFP becomes the Contract!

8. Final Award.

At this point the contracting officer takes over and works closely with the successful offerer to make sure that everything is in order. Some successful offerers may choose to withdraw or there may be some additional refinements that the offerer may want to make.

In addition, a person called the "Contracting Technical Officer" (COTR) has to be appointed for each contract. The COTR does not have to be a physician or someone who actually helped develop in the RFP. The COTR should, however, be the person who is most able to manage the contract. For instance, in a Radiation Oncology contract, the Administrative Officer for Radiology Service may be the COTR because that person may deal most closely with the day to day business of the contract.

9. Operation of the Contract and Renewal.

" the COTR has to monitor it according to the criteria in the contract."

Once the contract is in effect, the COTR has to monitor it according to the criteria in the contract. Depending upon how long the contract is in effect (a common practice is a one year contract renewable for 3-5 years) there may be more work to be done on a periodic basis. This is conventionally done via an amendment or formal deletion. Ultimately there may be a need to renew the contract at which time one really needs to look carefully at the original contract (Step 1) and go through all the steps again.

It is best to allow a long lead-time (we suggest one year) to get such renewals re-negotiated or re-offered. This is the time for questions concerning whether there are still unmet needs and whether you are satisfied with the current contractor.

Finally, clinical contract services must be monitored annually by the Medical Executive Committee or the facility medical staff. Note that many types of clinical services should be evaluated more frequently. Monthly external peer review is a commonly used method of doing so.

Close and frequent monitoring provides the opportunity to advise the contractor of the adequacy of their performance, and makes the operation and renewal component easier in the long run.

Regulations and bibliography

VISNs do business somewhat differently. Thus there may be no "manual", as such. There are 2 large volumes of Federal Acquisition Regulations (a.k.a. "FARs") and VHA Agency Regulations that govern purchasing and contracting. The VISN Business Center and/or Medical Center may have a policy manual that provides its preferred methodology to operationalize the contracting process.

Your contracting officer should be able to walk you through the above process.

A library of contract templates is under development at the time this document was prepared. Minimum requirements and suggested or mandatory language are included. Please access the Primary and Ambulatory Care website for linkages to the contract template website.

Summary

It should be clear that contracting is a necessary part of your responsibilities as a practice manager. Your most important role is to identify the services needed, determine measurements of quality and performance that will be used to monitor the contract, to provide input regarding criteria used to award the contract and to determine how much you will be willing to pay for the services. Monitoring the adherence to the contract services will also be your responsibility.

Problems in performance can be avoided by clearly defining the expectations in the Statement of Work. The Statement of Work MUST specify that the services meet the standards set forth by your accrediting bodies, such as JCAHO, or CAP if applicable. Specify clearly whether you expect coverage and care to continue in spite of vacation and sick leave for the contracted providers. It is important to share the Statement of Work and the requirements in it with your scheduling supervisors so that they are knowledgeable about the parameters of service established in this document.

It becomes important for the practice manager to be familiar with the process of contracting for clinical services. The practice manager often participates as a member of the contracting team and is the vital conduit of information regarding the needs for services and the range of services needed. Following the nine steps for contracting services will provide your clinic team with a well-crafted document that will outline the services to expect from the contractor and a useful tool to monitor the performance of the contract staff. Remember…

YOU CANNOT NEGOTIATE A CONTRACT.

CHAPTER 7
Continuity of Care

Victor Malabonga, MD

Goals:

To explain the central role of continuity of care in the practice of primary care medicine and how coordination of care is vital to achieving continuity. To explore applicable methods to enhance the continuity and coordination of care.

Objectives:

1. Review the need for, benefits of and criticality of information as the linking mechanism to achieve continuity of care.
2. Explore how to use Electronic Medical Record (EMR) and View Alerts to enhance care continuity.
3. Understand the reasons for needed back-ups or redundancy to the clinic information flow processes.
4. Review the role and utility of care coordinators for in the management of high-risk and complex primary care patients.
5. Review the manner by which primary care team structure can affect continuity of care.

Introduction

The four essential features of primary care are accessibility, continuity, coordination, and comprehensiveness. (1) The simple assignment of a patient to a primary care provider might achieve access – but does not achieve the goal that primary care also exhibit continuity and coordination. These latter features require managing the relationship between patient and providers and non-providers over time. (2)

Continuity of care is a process that provides for seamless transitions through linkages between formal and informal caregivers within the health system aimed at improved outcomes for the client.

The medical literature is replete with the benefits of continuity of care. (3, 4) These include improved patient satisfaction, enhanced physician-patient interaction, increased compliance, reduced hospitalizations, and lower levels of disability. (5)

This chapter looks at various modalities for providing continuity of care across care settings. Special emphasis is placed on use of the electronic medical record as a tool and case management.

Principles and Characteristics of Continuity of Care

The goal is to enable families and the patient to make an informed choice.

One challenging issue facing the practice manager is how best to establish the continuity environment. There are at least five principles underlying its creation.

1. ***Patient-Centered Assessment, Planning, Implementation and Evaluation.*** Continuity of is a process that includes assessment, planning, implementation and evaluation. The key is that all components of the process are focused on the client/patient's needs and resources. All policies, protocols, follow-ups, etc. are driven from that focus and perspective.

"Sufficient and correct information … that (is) comprehensive, accurate, current and available."

2. ***Patient and Family Involvement in Decision-Making.*** Though ways to ensure involvement are explained more fully in Chapter 15 on Shared Health Care Decision Making, involvement means that there is a systematic process that includes all parties in decisions that affect the veteran. In this effort, all parties are provided with information and there is a discussion of realistic goals and expected outcomes. The goal is to enable families and the patient to make an informed choice.

3. ***Comprehensive Client Information*** is a cornerstone of continuity of care. Sufficient and correct information for assessing the family's and patient's needs and resources, for developing a plan of care and outcomes and to ensure transfer mean that the information must be comprehensive, accurate, current and available.

"Documented verbal and written communication - conveyed and retrievable when needed."

4. ***The Right Method and Timing of (Documented) Communication.*** Communication can and should occur and reiterated in verbal and/or written formats when needed. Documentation especially regarding the patient and the plan of care must be also be accessible when desired.

Coordinated, interdisciplinary, team-based

5. ***Emphasis is on flow.*** Coordinated, interdisciplinary, team-based transitioning of the patient over time and settings is the planned outcome.

Continuity of Care Across Treatment Areas

Patients enter the health care system through various access points: primary care clinics, subspecialty offices, the emergency room, and inpatient wards for example. The key for the practice manager is to identify these entry areas then define or develop a thread to connect these points of care into a meaningful whole. We have no control over where or when a patient will choose to enter the system. We do have control over processes that will allow us to coordinate the events that take place in these disparate areas.

What is the primary care provider (PCP) missing when a patient shows up in a subspecialty clinic, or the emergency room, or is admitted to the hospital? Without knowledge of that visit, the PCP will not have the information related to the events surrounding that particular visit or admission.

"The thread holding the various patient encounters together across the system is *information*...The electronic medical record (EMR) is the technological development with the greatest impact on achieving continuity of care."

The thread holding the various patient encounters together across the system is *information*. (6) Clinical data must be shared with the PCP in a consistent, timely, and reliable fashion to provide continuity of care. The challenge for the practice manager is to design the systems and implement the procedures necessary for this to happen.

The electronic medical record (EMR) is the technological development with the greatest impact on achieving continuity of care. All sorts of clinical and personal data are in the central repository accessible anytime of day or night. The exploitation of the capabilities of the EMR is the crucial first step in weaving the web of information that will allow us to coordinate the patient's care.

View Alerts As Vital Links

Imagine that, when logging on to VISTA, the Patient Care Provider (PCP) is immediately aware that one of his/her patients visited the ER the previous evening, or was seen in a subspecialty clinic the day before, or was admitted to the hospital overnight. The EMR is currently capable of making this happen through the View Alert mechanism. Some of the features of the EMR are: Consults and progress notes can be forwarded to designated users. The emergency room note, or consult note, or admission note and discharge summary can be forwarded to the PCP.

> *Note: In this scenario the patient accessed an entry point other than the clinic. Information was shared with the PCP in a timely manner. When the patient returns to the PCP on a subsequent visit, the provider has the information needed to provide appropriate follow-up. What is more, the PCP has information to enhance the patient's healthcare now, long before the return visit.*

"One key to establishing view alerts is deciding to whom the information will be forwarded."

The information loop is completed.

One key to establishing view alerts is deciding to whom the information will be forwarded. It can be sent to the PCP or to a care coordinator or both depending on the individual clinic situation.

The care coordinator can be a nurse or social worker (see the section on case management). There may be a care coordinator for each team or for the whole clinic, depending on the configuration of each practice.

> Note: If a care coordinator is chosen as the view alert recipient, it is imperative that procedures be in place to ensure prompt and consistent relay of information to the PCP, including coverage during absences.

"Information technology personnel (must) enable the View Alert function."

The most difficult aspect of implementation will be the initial coordination of various services necessary to setup the process. Some pointers to accomplish this successfully are as follows:

1. Information technology personnel will have to make sure the view alert function is enabled in the menus of all PCPs and/or care coordinators.

"Train clerical staff throughout the facility on how to properly enter PCP data…"

2. Clerical staff throughout the medical facility must properly enter PCP data in the patient information file and other relevant electronic documents. Training and support materials are available to assist them in learning how to do so.

It is very important that there be a clear and detailed understanding between the primary care department and all other services which notes are to be forwarded and to whom they should go.

3. Clinical staff in the emergency room, Specialty Medicine, Surgery, Mental Health, Geriatrics, as well as other hospital services (e.g. Nutrition, Rehabilitation, Prosthetics, Recreation Therapy, etc.) must commit to using the view alert mechanism for communication as they must send their electronic progress notes to the designated recipient in the primary care clinics.

   It is very important that there be a clear and detailed understanding between the primary care department and all other services which notes are to be forwarded and to whom they should go. The computer programs can assist in getting the alerts out, but without this agreement, the alerts will have little effect or value.

To be effective, the view alert mechanism should be actively managed.

4. Be aware that clinicians can be overwhelmed by the volume of view alerts. Some facilities have formed `View Alert Committees' to oversee this process and optimize its utility. To be effective, the view alert mechanism should be actively managed.

Helpful Hint: Think about conducting a series of brief (10-minute) brainstorming sessions (This can also be done on a white board during the course of a day if you would prefer to take no meeting time or patient care team group time to obtain the information.) Prompt anyone and everyone to contribute ideas but do NOT have any discussion about the merits or problems with each at this time…

generate a list every morning to show the patients who accessed that area

Session 1: "*List the Circumstances that warrant a view alert" (post the sentence at the top of the list and elicit input.)*

Results should be reorganized and simplified. Strip out the obvious duplicates. Identify who should be responsible for posting it (e.g. site of the event). Keep the list to help people contribute input in Session 2.

have a designated care coordinator to ensure that the information flows consistently.

Session 2: "Who should receive the view alert in each circumstance listed?" *(Post the sentence at the top of the list and elicit input.).*

Hint: Make two columns with the results from Session 1 in the left hand column and blank bullet points in the column to its right for responses to be inserted.

Session 3: Think about creating some quick "boilerplate" phrases for those circumstances that are likely to occur frequently. This should help reduce the entry time hence increase the chances that it will be entered.

Alternative Procedures to the View Alert

Until use of the view alert mechanism can function reliably, it is prudent to have a back-up process. What follows is an example of such a process.

For ER Visits:

- In the emergency room (ER), generate a list every morning to show the patients who accessed that area the previous 24 hours or during the prior weekend.
- Or, the ER notes can be collected every 24 hours and forwarded to the primary care clinics.
- In both situations, have a designated care coordinator to ensure that the information flows consistently.

The coordinator's job is to relay relevant information about the ER visits to the appropriate PCP or to the clinic manager for patients who are new to the system.

For Hospital Admits:

- For patients admitted to the hospital, an alternate mechanism would be to generate a daily list of patients admitted the previous 24 hours or prior weekend.
- The PCPs can be informed by the care coordinator if any of their patients are on the list.

  This way, they are at least aware that their patient is in the hospital, and can review the circumstances of admission. This is a rudimentary process but it satisfies the basic requirement of completing the information loop.

Another way to deal with hospital admissions is:

Have a hospital liaison for each primary care practice or team.

- Have a hospital liaison for each primary care practice or team.

Note: This function has been reported to be crucial in facilitating continuity of care between various hospital sectors. (7, 8) Success in a VHA setting has also been reported. (9)

- The main roles of the hospital liaison are to ensure that important clinical information flows between the PCP and the inpatient provider, that proper discharge planning is conducted, and that patient follow-up with the PCP is scheduled in a timely manner.

Having an effective approach regarding hospital admissions may also involve:

- Using the care manager (whether this is a nurse or social worker). The care manager is well positioned to enhance communication between the inpatient team and the outpatient team, regardless of where in the hospital the patient may have been admitted.

This approach is particularly useful where the care manager is tied to a panel of patients rather than a location. An additional advantage is that since for a given primary care clinician there is a single care manager (who may already be familiar with the patient) communication becomes very efficient and effective.

For subspecialty visits:

Tracking subspecialty visits is especially difficult without the EMR. An effective (but tedious) method is to use the care coordinator to facilitate referrals from the PCP and document completion of the referral visit. However, bringing the actual consult information back to the PCP can be frustrating in this setting. Note too that in this process it would not be possible to be aware of a subspecialty visit that was not generated by the primary provider until well after that particular visit has occurred, unless the consultant calls the PCP.

Whichever method is utilized (electronic view alert, patient list, collated ER notes, etc.) the final pathway is the flow of information to the PCP. It is imperative that this information loop be completed in order to establish the continuity environment.

Whichever method is utilized (electronic view alert, patient list, collated ER notes, etc.) the final pathway is the flow of information to the PCP. It is imperative that this information loop be completed in order to establish the continuity environment.

Plan the use the above alternatives to View Alerts for as short a period of time as possible as they are more cumbersome and time-consuming.

To reiterate:

- **Get Info Technology to Activate the feature**
- **Train people to use them**
- **Commit and Reinforce their use**
- **Streamlining the individual work**

Note: Achieving continuity of care requires a change that various parts of the clinic delivery team may be unwilling to make. It is important to use a tool (such as the negative branch or conflict diagram shown in Chapter 2) to address their concerns if you want to ensure success.

Oral communication is an effective means for coordinating care. (6) Frequently, all it takes is a call or visit from the provider in the "other" setting to the PCP. In reality this process breaks down frequently for various reasons. (6, 10) The facility that is blessed with a large cadre of providers who value continuity and appreciate the utility of personal communication will achieve a higher degree of coordination, and ultimately a more fertile continuity environment.

Case Management

Case management is a clinical process designed to identify a patient's needs and interests (physical, mental, emotional, social, and community), facilitate the patient's access to the health care system, coordinate and optimize the utilization of the system's resources, and monitor the effectiveness of the interventions applied. (11)

Note that this description parallels the definition of primary care. To some extent, the primary care clinician is the main care manager for a patient or panel of patients. However, there are knowledge and time gaps which may be very well filled, and at a lower cost, by using social workers and/or nurses as care managers within the framework of the primary care team.

Once again, there are major advantages in linking the care manager to the patient or panel of patients rather than a particular location of care.

This section focuses on the coordination component of case management. The term "care coordinator" rather than case manager is used in order to place emphasis on the function rather than the terminology. A care coordinator, therefore, is actually a description of responsibility rather than a job or professional title.

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Figuratively, the care coordinator is the person who takes the patient's hand and guides him/her through the maze of the health care arena. This is the next higher level of coordination beyond that offered by the information web. The care coordinator function helps ensure that the appropriate care is delivered at the appropriate time.

To maximize benefit, the care coordinator should be part of the clinic staff assigned to the primary care practice and to a specific panel of patients.

To maximize benefit, the care coordinator should be part of the clinic staff assigned to the primary care practice and to a specific panel of patients. In many instances a care coordinator can follow a larger panel than a primary care clinician can follow, generally because a rather small percentage of the patients will be in need of active care coordination at any one time. Thus, the care coordinator will work with several different providers and their patients. However, there are many circumstances where the care coordinator may actually have a smaller panel. (12)

The critical roles of the care coordinator are:

- ensure that relevant information flows between the PCP and other care settings;
- ensure that consultations and referred procedures are done in a timely manner;
- ensure that patients with multiple medical problems or frequent ER visit/ hospitalizations or frequent missed appointments return for follow-up;
- help identify patients who are non-compliant or who walk-in frequently;
- manage or assist managing home contacts and telephone follow-ups;
- assist in discharge planning;
- ensure educational needs of the patient are met;
- assist patients and family in meeting social, emotional, and community needs.

The information web allows the PCP to develop an integrated plan of care. It is the care coordinator who executes the plan.

The information web allows the PCP to develop an integrated plan of care. It is the care coordinator who executes the plan. (13) This function is critical to maintain the continuity of care.

> Example: One scenario occurs in teaching facilities where there is a high turnover of residents and fellows, or a significant proportion of part-time attending staff. The care coordinator can serve as the bridge that links the dynamic clinical information of the patient with the providers that constantly go in and out of the system. Although provider continuity may not be achieved over long time periods, at least coordination of care can be maintained.

For patients who are relatively healthy and who access the clinic infrequently, the assistance of a care coordinator may not be relevant.

For patients who are relatively healthy and who access the clinic infrequently, the assistance of a care coordinator may not be relevant. *It might make some sense to include this as a checkpoint of some kind fairly early in the check-in or intake process so that those who do need such a coordinator are assigned one.*

There is a class of patients, however, where this function is extremely important. These are high-risk patients who frequently fit the following criteria (14, 15):

- 2 or more ER visits in the past 6 months
- 2 or more hospitalizations in the past 6 months
- 3 or more hospitalizations in the past 12 months
- non-compliance leading to frequent hospitalizations or ER visits or walk-ins
- multiple (3 or more) active medical problems
- requiring active input of 2 or more subspecialties for care
- HIV disease
- end-stage renal disease or late-stage cirrhosis
- organ transplant
- significant impairment in activities of daily living

The truly complicated patient (e.g. multiple medical problems with frequent ER visits/ hospitalizations, or with advanced organ failure, or with unstable social environment) will probably benefit from the most sophisticated form of care coordinator: the clinical nurse specialist (CNS). This is a masters-prepared RN with experience in the field of specialty case management. The role of the CNS is more involved than that of the usual care coordinator. (14) It requires close work with patients and their families, and constant coordination with various facility services. This is a specialized field and should be reserved for patients with the most complex care needs.

Provider continuity in the clinic setting

Just as an airplane's design affects how well it flies through the air, certain clinic structures may be more conducive to continuity of care. Take the example of a patient assigned to a PCP who is part of a primary care team with 4 providers. If this patient makes 4 visits in a year, it is possible that he/she will see the PCP 4 times or see each of the other providers once. There is a very big difference in provider continuity between these two scenarios, and it illustrates the effect of team structure on the application of the concepts of continuity of care.

A study by Becker et al demonstrated excellent continuity of care with a team of one provider with dedicated support staff. (16) In contrast, Breslau and Reed found that continuity (when defined as how often the patient was seen by the PCP) actually declined when a private practice of two physicians restructured to an academic primary care unit of three associates. (17)

Intuitively, we can conclude that a primary care team composed of one provider and dedicated support staff would offer the best chance of continuity. However, this structure lacks flexibility because when the PCP becomes unavailable there is no one to see the patients. In fact, Breslau and Reed found out that the drop in their measure of continuity was due to unscheduled illness visits in which patients were seen by whichever provider was available at the time the patient showed up in the clinic.

There is no universal opinion as to the optimal number of providers in a practice or team.

There is no universal opinion as to the optimal number of providers in a practice or team. A balance must be reached empirically to address provider availability and operational flexibility. It is important for the clinic manager to recognize the pitfalls inherent in primary care team structures that detract from the establishment of the continuity environment:

Single provider primary care team (PCT) is conducive to provider continuity (ideal setting) but lacks operational flexibility. Care coordinator is useful mainly for high-risk cases.

Double-provider PCT is closer to ideal with some flexibility added. Care coordinator is useful mainly for high-risk cases.

Three or more providers per PCT has maximum flexibility but can dilute unscheduled patient visits amongst many different providers. Since patients with chronic illness tend to have periodic health crises during the year (thus frequent unscheduled illness visits), special attention must be paid to coordination of care. Scrupulously arranging for providers to see their own patients who present unscheduled or same day, even if their colleagues are not fully busy, is an example of this attention. (Note this concept is fundamental to advanced access as well). A care coordinator would have a central role in this setting.

Summary

The central focus should be the provider-patient relationship. All care processes in the system must flow back to this focal point.

The redesign of clinic processes in order to establish the continuity environment begins with the acceptance of responsibility by the PCP for ensuring continuity of care. The central focus should be the provider-patient relationship. All care processes in the system must flow back to this focal point. The information web, care coordinators, and team structure are the critical elements to ensure that continuity is maintained.

Your major roles as a practice manager are to:

- utilize the electronic medical record to connect the primary care clinic with other access points across the system;
- establish a primary care team structure that is conducive to provider continuity with acceptable operational flexibility;
- utilize care coordinators as the backbone for integrating care processes, especially for high-risk patients; and
- establish an environment conducive to frequent personal communication between PCPs and practitioners in other healthcare settings.

CHAPTER 8

Primary Care Panels and Managing via the Primary Care Management Module (PCMM)

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Goals:

To review the importance of and set "best practices" for the managing of panel sizes

Objectives:

1. Clarify definitions and calculations of panel size
2. Explore available options to measure, correctly "size" and monitor panel size.
3. Summarize details regarding the Primary Care Management Module (PCMM):
   - What it does,
   - How to use it effectively,
   - Reports and information to improve clinic management

Introduction

The word 'panel' in the VHA has generally been preceded by the words 'primary care.' While this chapter has a distinct primary care slant, the panel concept also applies to consultative and other services. The importance of panels is because they tie directly to workload. A thorough understanding of provider workload is essential to effective management of an outpatient practice in the VHA.

Concerns regarding workload: Too heavy? Too light? Fair?

This is because of the following concerns about workload:

1. ***Is the workload too onerous?*** The concern is that if the workload is too high on a provider or caregiver, patient quality, satisfaction and outcomes will suffer.
2. ***Is the workload too light?*** The concern is that underutilizing any clinic staff is a potential inefficient or inappropriate use of resources.
3. ***Is the workload equitable?*** The concern here is that perceived fairness or balance of the workload is critical for staff and provider satisfaction and morale. Related to equitability of the workload is an often unspoken concern that productivity – or lack thereof – is what is really being examined.

how do you measure workload and does the measure enable us to address the concerns regarding amount and equity of that "load"?

There are two core issues that these concerns highlight: how do you measure workload and does the measure enable us to address the concerns regarding amount and equity of that "load"?

One of the most controversial aspects of ambulatory care workload is panel size. The controversy surrounds those issues and concerns just raised.

Within VHA, discussions of panel size generally focus on 'users', i.e. *it refers to veterans who actually are seen or scheduled to be seen by the provider during a defined time period.*

In contrast, the private sector and most published literature define panel size as 'enrollees' or actual potential users of the system. Thus, depending on the type of insurance coverage and other economic arrangements, 'enrollees' and panel size discussions refer to patients who may never see the physician, or may be seen very infrequently. Consequently, panel estimates in the private sector are frequently higher than those seen in the VHA. *The Ambulatory Care Infrastructure Report* of 2000 compared VHA and private sector panels and found them to be equivalent when actual visits and patient acuity were taken into account.

The fundamental challenge for you as a practice manager is how well panel size enables you to address the issues and concerns that exist regarding workload. Invariably, the challenge boils down to: large panel size vs. small panel size.

A panel is the number of individual (unique) patients assigned to a clinician's care… Patients are actual users (i.e. are persons who have been seen in any VHA program).

Definitions and Challenges

A panel is the number of individual (unique) patients assigned to a clinician's care… Patients are actual users (i.e. are persons who have been seen in any VHA program).

Most VHA sites define a panel as the number of individual (unique) patients assigned to a clinician's care. Thus, only "users" are considered in the calculation of panels. A person is defined as a user if s/he has been seen in any VHA program, or in other words, has come through the doors.

One source of difficulty hence variability in measuring panels this way is the time period.

Thus, "when" affects what "counts".

The time periods used for calculation of panel size vary from site to site.

The need is to determine the time period during which one can evaluate whether the veteran has "used" the healthcare system. The time periods used for calculation of panel size vary from site to site. The confusion lies in that some discussions limit "use" to the current fiscal year. Most sites in fact appear to use one year as the basic value.

Other discussions suggest that use in any of the three previous fiscal years enable the veteran to be counted in the panel. Thus, some sites calculate the number of patients seen for the past two or three years. Finally, still other sites use a combination of past visits and future appointments with a 3-year (36-month) time span.

Related to the time period dilemma is level of activity of the patient/user. 'Active' patients may be defined as those actively being cared for and followed in primary care

There is a workgroup currently developing a standard definition to be used as a national directive to settle the confusion. In the interim, you must be sure of the definitions applying to the terms applicable to your site.

clinics within a recent period of time. The provider may see an individual patient on several occasions during a defined time period; this still counts as one patient in terms of calculating the panel size.

There is a workgroup currently developing a standard definition to be used as a national directive to settle the confusion. In the interim, you must be sure of the definitions applying to the terms applicable to your site.

There are several reasons defining what constitutes panel size is important.

- First, if all parties don't have the same definition, any decisions regarding excessiveness or inadequacy of workload and equity will cause endless conflict unless this is resolved.
- Second, in order to manage clinic operations and to be able to be held accountable for its "performance", managing panels is critical.
- Third, "load" on resources is implicitly used to evaluate and make budgetary decisions for the clinic. Panel size is an integral part of this determination.

It pretty much boils down to the following: In order to appropriately manage the practice means is it critical that the measurement of the panel size be accurate and consistent.

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What are some of the drawbacks and pitfalls in the various conventional ways you may be tempted to measure panel size?

Drawbacks and Pitfalls in Measuring Panel Size:

Using appointment lists

An easy way that has often been used (and remains in use in some practices) is to *simply look at appointment lists* in order to judge workload. Such an approach is fraught with inaccuracies. How do you "count" a patient who shows up on a provider's list only because the provider was covering for another provider that day or week?

Including past visits

The practice of *including past visits may artificially inflate the panel size.* This is because you could end up including patients who may have been seen only once or if the patient decides to not be followed in the Primary Care practice.

Including "inactive" patients

What about those *patients who are no longer "active"* – i.e. they've moved or have died. Are they dropped from the panel?

Using future scheduled appointments

Using future scheduled appointments to create a panel jeopardizes the accuracy of estimates of true panel size for several reasons. One, it may lead you to include patients that may never be seen (i.e. no-shows and cancellations). It may lead to undercounts because you might omit walk-ins and unscheduled workload such as those patients who wait until the last minute to schedule appointments.

Looking at clinic enrollment in VistA

Another tendency is to ***look at clinic enrollment***. The term "enrollment" has been used in the VHA to refer to a variety of situations. 'Clinic enrollment' is a designated status in the VA computer system (VistA). The term enrollment was originally intended to simply indicate that the patient was to receive continuing care in that clinic. However, in reality, two phenomena were observed. First, the status became a default response during the

Joint assignment to physician and non-physician clinicians

scheduling process in the system. Second, the process of undoing this (i.e. dis-enrollment) was a cumbersome process that was therefore frequently not performed.

To complicate matters even further, "enrollment" in recent years has taken on additional meanings due to legislation that required patients to "enroll" for care in the VHA, regardless of whether they planned to actually receive medical care. Thus, clinic enrollment is essentially a useless indicator of ongoing care at most sites and is, therefore makes little sense to use as it has little or no relation to panel size.

Finally, even more confusion potentially derives when it comes to the practice of *assigning panels to a physician and a non-physician clinician jointly* rather than counting each clinician's panel independently.

The point? Don't fall into these traps.

The point? Don't fall into these traps.

Measuring and Adjusting Panel Size: Some Further Cautions

A rough calculation of panel size is:

$$\frac{\text{Total number of patients}}{\text{Number of physicians (FTE's)}}$$

This number can (and is) adjusted upwards or downwards to take into account factors such as age and sex of the population of patients, specific diseases, scope of the clinic practice (i.e., what the physicians do), and the presence of support staff, clinical pathways, or other types of support.

The denominator in the panel size calculation is reported in several ways. As such it makes sense to be attentive to definitions used here as well.

Some panels are adjusted per full time physician equivalent (FTEE). Some of the adjustments include only clinical time or paid hours only. Absolute values here can create spurious measures of panel sizes.

In some cases, adjustments are made to include only available time in clinic (accounting "out" things like annual leave, authorized absences, sick leave, and other non-patient care activities). Other sites report panel size on a 'half-day' basis, which is equivalent to a clinic session in many cases. The difficulty here is that a clinic session may range from 1 or 2 hours to 4 or 6 hours in some venues. Some sites view panels in terms of "per hour" to accommodate for varying schedules and responsibilities.

Table 8.1 Factors used to Adjust Panel Size lists the various factors that sites and providers have used in making adjustments to their panel sizes. For example, processes of care including in-clinic flow will affect the ability of an individual to perform their duties. Infrastructure, including space amount and design, staff mix and numbers, and telephone staffing and model used may also affect the appropriate panel size.

Additional responsibilities:

- Supervision of residents or other staff members
  Inpatient responsibilities
- Documentation requirements
- Collaboration with Nurse Practitioners/Physician Assistants

Clinic space:

- Exam rooms
- Waiting room space
- Check in facilities
- Parking

Support staff:

- Clinical (RN, LPN, health tech, phlebotomists, telephone triage, etc.)
- Administrative (clerks, practice managers, transcriptionists, etc.)

Unscheduled visits:

- Walk-ins
- Urgent Care clinics
- Telephone Triage

Scheduling:

- New patients
- Follow-up care
- Walk-ins
- Consultations

Administrative time for:

- Patient care related activities (returning phone calls, filling out forms, etc.)
- Continuing education
- Quality improvement activities

Case mix:

- More complex patients may require more visits, requiring a smaller panel size for the provider
- Co-managed or stable patients may require infrequent visits; provider can accommodate larger panel size

Table 8.1 Factors used to Adjust Panel Size

The Point: Regardless of what you do, the adjusted panel size for each physician, added together, must equal the total number of patients in the population being cared for by the clinic as a whole.

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The fundamental question is therefore what are the negative effects of attempting to adjust panel size vs. what is the goal of your efforts to do so? More importantly (and discomforting to think about for some practice managers): <u>are you achieving the goal of the system by doing so</u>?

VistA Options

There are several different options within VistA that can be used to help you measure panel size. The Primary Care Management Module (PCMM) is the gold standard. PCMM is discussed in some detail in the latter half of this chapter.

EAR (*Ambulatory Encounter Reports*).

One way to derive panel size is to use the *Ambulatory Care Reporting Project (*ACRP*) Reports* menu, which is part of the PIMS (*Patient Information Management System*) package. PIMS contains an option called **EAR (*Ambulatory Encounter Reports*).**

EAR essentially calculates visits and unique patients for a given time period. The report can be run by provider, hospital location (clinic), or stop code.

If clinics are set up to be provider-specific (one provider per clinic), then running this report by hospital location may be more accurate.

> **Caution:** Running by provider alone, however, might include encounters that are not specific to primary care. In the case of those sub-specialists who provide consultative and primary care services, this creates difficulty separating primary care workload from consultative workload.

If clinics are set up to be provider-specific (one provider per clinic), then running this report by hospital location may be more accurate.

PAS (*Patient Appointment Statistics*).

ACRP Reports includes another option called PAS (*Patient Appointment Statistics*). *PAS counts unique patients with future as well as past appointments.* Thus, there is source information to calculate panel size.

> **Caution:** PAS does NOT account for no shows and cancellations. Thus, care must be taken in interpreting the results of this report if past appointments are considered.

Developing a customized ad hoc *ACRP* report and saved template is probably the best way to get an accurate accounting of the number of patients seen by providers during a specified time period.

ACRP Reports also have an option for producing customized (Ad Hoc) reports, which can be run for specific divisions, stop codes, and a host of other parameters. Once a customized report is created, it can be saved as a template to use again.

Developing a customized ad hoc *ACRP* report and saved template is probably the best way to get an accurate accounting of the number of patients seen by providers during a specified time period.

Some sites have developed their own reports that look at combinations of past and future visits in a variety of ways. These reports generally require the cooperation of knowledgeable IRM and/or MAS staff.

***Primary Care Management Module* (PCMM)**

The ***Primary Care Management Module* (PCMM)** is a mandated package that keeps track of patients' primary care assignments. Target panel sizes can be set within the program, and warning notices appear when assignment of new patients to the provider's panel would exceed the target. **PCMM can generate reports that indicate the number of patients assigned to each physician or non-physician clinician panel.** Thus, the package has the potential to help you accurately measure, manage and monitor the practice better. Some details guiding its implementation and use are now addressed.

An Overview of the Patient Care Management Module (PCMM)

The Primary Care Management Module (PCMM) is a software package designed to assist facilities with the implementation of Primary Care and management of panels. PCMM allows a user to:

- Setup and define a team
- Assign positions to the team
- Assign staff to the positions within the team
- Assign patients to the team
- Assign patients to practitioners (both primary and associate providers)
- PCMM can also be used in non-primary care applications and to tie individual team members to a panel.

PCMM can be a valuable tool to define panels, to track the number of patients assigned for Primary Care, and to support practice management. Ideally, PCMM should provide the clinic manager the information needed to know when additional staffing is required.

VHA Directive 99-065, Installation and Use of the VISTA Primary Care Management Module (PCMM) Phase II, dated Dec. 20, 1999 mandates the use of PCMM and established business rules. This directive may be accessed at http://www.va.gov/publ/direc/health/direct/199065.htm.

Accuracy of any database requires ongoing maintenance and PCCM is no different in this regard.

The degree of implementation and ongoing maintenance of PCMM varies from site to site. Accuracy of any database requires ongoing maintenance and PCCM is no different in this regard. If there is inadequate attention paid to the database' integrity then reports produced by the system will be unreliable. Future enhancements, increasing familiarity with the package, and attention to data integrity and accuracy will improve performance.

This chapter and guide are not intended to be a "how to" for the use of PCMM. Rather, its goal is to provide some tips, resources and guidelines for what you can do to make sure it can be and is used effectively.

Tip 1: Designate an individual(s) to serve as the PCMM Coordinator and ensure that the PCMM Coordinators receive appropriate training.

PCMM Guidelines and Success Factors:

Tip 1:Designate an individual(s) to serve as the PCMM Coordinator and ensure that the PCMM Coordinators receive appropriate training.

Generally, sites have one person who is recognized as the main person responsible for PCMM use. This individual is frequently part of the Primary Care Service management team. Each primary care practice within the service may have one or more individuals responsible to maintain their practice's PCMM data.

The PCMM coordinator function does not have to fall on the shoulders of an Information Technology staff member, although IT should be involved in support of the package. Stated another way, use of the application should be a primary care responsibility. Technical installation, upgrades and troubleshooting are an IT function.

Handy Hint:*Some sites have opted to establish a full-time PCMM Coordinator, while others find that maintaining the PCMM database (after the initial setup of all teams and patient assignments) does not require a full-time position.*

PCMM training materials are available through the VA Intranet at http://vista.med.va.gov/VistA_Lib/Clinical/Pri_Care_Mgmnt_Module_(PCMM)/pcmmug.pdf. (Note there are underscores between each of the words in the web address, not spaces)

Tip 2: Local, "facility-specific" processes must be developed to assure that patients who are scheduled for Primary Care are also assigned in PCMM and that assigned but inactive patients are dropped from PCMM when appropriate.

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As stated earlier, currently there is not a national definition for an inactive patient. Thus a decision rule some sites have opted for is to *drop the PCMM assignment for patients who have not been seen in the prior 24 months and who do not have a future appointment.* Certainly, PCMM assignments should be dropped for *deceased patients.* Note however that the lack of a future appointment may *not* indicate the patient's wish to discontinue care. The potential for patients to be inadvertently lost to follow-up does exist, and for many reasons (including quality, safety, and service) patients without future appointments should be considered lost to follow-up until proven otherwise.

Tip 3: Data extracts, some available nationally, can be written to identify patients with assignments to more than one primary care team and provider, and to identify patients who are inactive.

Tip 3: Data extracts, some available nationally, can be written to identify patients with assignments to more than one primary care team and provider, and to identify patients who are inactive.

One example of how this utility can be used is that an extract was written to provide mailing labels to facilitate contact with inactive patients who are not listed in the data base as deceased, and who may have been lost to follow up.

Tip 4: Running weekly reports and taking appropriate actions to maintain an accurate PCMM database.

Tip 4: Running weekly reports and taking appropriate actions to maintain an accurate PCMM database.

The use of weekly reports and focusing on PCMM database accuracy is important to accurately track panel sizes. Knowing the panel size enables you to determine which providers can have new patients added to their panels and which providers should not have new patients scheduled because their panels are "full" or larger than others.

PCMM Assignment and Cleanup of Enrollments

As shown earlier – "enrollments" tend to be messy and an inaccurate base for calculating panel size. The following actions will help assure that patients are appropriately assigned in PCMM:

- With new patients: *Assign patient to Primary Care Team and Provider at the time the initial primary care appointment is requested/made* (based on patient selecting facility as the provider of care).
- Until the database is clean and accurate, incorporate the following step in the check-in process. *Review for correct PCMM assignment at time of clinic appointment check-in or when a reminder call is made*.

  Be sure to create a log to capture discrepancies for hand-off to the PCMM coordinator for corrective action.
- Until the database is clean and accurate, incorporate the following step in the Exit or equivalent stage of your chain process. *Have the clerk or designated position identify patients having future appointments with no PC Team/Provider assignment and make PCMM assignment as appropriate*.
- *Identify and correct inconsistencies and errors in PCMM files* using Patient Team Position Assignment Review and the PCMM Inconsistency Report.
- *Review encounters* transmitted to Austin as *PC workload (323 stop code) with no PC Provider,* and make PCMM assignment as appropriate (ACRP Ad Hoc Report).

Identification of Inactive PCMM Patients and PCMM Discharges

The following actions will help assure that PCMM assignments exist only for active patients, with inactive assignments dropped. The most important action you should take is to establish a point person or resource that has the responsibility to identify, review and discharge inactive primary care patients.

- Have a list created (see Data Extract tip above) to generate mailing labels for primary care patients who have not been seen by primary care provider during the past 24 months and do not have a future appointment (12 months). Mail those patients a letter informing them of services and requesting them to contact the Primary Care Clinic or scheduling clerk for an appointment if interested.

  (One site copied the labels and then had a clerk "check off" those who had responded s removal of the "inactives" could be tracked.)
- Discharge patients from Primary Care Team/Provider upon verification and E-mail notification of patient death entry. Use VistA VISN Report: Deceased Patients with PCMM Assignment Report as another source of information.
- Discharge patients from Primary Care Team/Provider upon patient request for transfer or discharge of primary provider care.

(One site copied the labels and then had a clerk "check off" those who had responded s removal of the "inactives" could be tracked.)

Ideal Panel Size

Some work suggests that the quality of care delivered is adversely affected the larger the panel size. However, as practice processes improve, panel sizes have been shown to be able to increase without adversely affecting patient satisfaction, quality of care, or staff satisfaction.

Panels may differ from provider to provider within the same institution. Further, panel numbers have ranged broadly, even after adjusting for many of the confounding factors mentioned previously in this chapter. To make this decision even more difficult, there is conflicting preliminary evidence regarding what the ideal panel size is.

Some work suggests that the quality of care delivered is adversely affected the larger the panel size. However, as practice processes improve, panel sizes have been shown to be able to increase without adversely affecting patient satisfaction, quality of care, or staff satisfaction.

So which is it?

Recall from Chapter 1 that your responsibility is to manage the facility so that clinic throughput continually improves. If you have poor quality, things such as medically unnecessary revisits, provider rework, errors, etc. are going in the wrong direction – throughput suffers.

Most clinic managers believe that determining the correct panel size target for your facility is the correct vehicle to do so. This is because experience has indicated what is shown in Figure 8.1 regarding the hypothesized cause of poor quality care:

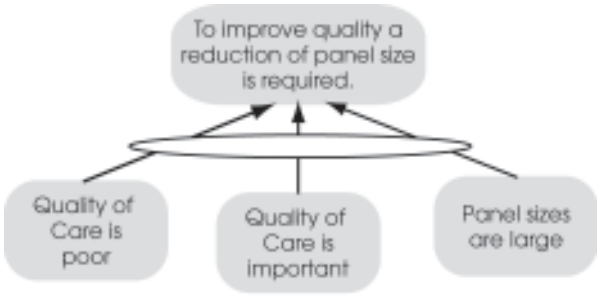

Figure 8.1 A Hypothesized Cause of Poor Quality Care

The way to read the figure is: IF the quality of care is poor (or unsatisfactorily low) AND quality of care is important AND our panel sizes are large, THEN to improve quality a reduction of panel size is required.

While panel size is correlated with flow, do not quest after the panel size "grail" without carefully thinking about your system as per Chapter 1.

If the hypothesized model above is valid, we would expect all facilities with large panel sizes to have poor quality. However, recall the conflicting evidence: changing practice processes has resulted in large panel sizes.

While panel size is correlated with flow, do not quest after the panel size "grail" without carefully thinking about your system as per Chapter 1. Perhaps the most concise way to think about this is as follows:

IF your process improvements are driven by managing the constraint to increase patient flow AND process changes focus non-constraint resources to optimize the constraint THEN

flow, satisfaction and quality improve. Another effect is that panel sizes can then probably increase.

If provider time is your weakest link, managing panel size as explained below is critical. Keep all of this in mind while reading further and note the *caveats* listed as well.
The general consensus among practice managers in recent years is that a panel of 100 to 120 patients per half-day in clinic seeing patients seems to be a reasonable range for a physician. The pertinent assumptions behind this range include:

The general consensus among practice managers in recent years is that a panel of 100 to 120 patients per half-day in clinic seeing patients seems to be a reasonable range for a physician...would translate into a panel size of 1000 to 1200 patients per MD FTEE.

1. The physician performs outpatient care only
2. Has a minimum of two examining rooms available for exclusive use when in clinic
3. Is adequately supported with clinic staff, and
4. Sees their own same day/walk-in/urgent patients. Note: time spent in attending clinic supervising a group of residents is not considered time available to see patients.

Using the above range, with ten half-days available in a week would translate into a panel size of 1000 to 1200 patients per MD FTEE. However, in many sites a full time physician has administrative responsibilities, such as committee work. To account for this and other activities such as telephone time, many sites count construe a 'full-time' clinician as having nine half-day sessions. Thus an ideal panel size actually means a panel size of 900 to 1080.

Non-physician providers are usually rated at 50-85% of the target panel size for MDs, assuming time is needed for physician consultation and supervision. For an unexplained reason, no sites are known to also reduce the panel size of the physicians supervising non-physicians to allow them time to supervise or be consulted!

Managing Panel Size

No matter what panel size is chosen as a goal, each facility will probably need to develop procedures to monitor and adjust panels. It's critical that it results in a real and correct adjustment to workload however.

Checking panel size should probably be done no less than quarterly though monthly may be preferable. Once appropriate reports are run and analyzed and depending upon what's happening in your practice, any of the following changes may be warranted and considered.

The trend seems to be that there a 10% attrition rate per year for panels.

Option 1: Sometimes, closing a clinician's panel to new patients may be required. This should be satisfactory as long as there are other providers who are available to see these new patients.

Note: The trend seems to be that there is a 10% attrition rate per year for panels. Thus, as long as your panel assignment process is equitable, most clinicians will have a continuous mix of new and old patients and this option may not have to be implemented.

Option 2: Panels can be split and patients reassigned.

Option 3: New providers can be brought in to take over some of the workload if they seem excessively high or growing at too rapid a rate. (See Chapter 7 on Contracting for your role in this instance.)

Any of these solutions obviously can result in conflicts and what may appear to be compromises to continuity and staff morale. Use the Negative Branch and/or Conflict Cloud tools in Chapter 2 to evaluate and refine each alternative and/or to help gain the collaboration of those affected.

Notice too the perspective from Chapter 1 regarding the clinic's constraint. Each clinic has one **most limiting** resource or capability. Taking the time to identify and manage it will surface capability in the other links. Given the strain on resources and the difficulty in procuring more from funding sources (recall the material from Chapter 4 on Budget and Finance) the challenge you face will always be to improve processes and outcomes with minimal resources. Frequently, this will mean a gradual expansion of panel size.

Some solutions are contained within this document; others will be included in later editions, or can be found through the Office of Primary and Ambulatory Care and the CMI effort.

Waiting lists are not recommended by the Office of Primary and Ambulatory Care as a solution!

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PCMM Reports

PCMM is an excellent resource for managing providers' panels. It allows a quick reference point for how many patients are assigned to a provider. When PCMM is accurate and up-to-date, a wide variety of management reports based on the data can be run to determine the size of a panel compared to the local target. Two of the most useful reports are explained below.

Practitioner's Patients report

- The Practitioner's Patients report (on the PCMM Reports Menu) report, shows the last appointment with the provider as well as any future appointments. It is an excellent source to keep your panel size information up to date.

ACRP Ad Hoc Report

- The ACRP Ad Hoc Report can be used in various ways to assist in managing the panel size. This is because the data can be sorted by primary care provider and/or team. As such you can obtain information on things such as:
    - Unique patients seen by each primary care provider
    - Return rates for each provider,
    - Frequency of a patient seeing his/her primary care provider, etc.

  If a provider starts finishing later than previously, and the next available appointment for that provider is slowly creeping up, the number of active patients in their panel might be increasing. The ACRP Ad Hoc Report helps determine if this is applicable in your practice.

Practice Profiling – Some Local Initiatives

Essentially, profiling is creating a picture of various characteristics of the practice.

The words 'practice profiling' generally cause a visceral and unpleasant reaction among clinicians. Essentially, profiling is creating a picture of various characteristics of the practice. There are some circumstances where knowing characteristics of a practice can be useful. This topic will be covered in more detail in future editions.

However, if this is something you want to investigate, your IRM Service may be able to assist locating software to help. Several VA facilities have written third class software (locally developed software, not distributed or supported nationally) that deals with practice profiles on a more detailed basis. The software breaks down information by primary care provider for such things as total completed clinic visits, total number of consults ordered, bed days of care, total number of lab tests ordered, total number of radiology procedures ordered, total number of prescriptions written, etc. The information is obtained by using the primary care assignments in PCMM.

The software breaks down information by primary care provider for such things as total completed clinic visits, total number of consults ordered, bed days of care, total number of lab tests ordered, total number of radiology procedures ordered, total number of prescriptions written, etc.

SUMMARY

Primary care provider productivity and effectiveness can be managed through effective use of panel size measurement and control. This important dimension of workload may be a major factor in controlling clinic waiting times and insuring provider and patient satisfaction. Clear panel definition and management are crucial for any use of advanced access scheduling. Finally, PCMM can be a valuable tool for clinic managers, but monitoring and maintenance of the data and software is essential to ensure accuracy.

CHAPTER 9
Scheduling

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Goals:

To provide a comprehensive review of considerations, problems and solutions for scheduling that integrates innovations with the introduction of Advanced Access.

Objectives:

1. To summarize the common problems and issues in scheduling and what they imply for clinical practice managers.
2. To critically examine the general process of scheduling and actions taken to address the problems of scheduling in light of the effects observed and contrast what Advanced Access would suggest be done.
3. To propose improvements to the scheduling process overall that perhaps should be considered and customized for your own clinics.

"Waiting is frustrating, demoralizing, agonizing, aggravating, annoying, time consuming, and incredibly expensive"
(Federal Express ad, Fortune, 28 July 1980, p. 10.

Introduction

Managing scheduling is vital to manage workload such that maximum flow of patients is achieved within minimal waits and delays while accommodating the preferences and requirements of providers and clinic staff.

Unfortunately, the goals of scheduling seem unachievable and unrealistic because they frequently appear to be in conflict with each other. The ultimate goal is to meet patient needs when they arise without disrupting other commitments regarding provider availability and the need to not waste resources and time.

The needs or problems that are frequently encountered in scheduling are widely known:

1. Patients don't require the same amount of time for appointments.
2. Some patients require immediate service (Same Day or "Urgent Care" patients).
3. There are often Walk-ins.

4. There are an unacceptable number of No Shows (15-20% on average).
5. No Shows, Urgent Care, Same Days and Walk-ins disrupt flow and result in expensive and unnecessary idle time.
6. Sometimes clinics overbook.
7. It is difficult to ensure that ancillary appointments and results are completed prior to a revisit or follow-up.
8. Waiting times are frequently too long for patients.
9. Having too many clinics complicates scheduling.
10. The backlog of patients is continually growing.

There have been a number of changes made and adopted by a variety of clinics to address these problems. Unfortunately, this is where problem #11 comes into play.

11. Frequently, solutions to one or two of the chronic problems to improve scheduling results in substantially more work or new sets of problems.

Improving scheduling processes provides an opportunity to dramatically impact patient and staff satisfaction, to improve access to care, and to create a database that accurately reflects a more equitable workload.

Improving scheduling processes provides an opportunity to dramatically impact patient and staff satisfaction, to improve access to care, and to create a database that accurately reflects a more equitable workload.

But you have a choice: treat each problem, each symptom, individually – or treat the root cause. (No offense intended but there's a fairly widespread and nagging sense that many facilities have been doing the former and not the latter.)

The problems exist because the environment of treating our nation's veterans HAS changed dramatically.

The problems do not exist because clinic managers and schedulers are stupid nor that staff are lazy or incompetent. Rather they exist because the environment of treating our nation's veterans HAS changed dramatically. What we're experiencing and coming to realize is that traditional scheduling tools and solutions may no longer be sufficient to address the demands being placed upon the system.

A High Level Summary of the Conventional Scheduling Process and its (Negative) Effects

Determine Clinic Appointment Availability: Clinic appointment availability is traditionally determined based on the number of providers in clinic and the average length of time providers require to conduct the examination. If you have one provider who averages 30 minutes per patient, you would set up 1 slot every 30 minutes for the length of time that provider is available in the clinic.

Example:	**8:00**	**8:30**	**9:00**	**9:30**	**10:00**	**10:30**	**11:00**	**11:30**
	1	**1**	**1**	**1**	**1**	**1**	**1**	**1**

If you have 3 providers available in the clinic and the providers average 20 minutes per patient, you would set up the clinic on 20-minute increments with 3 slots available per time slot.

Example:	**8:00**	**8:20**	**8:40**	**9:00**	**9:20**	**9:40**	**10:00**	**10:20**	**10:40**	**11:00**	**11:20**	**11:40**
	3	**3**	**3**	**3**	**3**	**3**	**3**	**3**	**3**	**3**	**3**	**3**

The negative effect (especially if you want patients to be followed by the same provider over time) is that an individual clinic profile needs to be built for each clinician.

Consider Clinic Process Flows: Designing good clinic profiles requires consideration of clinic staff, space, and clinic process. Ideally, this entails *eliciting provider input about the number and length of slots, and their preferences on how to handle the scheduling of patients who need to be seen sooner than the next available appointment*. Slots are reserved for patients that need to be seen urgently and walk-in patients and, ideally, some work-in/same-day slots are placed in both morning and afternoon clinic sessions. This is usually done via *Carve Outs*.

Clinic profiles are then built to maximize provider capacity and patient access but with crossed fingers that they are realistic and flexible enough to allow time for the multiple unknowns while meeting the targeted 20 minute target for the patient to be seen.

The effects of this effort are highly mixed and frequently troublesome.

The effects of this effort (creating clinic profiles based upon various models of appointment availability and clinic process flows with carve outs) are highly mixed and frequently troublesome. How, for example do you incorporate critical administrative time? What about patient education, preventive medicine interventions, electronic record entries? How can you get providers to participate in effective scheduling of patients?

Overall, what has evolved is a scheduling system that is attempting to be patient-centered by becoming a continual tug of war between staff, providers, and clinical processes all focused on finding <u>what's available</u> for patients rather than a system whereby patient needs are determined and drive the creation of systems and processes to meet them.

Some sites have allowed for daily administrative time while others carve out an administrative half-day when clinic is not scheduled. Planning time for patient education, preventive medicine interventions, and the entries needed for an electronic record are important but can easily be compromised or skimped upon when delays occur. Continual monitoring of overbook rates, no-show rates, and appointment timeliness to permit continual modification of clinic profiles is time consuming. Attempts to ensure providers are aware of their clinic profiles at each clinic session, including the date of the next available appointment in the profile are frustrating and not always accurate or able to be used because patient of requirements. The hope that providers have needed information to integrate into their writing of orders for return appointments is frequently dashed.

Overall, what has evolved is a scheduling system that is attempting to be patient-centered by becoming a continual tug of war between staff, providers, and clinical processes all focused on finding <u>what's available</u> for patients rather than a system whereby patient needs are determined and drive the creation of systems and processes to meet them.

Solutions to Symptoms versus Systemic Solutions

The list of problems identified in this chapter's introduction is reproduced in the left-hand column of Table 9.1 Typical Scheduling Problems and Related Solutions. The various responses and solutions are summarized in the right-hand column.

Problems	Conventional Responses and Solutions
1. Patients don't require the same amount of time for appointments.	• Variable appointment lengths
2. Some patients require immediate service (Same Day or "Urgent Care" patients).	• Don't allow/discourage them. • Urgent Visit Clinics • Triage & shifting patients
3. There are often Walk-ins.	
4. There are an unacceptable number of No Shows (15-20% on average). 5. No Shows result in expensive and unnecessary idle time.	• Call lists and reminder calls (by healthcare team member) • Overbook • Monitor no-show rates and factor into scheduling clinics
6. Sometimes clinics overbook.	• Determine "safe" levels based upon average number of allowable overbooks • Balance/juggle reserved vs. open slots • Computer program to visually see magnitude of overbooks • Restrict overbook privileges to designated individuals
7. It is difficult to ensure ancillary appointments and their results are completed prior to a revisit or follow-up.	• Mandate better communication with ancillary services • Use charts notes/reminders • Pre-tests
8. Waiting times are frequently too long for patients.	• Mandate a decrease in wait time and post performance
9. Having too many clinics complicates scheduling.	• Audits to prevent inappropriate scheduling in specialty clinics
10. The backlog of patients is continually growing.	• Create First Step clinics • Offload return visits to nurses • Increase search capability across multiple clinics.

Table 9.1 Typical Scheduling Problems and Related Solutions

What each solution entails, as well as the benefits and the negatives are now discussed. For each of the innovative but existing sets of responses or solutions, actions that are part of Advanced Access recommendations (summarized in Chapter 3) are incorporated.

The contrasts are included to help you better plan and evaluate how to incorporate Advanced Access into your scheduling functions.

Variable Appointment Length

Typically, new patient appointments and annual health assessments take a longer amount of time. Setting up a clinic that allows variable appointment lengths appears to be a logical alternative.

as long as consecutive slots are available to be booked.

With variable appointment length, the scheduler may select multiples of the basic appointment length unit, as long as consecutive slots are available to be booked. For example, if your basic unit is 20 minutes, the scheduler has the option to select an appointment length of 20 minutes, 40 minutes, or 60 minutes, but cannot book 30 minutes, because 30 is not a multiple of 20.

Planned Benefits: Clinic could achieve the desired flexibility. The use of variable booking could obviate the need to create more than one clinic profile for each provider (i.e. Primary Care New and Primary Care Return clinics).

Negative Effects: Booking a patient appointment that is twice as long as the typical appointment slot does not prevent another patient being booked during the same time. Thus overbooking is a common result. Clinics that use variable appointment lengths must be constantly vigilant about the placement of overbook appointments on a provider's schedule when attempting to reserve more clinician time for selected patients.

How Advanced Access Recommendations Can Help: Step 4 in the Advanced Access scheduling process targets the variability in patient appointment lengths specifically. The thing to keep in mind is that variation exists. You can try and accommodate all combinations and permutations of it – or you can design scheduling systems that will help you minimize its impact.

The essence of Step 4 of Advanced Access implementations is to first: Reduce appointment types which entails standardize appointment length. This may mean only two types of appointments: Type (1) – Consults, routines and returns, and Type (2) – Procedures (requiring special room set-up or equipment). The corollary piece to Step 4 is having only one or two basic appointment lengths (e.g., 15 minutes or 20 minutes) that can be utilized either as a single unit or grouped together for a longer appointment as needed. Unlike many current clinic practices, *times for longer appointments should not be predetermined for certain days*, but should be applied as needed.

Same Day, Urgent Care and Walk-Ins

There are two major issues that the practice manager faces with same day, urgent or walk-in patients. One has to do with the "treat now or don't treat now" dilemma – and the attendant headaches associated with increasing the complexity of the process. "Should we fit them in and, if so, how do we do it?" The second has to do with the problem of ensuring workload credit. Frequently, "inserting" patients leads to uncounted workload.

Same day and walk-in appointments: are handled differently through the VHA system as well as throughout each facility. Regardless of how same day and walk-in appointments are viewed at each facility, the key to a successful program is to have a policy and/or procedure outlining the process. The policy will provide the consistency necessary for the process to work.

the key to a successful program is to have a policy and/or procedure outlining the process.

Some VHA facilities encourage same day and walk-in appointments while other facilities discourage them.

Some VHA facilities discourage same day and walk-in appointments

Planned Benefits: A policy of discouraging them has its pros and cons. The biggest benefit is that it may dissuade, hence minimize the number of providers or patients who learn how to "squeeze in" those that may need or desire an appointment. In addition, the headaches associated with doing so should be reduced.

Negative Effects: Unfortunately, it doesn't solve the problem that there are legitimate instances for those who need to be seen "today".

utilize an Urgent Visit Clinic (UVC) to handle walk-ins

A number of facilities throughout the VHA utilize an Urgent Visit Clinic (UVC) to handle walk-ins during administrative hours. However other facilities are closing their UVCs over the years (which tend to consume scarce resources). It would appear that a UVC is not a solution to the walk-ins/urgent/same day patients.

Further, the problem that then faces clinic management and staff is how to close the urgent visit clinic. As shown below – the closing process starts a chain reaction of actions that must be done in order to close UVCs or any clinic.

the closing process starts a chain reaction of actions that must be done in order to close UVCs or any clinic.

The *primary issue that must be addressed is determining how patients will be processed without the UVC*. The decision often means a scramble to gather data on the volume of patients who used the UVC, how many of the patients have established primary care providers, the number of new patients seen, which days of the week are the busiest, which hours of the day are the busiest, and anything else that might make a difference when determining where the patient will be seen if the Urgent Visit Clinic is closed.

Involvement of all the staff that is part of the process now becomes an absolute necessity. Depending on how the patients are going to be handled, the decision to close a clinic may involve staff from a areas such as the Emergency Department, Primary Care, Fiscal, Pharmacy, Laboratory, Radiology, etc. The process must ensure that everyone is aware of the new process so each can do its part to reduce confusion and anxiety for both staff and patients.

Communication with the patients and their families now must also be planned and started. Practices that have closed clinics begin as much as a month in advance of to prepare patients. Clear instructions on how to access care then needs to be provided to the patients. If primary care clinics will see their own walk-ins, then procedures need to be put in place to ensure that this will occur in a timely and consistent manner. Decisions need to be made about what happens to first-time patients and who will see them.

The point: A separate urgent care/walk "clinic" may not work. And, once you've created it and discover that it's not the solution, you will have a whole host of work to undo it.

The relevant components of Advanced Access' recommended actions to reduce backlog must be put into place immediately.

Relevant Advanced Access Recommendations: The first two steps in the Advanced Access initiative targets reduction and prevention of backlog. The current scheduling process does not seem able to accommodate insertions. The legitimate concern in fact, would appear to be that the more you insert Same Days, Urgents, or Walk-ins – the greater the likelihood you would create more backlog.

The relevant components of Advanced Access' recommended actions to reduce backlog must be put into place immediately.

working down existing backlog *eliminating duplicate appointments and the temporary addition of appointment slots to do so (ways to implement Step 1) will open slots up each day*.

You will still face the problems of "treat now"-type patients during the interval that your system is working down existing backlog (Advanced Access Step 1). But the actions of *eliminating duplicate appointments and the temporary addition of appointment slots to do so (ways to implement Step 1) will open slots up each day*. In other words, implementing step 1 of Advanced Access will give you capacity to address patients who need same day care.

Step 2 of Advanced Access is "take action to reduce creating additional unnecessary demand". Two actions to do so are changing practices such that there is no automatic rebooking of no shows and returns and developing alternatives to traditional, face-to-face care. Both of these actions will also free up some capacity.

no automatic rebooking of no shows and returns and developing alternatives to traditional, face-to-face care, this will free up some capacity.

A caution:think carefully about filling ALL or even the majority of the newly-opened slots with same days or walk-ins. If you do –you won't be able to reduce your backlog.

Chapter 3 has several other features that will help address walk-ins, same days, etc. Look at several of Step 5 and Step 6' recommended actions.

advantages to not having a separate Urgent Visit process in the Primary Care practice.

Intuitively, there are advantages to not having a separate Urgent Visit process in the Primary Care practice. Greater reduction in demand for appointments, enhanced continuity and access, better coordination of care, and patient satisfaction are among the reasons which influence the recommendation to incorporate same day, walk-in, or 'urgent' visits in to the primary care practice rather than remaining as a stand-alone operation.

At the beginning of this section two issues were raised regarding addressing same day, urgent or walk-in patients. It appears that Advanced Access could address the "Should we fit them in and, if so, how do we do it?" reasonably well.

The second issue, the problem of ensuring workload credit.

The second issue has to do with **the problem of ensuring workload credit**. Frequently, "inserting" patients leads to uncounted workload. In order to assure proper workload credit, the appointment must get into the computer.

The question facing clinic managers regarding these unscheduled visits lies in WHEN to schedule them. Should the appointment be made as soon as the patient indicates he/she wants to be seen as a walk-in? Should the appointment be made after the nurse triages the patient to ensure that the patient is going to be seen today as a walk-in? Is the patient a walk-in or a same day appointment? Did the walk-in appointment get made as an unscheduled visit? If so – how can you ensure that the number of walk-ins is captured accurately?

Helpful Hint: To derive a correct process first read through Chapter 12 on Data Collection and Validation to more clearly understand what happens and when with respect to data collection. Then, familiarize yourself with the Negative Branch tool described in Chapter 2.

Use the negative branch to create a clear understanding of the cause-and-effects of what you are currently doing versus what you plan to put into place as a process.

This should enable you to create a process that will lead to the desired effects while minimizing the likelihood of creating undesired ones.

Whatever the process, it needs to be well documented so that the appropriate action occurs at the appropriate time.

No-Shows

No-show rates in VHA clinics have historically been 15-20%. A Health Care Advisory Board study conducted in 1999 found multiple factors contribute to this rate. Lessening the rate of no-show appointments continues to be a goal for many clinic managers.

reminder phone call to a patient in advance of the appointment can result is a smaller no-show rate, if the calls are made by a member of the healthcare team.

What Works – Sometimes: Sites report that a reminder phone call to a patient in advance of the appointment can result is a smaller no-show rate, if the calls are made by a member of the healthcare team. There is an advantage to having a staff member contact the patient and take immediate action to cancel an appointment for a patient who is not planning to report, and contacting a patient to fill the slot who needs to be seen.

The use of automated reminder calls appear to be less successful at decreasing no-show rates – perhaps because requisite follow up to cancel appointments and reschedule other patients in place of those who are canceling is absent.

What's Probably Happening: As a rule, as access to appointments improves, no-show rates tend to decrease. Studies have shown a direct relationship to the wait time for appointments and the no-show rates.

The cause-effect as to why this occurs may be as follows: If access is complicated or delayed then patients and providers have less confidence that a slot that may be needed will be available when it's needed. If that's the case, then patients and

providers tend to schedule appointments as a contingency. If you have a number of these "just in case" type appointments and the initial reason that the appointment doesn't or no longer exists, then patients will not show up.

Targeting your improvement efforts on improving access and decreasing the wait time is probably the best solution for No Shows.

Targeting your improvement efforts on improving access and decreasing the wait time is probably the best solution for No Shows.

Relevant Advanced Access Recommendations: The entire focus of Advanced Access is on improving access and decreasing wait time. The systematic, sequenced implementation of many of its recommended actions has been shown to achieve both objectives.

What appears to make more sense, therefore, is to couple the implementation with the practice of healthcare team member reminder call. The cause-effect cycle described above should start to break. And, if the additional supply capability that emerges by the no shows that will still remain is used for "same day" and backlog reduction, the promised effects of Advanced Access are more likely to occur sooner.

The need to continually monitor no-show rates and attempting to factor it into the calculation of the number of patients to be booked for each clinic should also be reduced.

Overbooking

Overbooking is a strange beast with which practice managers have a love-hate relationship. It's generally hated when it is accidental or inadvertent – as happens when attempting to use variable length appointments and multiple clinics. Overbooks which are excessive and which are scheduled without balance throughout the day undermines the provider's ability to see patients on time.

But sometimes overbooking is "allowable" largely because of the no-show problem. It is felt that overbooks, used judiciously and with planning, can open up slots for patients requiring short-interval return appointments and to even patient flow by negating the impact of patients who do not report as scheduled.

Thus it is generally felt that decisions need to be made about the use of overbook appointments, and the number of overbooks that may be allowed for a clinic or provider. Some clinics are better able to absorb overbooks, while this would pose a problem for other clinics.

***current practice is essentially...* Staff providing care in the clinic determines the number of allowable overbooks.**

The current practice is essentially as follows: Staff providing care in the clinic determines the number of allowable overbooks. (This is based on the average number of anticipated No-Shows to the clinic.)

Planned Benefits: With the current scheduling software, the planned use of overbooks is used to meet the need for urgent appointment capacity (especially if the number of routine slots are decreased to accommodate the expected number of overbooks in the

schedule, or if the planned times for reserved slots are not initially built into the clinic profile schedule.)

often means that overbooking privileges must be restricted to designated individuals ... monitor that this is done properly

Negative Effects: Such a practice often means that overbooking privileges must be restricted to designated individuals who are delegated a security key in order to overbook a scheduled clinic profile. This results in the need to monitor that this is done properly and not abused – usually done by using software to track the name of the individual scheduling each appointment. The reason this is important is because once a user is delegated the security keys for overbooking, he/she may overbook *any* clinic because the current scheduling software does not give a user the ability to overbook only selected clinics.

in advance of each clinic date must now also be included

The need to monitor overb**ooks in advance of each clinic date must now also be included so any problems** can be remedied before patients and staff are impacted. This is requires that a local computer program be written to allow a quick review of overbooks for multiple clinics. But it also requires some "tap dancing" with patients and staff.

The question clinical practical managers must ask themselves is: does it makes sense to remain in the time and resource-consuming practice of "balanced overbooking" with the additional effort to monitor and react cycle?

The question clinical practical managers must ask themselves is: does it makes sense to remain in the time and resource-consuming practice of "balanced overbooking" with the additional effort to monitor and react cycle?

Relevant Advanced Access Recommendations: The goal of the clinical practice is to achieve more throughput – continually improve the flow of patients. Step 3 of implementing Advanced Access is to address the imbalance between supply and demand. Overbooking exacerbates the imbalance. One of the recommended actions to implement Step 3 is to make panel size equitable and based upon clinical FTEs but not adjust it according to practice variations that exist. Coupling this with the reduction of appointment types of standardized appointment lengths is probably more appropriate.

Further, Step 6 – Manage the Constraint, will do more to ensure the flow of patients through the clinic. The details provided about how to do so that are provided in Chapter 1 and Chapter 3 regarding this step should be your priority.

Scheduling Ancillary Appointments

The difficulty with ancillary appointments is scheduling them with enough lead-time for results to be ready for the provider to complete the patient's visit.

The scheduling of patients for lab tests, x-rays, or an EKG on the same day, and in advance of the provider appointment, often required for quality patient care. The difficulty with ancillary appointments is scheduling them with enough lead-time for results to be ready for the provider to complete the patient's visit.

Relevant Advanced Access Recommendations: **There are two steps in the Advanced Access implementation process that can be leveraged to integrate the scheduling of ancillary appointments (and timely receipt of results).**

Step 8, Synchronize Patient, Provider and Information and Step 9, Predict and Anticipate Patient's Needs include a number of possible actions to incorporate. Obtaining patient information by alternative means prior to visits, the use of chart checks and health prompts and the use of the "care team huddle" are nearly identical to best practices being used in clinics already. In other words, as explained below, actions currently being performed by practice managers integrate easily with those required to implement Advanced Access.

using chart notes as a reminder

For example, using chart notes as a reminder to order the test at the time of the next visit and the mailing or phoning of results is a way to accomplish synchronization. Judicious use of pre-testing enhances lab turn around times, and can also reduce the number of venipunctures a patient must endure. Typing in comments specific to a patient's future visit in the free-text field, "other info", in the Make Appointment option can also be very helpful. This practice is precisely that which is described in Chapter 3, Action 2.4.

use of pre-testing

eliminate many stops to different locations may enable routine lab specimens to be drawn or, for example, EKG testing to be done in the clinic.

Challenging assumptions regarding clinic and scheduling processes in order to eliminate many stops to different locations may enable routine lab specimens to be drawn or, for example, EKG testing to be done in the clinic. Actions such as these enable synchronization to occur and obviate the need for patients to go to wait at multiple ancillary locations resulting in an increase in patient satisfaction and increase clinic flow.

Waiting Times for Next Available Appointment

The challenge: Timely access and reduced waiting times can contribute to increased customer satisfaction, quality of care, lower no-show rates, and less walk-in demand. Increasing access to care by decreasing the waiting times for the next available clinic appointment remains a high priority in VHA, which is reflected in the following wait time performance measure.

By September 30, 2001, the average waiting time will decrease for the following DSS identifier categories (clinics): eye care, audiology, orthopedics, cardiology, urology, and Primary Care.
Achievement levels - Fully successful: 45 days
Exceptional: 30 days or less

VHA Directive 2001-006, Veterans Health Care Service Standards, dated February 7, 2001, includes the following national timeliness goals to be accomplished by FY 2006: Patients will be able to schedule a follow-up appointment with their primary care provider within 30 days. Patients will have an appointment with a specialist within 30 days of referral.

The waiting times for all clinics (including the six performance measure clinics) are posted each month at the following web site: http://klfmenu.med.va.gov/.

Relevant Advanced Access Recommendations: The 10 steps outlined to implement Advanced Access are focused on this challenge. Its first three steps regarding reduction and prevention of backlog and creation of new backlog or unnecessary demand and aligning supply and demand are particularly applicable as a methodology. Actions that are in alignment with these steps that a number of clinics are following include:

- The use of virtual clinics (scheduled follow-up by phone call),
- Increasing return appointment intervals, and
- Contracting for additional provider capacity as suggested actions to

accomplish these steps will better balance supply and demand.

Some Innovative Practices and Solutions to Scheduling that need to be evaluated in light of Advanced Access

There are several innovative practices being implemented to scheduling problems that need to be evaluated in light of Advanced Access. Each is briefly summarized below with some recommendations about each in light of VHA's initiative for Advanced Access.

First Step Clinics: Some sites have established First Step Clinics to address the requirement to schedule new patients within 30 days and to increase access. In such clinics, new patients are seen for initial workup by nurse practitioners, a pharmacy tech reviews medications and discusses what is and is not on the formulary and creates notes with recommendations for the provider, LPNs complete prevention index interventions such as immunizations, and colon cancer screen. Patients are then scheduled to see their assigned primary care provider at another visit and often can be seen in a standard length appointment slot rather than the longer 'new patient' appointment slot.

The dilemma is that Advanced Access encourages the reduction of the number of clinics (see the example explained in Chapter 3 for Action 4.2). However, First Step Clinics are representative of ways to accomplish Step 6 in Advanced Access – manage the constraint.

> **Recommendation:** First Step Clinics may be one of the clinic structures that should be retained because they help ensure flow and offload demand from likely constraint links in the system.

Scheduling Return Visits to Nurses: It may be possible to identify instances where patients can be scheduled to see a nurse or other member of the healthcare team, further reducing demand for appointments with the provider. For example, patients can be scheduled to see the Registered Nurse for routine suture removal, removal of Foley catheters, and dressing changes, as one site did.

> **Recommendation:** A good basis on which to make this decision is if return visits to nurses is off-loading demand on the link in your throughput-generating chain that is the weakest. For example, if physician providers is the constraint, this action makes sense.

Increasing Availability in Specialty Clinics: As the system evolves to providing much of a patient's care in a primary care clinic, we must also expect that additional patients receiving ongoing and coordinated care may increase demand for sub-specialty consults.

As work continues to decrease waiting times for appointments, many sites have looked closely at the available capacity in sub-specialty clinics and taken steps to be sure that patients are not inappropriately scheduled for sub-specialty care. The review of consult requests by the sub-specialists prior to the scheduling of a patient for sub-specialty care has become common.

Strategies undertaken to increase capacity in sub-specialty clinics and the factors to consider in determining if they are in alignment with Advanced Access are:

- Identify patients that are in specialty clinics that could or should be seen in a primary care clinic. The biggest caution here is that additions here are increases in demand.
- Create Primary Care Nurse clinics for removal of Foley catheters, removal of sutures, and dressing changes.

  Recommendation: This action makes sense if this offloads demand on the system's constraint and there is sufficient nurse capacity to do so.

- Establish guidelines to schedule stable patients for annual follow up visits in Primary Care;
- Use reports generated by scheduling staff to track demand and channel resources including additional rooms, equipment, or staff;
- Establish daily clinics with capacity for same day appointments for Dermatology, Optometry, Podiatry, Mental Health, and Nurse Procedure.

A big caution with respect to sub-specialty consults: The computer tracking of timeliness for consult requests is problematic with current software. If consult requests must be reviewed and approved prior to scheduling, the consult requests must be tracked to measure both the time between the request for consult and approval of the consult, as well as the time between approval and the scheduled appointment.

The problem is that neither of these is reflected in current 'next available' measurements, and both of these affect the individual patient's actual waiting time. Further, if a consult appointment cannot be scheduled as requested, then the requesting provider and patient must be notified promptly with the reason and suggested alternatives for care.

Recommendation: It is probably best to undertake these actions only when backlog reduction has taken place, supply and demand are aligned, and it will offload demand on the link in your throughput-generating chain that is the weakest.

Decision Trees or Flowcharts: Required pre-approval for the scheduling of consult visits described above is neither a panacea nor a preferred approach. To allow real time scheduling of consult requests, some sites have opted to develop decision trees or

flowcharts that guide the primary care provider to order consult appointments, when appropriate, and to facilitate the scheduling of the patient to the correct clinic.

For the use of decision trees to result in getting the patient scheduled to the correct clinic, sites find they must review their list of clinics and to move toward more standardization of clinic profiles. For example, many sites currently have so many specialized clinic profiles, that it is not possible for anyone other than a few staff members to determine the purpose of the clinic. Recall: having scheduling profiles and clinics over-specialized (left knee pain clinic, right knee pain clinic…) frequently reduces accessibility.

> **Recommendation:** The Advanced Access action that encourages the reduction of the number of clinics and resulting increase in access should probably take precedence. Minimizing this number creates capacity. Only then, should restructuring of clinics and the use of a decision tree or flowchart to assist schedulers be considered or used.

Searching Multiple Clinics for Next Available Appointment: Even before the emphasis on increasing access to care, front-line schedulers who needed to find a next available appointment for a new patient needed an option that would allow a search for the "next available" appointment among many clinics. (Without such an option, the scheduler is often required to display availability for a single clinic multiple times to find the next opening for the new patient.) The result was that some clinics were booked much more heavily and had longer wait times than others and new patients were not assigned to the provider who actually had the earliest available appointment.

> **Recommendation:** Once again, if Advanced Access is implemented as described in Chapter 3, finding "next available" appointments should be less onerous. The increased supply and reduced backlog should increase the number of slots of available to "take care of today's demand today". The reduced number of clinics will also simplify this process.

The current scheduling package does not offer an option to allow searching multiple clinics for the next available opening. As a result, some facilities have created local display options to meet this need such as the one shown in the box below.

Example:

```
Search CLINIC NAMES that begin with CARD
Select Date to Begin :  T (April 3, 2001)
Select Date to End :  T+ 90 (July 02, 2001)

EARLIEST appointment(s) available April 3, 2001 thru Jul 2, 2001
May 01, 2001    TU      Cardio Dr. Jones
                        Cardio Dr. Smith
May 03, 2001    TH      Cardio Dr. Allen
May 03, 2001    TH      Cardio Dr. Doe

CONTINUE (Y/N)?  Y

May 10, 2001    TU      Cardio Dr. Doe
May 10, 2001    TU      Cardio Dr. Smith
```

With this display, the scheduler can see which Cardio Clinics have the earliest availability without taking the time to try to make appointment to each of the various Cardio clinic profiles. Without such an option, it is likely that Cardio Dr. Allen, alphabetically the first clinic accessed by default, would be booked for many months, while Cardio Dr. Smith might have openings within one week, which are not utilized.

Clinic Performance Measures

Details regarding how performance measures for clinics are of interest to many practice managers. What follows are brief explanations for those of greatest interest. Recall however, that most of these measures should improve with the proper implementation of Advanced Access.

Calculation for "Next Available Appointment Time" Performance Measure: On a monthly basis, data extracts are pulled from each medical center to calculate the waiting times for clinics. The extracts pull information on all scheduled appointments made during the preceding month. Only those appointments classified by the scheduler as being a next available appointment are extracted for the calculation of the average wait time for each clinic. For each appointment classified as 'next available', the number of days between the appointment date and the day the appointment is made is totaled, and then divided by the total number of next available appointments. Appointments not classified as next available are not included in the calculation.

Data Validation of Wait Time Performance Measure Results: The importance of the schedulers answering the prompt `Is this a "Next Available" Appointment request?" cannot be overstated. Appointments incorrectly classified by schedulers can result in inaccurate clinic waiting time results. For example, a scheduler responding to the prompt by classifying all six month follow up appointments as next available appointments would result in appointments with wait times of 180 days incorrectly being included in the average wait time calculation.

Clinic managers may wish to review a snapshot of data entry by clerks to assure that appointments are being accurately classified for the waiting time measure. Network 7 has created such a snapshot that captures the detailed information for each appointment that may serve as a useful data validation tool for clinic managers.

Waiting Times –Provider Performance Measure: The performance measure for the current year is:

> "By September 30, 2001, percent of patients who report in the Veteran Health Satisfaction Survey (VHSS) waiting for a provider more than 20 minutes will decrease."

The data for the baseline measure in FY 2000 was collected from the following question on the Outpatient Customer Service Survey:

How long after the time when your appointment was scheduled to begin did you wait to be seen?

- No wait
- 1 to 10 minutes
- 11 to 20 minutes
- 21 to 30 minutes
- 31 to 60 minutes
- More than 1 hour
- Can't remember

The FY 2000 results (organized by VISN and facility) may be found at: http://vaww.npdfc.med.va.gov/customer_satisfaction_surveys/main_page_css/css_online.htm

Time studies: Time studies measuring wait time on the day of appointment could provide useful data for modification of clinic profiles and processes. The VISTA Scheduling Package can provide a report of the time from check in to check out only. The ability to measure the interval between the time of a scheduled appointment and the time the patient is seen by the provider, and the ability to measure time spent on each step of a visit does not currently exist within the scheduling package.

Historically, local attempts to gather such information have involved manual collection and analysis of the data, which is cumbersome. With IT support, it is possible to generate a time-study data collection instrument that prints the scheduled patient's name, date/time of appointment, and clinic name, to obviate the need to capture those data points manually

Clinic Rescheduling and Requests to Reschedule Clinics: It may be helpful to have a written local or Network policy on clinic rescheduling. In many cases, provider absences can be predicted with sufficient lead-time to allow the clinic profile to be cancelled prior to patients being scheduled for those dates.

Many of the following actions are in alignment with Advanced Access Step 5 Plan for Contingencies. Notice that many essential ensure balanced supply and demand by encouraging the use of flexible, multi-skilled staff and the anticipation of unusual but expected events. This is because policies on clinic rescheduling are focused on addressing unexpected provider absences due to unforeseen circumstances, such as provider illness.

Policies on clinic rescheduling should address how patients will be notified of the appointment change. In some cases, it may be preferable to have a staff member phone the patient to discuss the time and date of the rescheduled appointment

- Clinicians should be asked to submit their planned absences for annual leave and professional meetings several months (preferably 6 months) in advance. Even if the exact dates change closer to the time of the provider absence, the dates blocked previously provide slots for moving rescheduled patients when the actual dates become known. Some sites have adopted policies that require patients rescheduled by the clinic to be seen within 30 days before or following

the original appointment. To meet this requirement, providers may wish to hold clinic on an additional date, which may be preferable to adding to the backlog of pending appointments in a provider's clinic profile.

- Consecutive clinic cancellations or rescheduling for patients should not be allowed (i.e. a patient should not be cancelled by the clinic, rescheduled for a new date, and then cancelled again). This should not be confused with rescheduling initiated by and for the convenience of the veteran patient. The veteran may reschedule sequentially, the healthcare system may not. It may be helpful to design a local option to quickly identify these patients when clinic rescheduling is requested. The following is a sample report to address this need:

Example:
Patients Whose Previous Appointment Was Rebooked By Clinic
PC Dr. Jones - April 30, 2001

Patient	SSN	Date Rebooked
Smith, John	111-22-3333	April 2, 2001
Doe, Jim	222-33-4444	April 2, 2001

Note: Providers requesting clinic rescheduling when patients are already booked should review the medical records of the patients, and determine if the patient requires additional medication refills and when the patient should be rescheduled.

Evaluating Requests for New Clinics and Modifications of Existing Clinics: Requests for the addition of a new clinic schedule (or the modification of an existing clinic schedule) need to be evaluated in the context of Advanced Access.

The key factor that should drive the decision is the impact on the system's constraint. If it enables flow through the constraint to increase or improve, the request probably makes sense.

Only then should addition factors such as availability of exam room space, patient waiting space, clerical support, nursing support, impact on lab and radiology services, and even patient parking be considered. Some sites attach a routing slip and require the concurrence of specific individuals before finalizing these requests. E-mail is another option to secure the concurrence needed from various individuals.

Finally, if approved, requests for new clinics and clinic modifications will need to be completed with enough lead-time to properly notify scheduled patients and medical center staff about the changes. If pre-appointment letters are used as appointment reminders, it will be important that clinic profile setups or modifications are completed in advance of the mailing of the pre-appointment letters for the earliest affected date.

Some final thoughts and pointers words about Scheduling

Scheduling is vital to manage workload such that maximum flow of patients is achieved within minimal waits and delays while accommodating the preferences and requirements of providers and clinic staff.

The "bottom line" is waiting lines and waiting time.

The "bottom line" is waiting lines and waiting time. An interesting article by David Maister (" The Psychology of Waiting Lines", in J.A. Czepiel, M.R. Solomon, and C.F. Suprenant (eds.), The Service Encounter, Lexington, MA: Lexington Books, 1985, pp. 113-124) is relevant here.

Maister argues there are two "laws" of service:
Law #1: Satisfaction = Perception – Expectation
What this means is if the patient expects a certain level of service and perceives the service received to be higher, s/he will be satisfied. If the patient perceives the same level as before but expected a higher level, s/he will be dissatisfied.

Law #2: It is hard to play "catch up"
If the patient has negative experiences in an early point of interaction, it is nearly impossible to make the happy later on.

Some "quick tips" that are easily implemented found in his article are summarized in Table 9.2 Waiting Line Realities and Ideas to Address Them.

Realities of Perception	Possible Solutions
1. Unoccupied time feels longer than occupied time.	• Use activities, videos, etc. to fill voids • (Note: activities that have benefit in and of themselves and/or are related to the encounter are even more effective.)
2. Preprocess waits feel longer than in-process waits.	• Have a representative of the clinic stop by and give periodic updates ("I'll check whether there's a hold up", "I'm sorry we're a bit backed up – I'll see if its going to be much longer.")
3. Anxiety makes the wait seem longer.	• Have a video explaining what to expect • Provide pencil an paper to write questions. • Have a "de-stresser" like a semi-completed puzzle available.
4. Uncertain, unexplained waits are longer than known (finite) and explained waits.	• Say "10 minutes" not "soon", or "30 minutes" not "awhile"
5. Unfair waits are longer than equitable ones.	• Post and/or inform verbally what the rules are (First-In, First-Out; severity, etc.) and apologize
6. The more valuable the service, the longer the customer will wait.	• Provider and caregivers coached to be more attentive and/or ask if there's anything else the patient needs or doesn't understand while looking at them.
7. Solo waits feel longer than group waits.	• Avoid putting patient alone until next link in the chain is ready to take care of them.

Table 9.2 "Waiting" Realities and Ideas to Address Them

They're food for thought.

Summary

The recent Institute for Health Care Improvement (IHI) Collaborative recommends open access as the standard and same day and walk-in appointments as the norm. Advanced Access has been adopted as the recommended approach by VACO, including the Office of Primary and Ambulatory Care.

The reason for this initiative is because of the myriad of problems that exist that scheduling is expected to address. However, as this chapter has tried to show, a number of efforts suffer from an overall systematic and systemic approach to address them. Piecemeal efforts, heroically implemented frequently will not address all of the problems consistently.

There are a number of initiatives that, if integrated thoughtfully in alignment with Advanced Access are more likely to achieve the desired objectives.

CHAPTER 10

Integrating Telephone into the Practice

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Goals:

To provide detailed information as to how telephone technology can improve clinic operations

Objectives:

1. Review the various types of telephone care models (centralized, decentralized, mixed) to ensure maximum coverage
2. Explore staff roles, responsibilities and skills needed to ensure quality telephone care
3. Identify considerations and "best practices" to create and manage processes for call routing, documentation, "special circumstances", etc.
4. Explore the use of patient education to utilize telephone care
5. Review the legal and quality issues

Introduction

The telephone is a vital and increasingly important tool in any medical practice. Telephone Care is a clinical program to provide access to information and care for the patient and their significant others. It is an integral service of Primary Care that is an appropriate aspect of the primary care practice. As such, its use must be carefully and correctly integrated into the practice.

The objective of Telephone Care is to provide patients with care at the right place and right time while ensuring efficient use of resources.

The objective of Telephone Care is to provide patients with care at the right place and right time while ensuring efficient use of resources.

Telephone Triage and Telephone Care are not synonymous though frequently equated. Telephone Triage involves the specific process of evaluating patients' health problems by telephone and advising, educating, assuring and referring patients to appropriate health care services. It is a much more limited view of using the telephone in the practice.

Telephone Care may include all aspects of telephone triage, but also provides:

- telephone access for clinical advice or urgent appointments for new and established patients;
- medical advice for specific patient problems and concerns which may be acute or non-acute;
- information regarding appointments, cancellations, rescheduling and/or the provision of other general non-medical information;

- education concerning medications and assistance with obtaining medication renewals and refills;
- follow-up on procedures and treatment plans.

MODELS OF TELEPHONE CARE – AND SOME CARROTS AND STICKS

There are two basic models of Telephone Care: centralized or decentralized. There is also a hybrid that combines both models. All are used within the VHA.

Centralized model: A centralized telephone care model manages telephone calls from patients enrolled in an entire facility or region. Examples include a Network- or Region-wide Telephone Call Center or a Medical Center Based Call Center.

With centralized models, any action requiring follow-up for an immediate medical complaint, scheduling of an appointment, rescheduling an appointment, or obtaining a medication renewal or refill *requires referral to the specific clinic in which the patient is enrolled* for action on these issues. An identified nurse or staff member at the clinic level is then responsible for providing the needed follow-up.

As telephone care programs become formalized, the structure, staff, rules, protocols and reporting tend to become more specific and detailed.

In the decentralized model, the telephones are located in or immediately adjacent to the practice setting rather than at a remote location.

Decentralized model: The decentralized model for Telephone Care incorporates telephone care into the basic structure of primary care delivery and provides patients more direct access to their providers and health care team for clinical and health information questions and concerns. It is an increasingly preferred method for delivering Telephone Care.

In the decentralized model, the telephones are located in or immediately adjacent to the practice setting rather than at a remote location. The Telephone Care staff in this model directly schedule and/or cancel appointments, provide follow-up information concerning tests and treatments, and facilitate obtaining medication renewals, refills or advice. There is no other referral for action except to inform providers of their patients needing individual follow-up and attention.

Overall, this model provides the best access and continuity for patients and is recommended for normal, weekday tour of duty coverage for telephone calls.

The Carrots and Sticks: There are numerous benefits with a well-planned and executed Telephone Care process. The realities of executing such a process, however, tend to create some resistance that you must address as the practice manager.

Patients make informed choices... shared health care decision-making becomes a reality.

Telephone Care provides for safe, effective and appropriate disposition of health concerns. It allows patients and families access to discuss the wide range of concerns they have related to their health care such as eligibility and scheduling, treatment and follow-up, or medication issues. Advice provided through Telephone Care can help reduce walk-ins (unscheduled visits) and the resulting long waits and patient frustration. Patients learn to use this system to make informed choices about their care thus they can do their part in making shared health care decision-making a reality.

When performed in a decentralized model, registered nurses in the practice are trained to cover a number of the telephone functions and the in-clinic face-to-face functions. While this requires process and role changes that must be "sold" to affected individuals (i.e. co-location and cross-training in some instances) the reduction in staff burn-out, increased ability for clinic management to ensure coverage for unexpected supply shortages and demand bumps, and greater staff familiarity with the patients.

Telephone Care therefore, improves access to health care support and information; increases patient satisfaction; improves self-care skills; supports decision making programs; and ensures consistency and quality of health information.

The Reality: **Simply identifying the need and benefits for effective Telephone Care is not sufficient to ensure its proper implementation.**

The Reality: Simply identifying the need and benefits for effective Telephone Care is not sufficient to ensure its proper implementation. The Telephone Care directive is currently being refined and implemented. While information is available and updated on the Primary Care web site, the material below is designed to ensure its successful integration.

Roles and Responsibilities

Obviously, staff covering telephones should possess excellent communication skills and are required to receive ongoing training in telephone etiquette and telephone communications. Overall, however, the goals of Telephone Care communication are: accuracy, efficiency, and supportiveness. More importantly given the movement toward Advanced Access, effective Telephone Care is a valuable tool in reducing unnecessary demand within the clinic.

More importantly given the movement toward Advanced Access, effective Telephone Care is a valuable tool in reducing unnecessary demand within the clinic.

Staffing the telephone section is affected by factors such as call volume and the clinic profile or characteristics such as skill mix of personnel and availability and the range of clinic services. The challenge you face as the clinic manager is how to ensure the goals are met such that required services are provided by the person who has the right skill and authority to do so.

The challenge you face as the clinic manager is how to ensure the goals are met such that required services are provided by the person who has the right skill and authority to do so.

The telephone communication entails greeting, listening to the caller's concern and gather pertinent data, making an assessment of what is needed, correctly addressing the need(s) and verifying caller understanding and terminating the interaction. Thus, a good process ensures that the 4 R's are delivered consistently:

Reason – determine the caller's specific need(s)
Route – to the appropriate person
Respond – address the caller's need(s)
Record – ensure proper documentation in patient record and regarding workload credit.

The following staffing approach and process may be best suited for a large centralized call center though modified versions are frequently used in decentralized centers.

The call center is staffed with two individuals, the telephone care receptionist and the Telephone Care RN. The route the call takes and the responsibilities for each are summarized below.

Telephone Care Receptionist receives ...determines ...need, verifies ...information ...performs all administrative tasks

- The Telephone Care Receptionist receives the initial calls, determines the caller's need, verifies demographic information and transfers all calls to the appropriate person. As a rule, it is beneficial to have an administrative person receive the initial call since many do not require medical personnel input.

Tip 1:Conduct a quick (15 minute) brainstorming session with those who've answered telephone calls. The focusing question that should be used could be something like: "What methods or questions seem most effective at getting the caller to state the purpose of the call better and/or helping you better determine what the caller wants?" Use the input to provide training and/or a process that is followed by all individuals fulfilling this role.

Conventionally, this individual performs all administrative tasks such as determining patients' eligibility, collects demographic information, handles all scheduling tasks.

Note: Triage functions cannot be performed by this individual.

Telephone Care RN ...assesses acuity ...recommends interventions ...provides information ...assesses understanding ...refers questions to appropriate staff ...recommends appointment scheduling

- Any call regarding medical concerns are then routed to the Telephone Care RN or Pharmacist.

- The Telephone Care RN interviews all callers who have a clinical question. She/he assesses acuity then recommends interventions according to applicable protocols, provides information about disease processes and assesses understanding about therapy and medications, refers remaining questions to appropriate staff, or recommends appointment scheduling according to the severity of the problem.

Pharmacist ...fills emergent medication refill requests, handles ...renewals and refills ...provides information

- The Pharmacist receives those calls concerning medications. The pharmacist fills emergent medication refill requests, handles requests for renewals and refills for chronic conditions, and provides information concerning drug use and compliance.

Access to other disciplines should be arranged and agreed upon in advance of opening a telephone access point and in advance of an emergency.

- Access to other disciplines should be arranged and agreed upon in advance of opening a telephone access point and in advance of an emergency. Access to psychiatric staff is recommended for brief emergency counseling, triage and rapid referral for care. Access to care managers is also recommended for referral of concerns dealing with continuity of care, mobilization of community services and/or social/family support problems.

Table 10.1 Worksheet to Clarify Telephone Care Roles and Responsibilities may be a useful tool to quickly capture the bulk of incoming calls and simplify the routing process. Additional columns for skills your facility might have or rows for additional reasons for the call should be added. The key to having an effective process is how well the reason for call can be discerned (hence, Tip #1 above).

Position of Person Responsible for Determining "Call Purpose": _____

Reasons for calls [add other rows as needed]	Required Skill/Level [add other columns if necessary]				
	Phone Care Reception	RN	Patient Care Manager	Pharmacist	Counselor
Pick-up/Answer call					
Administrative/ Non-Medical					
Appointments: Make one Change existing Cancel					
General Questions: Directions to facility Duration of appt. Who's the MD? Where to go/when? What will be done? . . .					
Medical					
Medications					
Refill					
Reactions/Effects					
Use Instructions					
Possible Error Dosage Other meds . .					
Treatment Plan					
Post-visit problems					
Education					
Pre-procedure prep					
Post-procedure care					
General Info					
Available services					
Access					
Eligibility					
Insurances					

Table 10.1 Worksheet to Clarify Telephone Care Roles and Responsibilities

ACTIVITY 10-A

Telephone Care Roles and Responsibilities

Use a staff meeting with the stated objective of clarifying Telephone Care roles and responsibilities. (Note: if you don't plan it out it could deteriorate into a gripe and finger-pointing session.)

You might want to either expand the focus to cover all "inbound" contacts such as e-mails, faxes, etc. or create a similar worksheet for non-telephone contacts and repeat the process below. It is recommended that you make an overhead of Table 10.1 or provide copies for all individuals present – and have someone record what is happening on a flipchart with each task done on a separate sheet.

1. Use an overhead copy of the list in the left-hand most column of the table as a "straw man" base of discussion. **Your objective is to create a master list of "reasons people call our facility".** Record additions or modifications and feel free to let people "vent" but don't let it turn into a "the stupidest question I got" free for all.
   Time Frame: 5-10 minutes

2. Flesh out the column headings with the different types of staff who receive or answer calls. Your objective is to simply ensure the potential responders are identified.
   Time Frame: 5 minutes

3. Have a focused discussion to fill in the matrix boxes. An "X" denotes to whom the call should be routed *once the initial need has been determined as best as it can.* Post your criteria (you might want to use the following criteria and/or modify them to suit your preferences) to help make this determination.

   - Are any of the positions identified in step 2, the constraint link in the facility? (*Rationale:* you always want to off-load any unnecessary capacity from this position.)
   - Is the person legally permitted to respond to the request? (*Rationale:* certain requests cannot be performed by some skill levels.)
   - Does the responsibility enable that resource to work at the highest level of their training and expertise? Or, does the responsibility require a person at that level of training and expertise? (Rationale: as a rule you don't want to overload those with specialized skills unnecessarily.)

   Time Frame: 15-20 minutes

4. Check that all needs have a responsible party. Prepare a clean copy for use in the telephone service area.

5. Use workgroups by position to brainstorm procedures that will enable them to identify "best practices" in fulfilling the responsibility most effectively and efficiently and fulfilling documentation requirements explained next.

Other Considerations:

This ensures effective continuity of care and case management, legal requirements and workload credit.

Documentation: Documentation of all clinical telephone encounters is required. After eliciting the necessary information and deciding on a course of action the clinical person needs to adequately document the interaction with the caller. This ensures effective continuity of care and case management, legal requirements and workload credit.

Progress notes should be entered into the electronic medical record

Progress notes should be entered into the electronic medical record and should contain at minimum the following elements:

- caller name;
- identity of the caller (remember this can be the veteran, spouse, or another individual);
- medical concern;
- assessment;
- action plan to include protocol used if applicable;
- disposition

emergent or urgent medical concern should immediately be linked to a nurse or provider for further assessment.

Documentation of this note should elicit an electronic encounter form to be completed for workload credit.

Space and Equipment: Effective Telephone Care often means the following with respect to physical space and equipment:

- Staff should be located in a room with sufficient auditory privacy
- There should be dedicated phone lines with telephone head earphones and hands-free devices
- Individual computer access

Protocol for special events: Patients indicating the purpose of the call is an emergent or urgent medical concern should immediately be linked to a nurse or provider for further assessment. Access to a registered nurse or clinician must be immediately available. This means

> **Tip #2:** When "fleshing out" your procedures, consider ways to ensure that these calls route to a live human, not a voice mail or 'hold.'

Be aware that such instructions generally mean the VHA has instructed the patient to seek care, and the VHA may be liable to cover any resulting bills.

Only registered nurses or 'higher' (meaning physician, physician assistant, or nurse practitioner) are trained to perform triage assessments. For patients determined by the triaging individual to have a psychiatric emergency, the patient should be kept occupied on the telephone while assistance from a Mental Health professional is summoned. (This needs to be incorporated into your staff training instructions.)

Individuals determined to have a true medical emergency that cannot safely be transported to a VHA facility should be advised to use their local emergency service activation number (usually 911) to summon an ambulance. Be aware that such instructions generally mean the VHA has instructed the patient to seek care, and the VHA may be liable to cover any resulting bills.

Telephone Care Legal Issues:

legal DUTY that will attach to Telephone Care will be the duty to perform as a Reasonable Professional Performing Telephone Care.

Telephone Care raises special legal concerns. A key point to keep in mind is that the legal DUTY that will attach to Telephone Care will be the duty to perform as a Reasonable Professional Performing Telephone Care. The legal parameters are still uncertain because of pending litigation. However, to define the duty, the courts will look to existing writings that could be:

- VHA and local policy.
- American Academy of Ambulatory Care Nursing Telephone Practice Standards.
- Published Telephone Care Protocols.
- Opinions of "experts" in the field of telephone care.
- American Accreditation Healthcare Commission-URAC

URAC is currently the only accrediting body for telephone care and triage call centers.

As time of publication, the courts may expect Telephone Care Nurses to conform to the American Accreditation Healthcare Commission-URAC standards. URAC is currently the only accrediting body for telephone care and triage call centers. URAC standards address: confidentiality of patient and provider information; staff qualifications; program qualifications for triage; and health information upon which clinical activity is conducted. Telephone Care nurses would also be expected to comply with established policies, including required documentation, and to receive both initial and continuing education in Telephone Care.

Coverage:

Many healthcare systems use decentralized, practice-based telephone access around business hours then roll the phone calls to a centralized access point/call center during the WHEN hours.

Access to a healthcare system means 24-hour /7day access to medical care and health management for patients and their families. To accomplish these expectations, the system may be centralized or decentralized as long as it is formalized and complies with the requirements for a Telephone Care Program outlined in VHA directives.

The sticking point in coverage deals with the **"WHEN"** issues (**W**eekends, **H**olidays, **E**vening, and **N**ights).

Many healthcare systems use decentralized, practice-based telephone access around business hours then roll the phone calls to a centralized access point/call center during the WHEN hours. Physician back-up for the call center staff after hours is not consistently done yet across the healthcare system. The Primary and Ambulatory Care Office recommends movement to provide such `on call' telephone backup coverage.

Patient Education: Effective Telephone Care requires education of the patient on use of the system. This education needs to be included during the development and implementation phase as well as at each scheduled or unscheduled visit. All staff should have knowledge of how their facility provides telephone access during clinic hours as well as during weekends, holidays, evenings and nights.

patient education materials, posters, articles, patient newsletters, pamphlets, and magnets

Various patient education materials can be employed to promote use of this program and to remind patients of the benefits of calling versus walking in without a scheduled appointment. Some of these materials include: posters describing telephone access strategically placed in the facility; articles describing telephone access and its benefits in patient newsletters; and pamphlets or other patient education devices, such as magnets, distributed to all patients to remind them of numbers to call to access this service.

Staff orientation

The question is: how to best prepare them to do what is needed properly and with the attitudes that reflect the commitment to patient-centered care embraced by the VHA?

Staff who perform telephone care duties need to be oriented to the role and responsibilities of each member of the primary care and telephone care teams. This includes policies, procedures, and required reporting.
The question is: how to best prepare them to do what is needed properly and with the attitudes that reflect the commitment to patient-centered care embraced by the VHA?

the orientation must be planned to accomplish thus should include the following:

At the very least, the orientation must be planned to accomplish thus should include the following:

- Establishes the importance of Telephone Care
  - A brief brainstorming exercise that essentially has participants give "phone call nightmares" is a nice warm-up.
  - Also, as explained more fully in Chapter 9, Law #2 regarding the psychology of waiting lines applies here as well.
- Clearly outlines the procedures or steps in the process with an explanation about:
  - Why the step is important or required
  - Instructions regarding "how to" complete the step (a "sample script" can be provided along with an exercise that allows participants to customize it according to their preferences).
  - A way of knowing the step is completed ("when it's done, how do you know?"), and
  - A list (with examples) of special events and instructions on what to do when these arise.
- Incorporates a role playing component so responsible staff can practice and receive feedback in a non-threatening environment.

Tip #3: The more interactive or participative you make the session, the more quickly and effectively the process will be internalized by the staff person being trained.

RNs assigned to centralized programs need specialized training and orientation.

Effective interpersonal and "query" skills are critical for front-line staff in this role.

RNs assigned to centralized programs need specialized training and orientation. The field of Telephone Care has reached a level of maturity as evidenced by the establishment and inclusion of nursing process and standards. These nurses need expert knowledge and skills to provide high quality patient care.

The American Academy of Ambulatory Care Nursing defines Standards of Practice for Expert Practice of Telephone Advice. Experts have published volumes of standardized telephone practice protocols to introduce quality into the practice of telephone care. These protocols guide the user in data collection, options or issues to consider for assignment of acuity and problem management. These protocols also include specific home treatments and patient instructions if applicable. Using these protocols allows the nurse to reference the specific protocol in the Telephone Care Progress Note versus writing out the entire assessment process.

SUMMARY

Telephone Care is an important initiative for VHA facilities to implement in order to enhance access, continuity and quality of care for their patient populations. Telephone Care is designed to provide safe, timely and consistent clinical advice, to promote shared decision making with patients and to provide 24-hr/7-day/week access to assistance and advice.

Centralized Telephone Care Programs are expected to be in compliance with the American Accreditation Healthcare Commission–URAC standards and to receive accreditation by December 31, 2003, according to VHA directive.

CHAPTER 11

Measuring and Monitoring Clinic Performance and Process Improvement

Victor Malabonga, MD
David Reagan MD

Goals:

To provide a suggested methodology to view and understand clinic processes so the practice manager can evaluate them and, therefore, make useful improvements to them.

Objectives:

1. To clarify definitions regarding processes, clinics, performance and improvement.
2. To improve understanding of what measurements are, the different types, and their use – especially in terms of the various measures used in VHA.
3. To clarify what is meant by the term "improvement process" and present a set of characteristics of a sound process for programs and improvement initiatives.
4. To address the most likely questions and concerns clinical practice managers have regarding performance improvement and process evaluation.

reasons why these topics are important in VHA overall and in its clinical practices specifically.

to determine if and how well the practice is achieving its goals.

demonstrated evidence that you, as a manager, make changes that enable more of the system's goal to be accomplished, and that you do the "right things", i.e. actually improve what needs improving and discontinue that which does not yield better results.

Introduction

One of the most challenging tasks of a clinic manager is to look for opportunities to improve the functioning and outcomes of the clinic. This is because healthcare today is delivered in a constantly changing environment. Responding to changing paradigms is now a core responsibility of practice managers, who must carefully select and tailor changes that will actually result in improvements in overall practice and clinic functioning.

There are several reasons why these topics are important in VHA overall and in its clinical practices specifically. Perhaps the most important reason is the need to determine if and how well the practice is achieving its goals. Decisions about continued and additional support in the form of required resources to operate the system depend upon demonstrating that you're doing what needs to be done, well.

Another reason why VHA is concerned with these topics is to ensure that the system learns. There needs to be demonstrated evidence that you, as a manager, make changes that enable more of the system's goal to be accomplished, and that you do the "right things", i.e. actually improve what needs improving and discontinue that which does not yield better results.

Thus, improving clinic performance is critical. A way to improve clinic performance is to improve processes.

the key word is "improve".

In either case, the key word is "improve".

This chapter is divided into four sections. The first section defines terms in order to provide a sensible way of looking at processes, clinics, performance and improvement. The next section is a discussion about measurements: what they are, the different types, and why they often end up being that they shouldn't. It also summarizes the various measures used in VHA in the context of this explanation. The third section will focus upon "the process stuff". Thus, it will reiterate what is meant by the term "process" and present a set of characteristics of a sound process for programs and improvement initiatives. The fourth section will attempt to deal with the most likely questions and problems you will encounter as you attempt to fulfill this important responsibility. In this way, many of the barriers we've experienced to effectively improve are identified and addressed – and learning is achieved.

Performance and Process Improvement Alphabet Soup

The purpose of this section is to define some basic terms in order to clarify what is meant when we talk about processes, clinics, performance and improvement.

Performance Improvement is a systematic process by which we look at what we do. The goal of performance improvement is to find and implement ways of improving the system.

Performance Improvement is a systematic process by which we look at what we do. The goal of performance improvement is to find and implement ways of improving the system. A corollary of this function is performance monitoring, which is the means by which we can ascertain if the changes that have been implemented are effective or not.

Performance improvement processes are known by many names and acronyms (this guide must remain true to its military legacy after all). Total Quality Improvement (TQI), Continuous Quality Improvement (CQI), Total Quality Management (TQM), Quality Assurance (QA) and Quality Improvement (QI) are just a few. There will certainly be others.

In order to improve, we must know what to change, what to change to, and how to effectively implement the desired changes (1). This knowledge is dependent on a thorough understanding of the processes by which care is delivered in the clinics and practices. Our understanding of any processes is largely obtained through process evaluation.

Process Evaluation focuses on how a program was implemented and operates.

Process Evaluation focuses on how a program was implemented and operates. It identifies the procedures undertaken and the decisions made in developing the program. It describes how the program operates, the services it delivers, and the functions it carries out.

addresses whether a program was implemented appropriately and is providing services as intended.

Process evaluation addresses whether a program was implemented appropriately and is providing services as intended. Thus, much of traditional process evaluation tends to check that required pieces for implementation are present or not. However, by additionally documenting the program's development and operation, process

evaluation provides clues and reasons for successful or unsuccessful performance. This in turn provides information for potential replication in broader and additional settings.

a series of interdependent links that generate the system's throughput.

In order to evaluate clinic performance, you must understand the system and its goal. Chapter 1 was designed to provide insight about how to correctly view the clinical practice as a system and to clarify the essence of its goal. In Chapter 1, therefore, you were led to view the clinic is as a series of interdependent links that generate the system's throughput. The entities of the clinic's organization are the set of links directly involved in the generating of throughput. The remaining entities are support links. Recall, support links are not directly involved in the generation of throughput – they exist to ensure the links that are directly involved can work well.

A good practice manager ensures the clinic accomplishes more of what its goal is.

A good practice manager ensures the clinic accomplishes more of what its goal is. From the primary care standpoint, the goal must signify the main reason why our practices and clinics exist. And the goal of the practice is essentially *to increase the rate at which your operation successfully treats its veteran patients*. From the perspective of the veteran, it can then be stated that the goal of a clinic manager is to ensure that quality healthcare is delivered through the clinician-patient interaction. As far as the veteran is concerned, this is the event in the clinic that has the most direct impact on his/her health and well-being.

What constitutes an improvement?

to increase the rate at which your operation successfully treats its veteran patients.

A common misconception that exists in nearly all organizations and managers minds is that an improvement anywhere is an improvement for the system. Examples of this abound: improvements in numbers of patients treated, number of CPT codes updated, the amount of time taken to process claim forms. However, we intuitively know that results such as the above do not necessarily mean an improvement to the system. The fact that we know this means there is a flaw in our logic. The belief that an improvement anywhere is an improvement for the system is true only if there are no interdependencies in your organization.

what is an improvement for a system? A system improves when its weakest link, its constraint, improves.

If most organizations, primary care clinics included, are comprised of interdependent links what is an improvement for a system? A system improves when its weakest link, its constraint, improves.

This means that in order to improve a system, one must know the system's constraint or weak link and that improvement processes must improve that.

The question "what is an improvement?" thus should have a very specific meaning. It is an improvement in some measure that reflects an improvement in system performance.

An improvement is a *measurable change* in appropriate indicators.

An improvement is a measurable change in appropriate indicators. A measurable change is when the average (i.e. the mean or mean-like measure if different types of data are used) moves in the appropriate direction and/or if the variation around the mean shrinks.

Example: Say the throughput-generating chain of the clinic is comprised of the five links shown in Chapter 1 of Check-in – Intake – Provider Time – Actions – Exit. You've introduced an initiative that includes better maintenance of the EMR by the provider coupled with a patient education component that results in reducing the amount of time for patient-provider interaction. If Provider Time is the constraint and the mean time of the patient-provider interaction is reduced by 20% or if the variation around the mean goes from ± 10 minutes to ± 5 minutes you can say that the SYSTEM has improved.

In other words, there is system performance improvement and evidence of an effective process. The measurements provide the evidence. A description of the initiative will be part of the process evaluation.

Measurements

There are different types of measures.

This section is a discussion about measurements: the different types and what each does – and why they often end up being that they shouldn't. It also summarizes the various measures used in VHA in the context of this explanation.

A General Primer on Measures

One level of differentiation is distinguishing between measures of outcomes of performance and measures we use as indicators.

There are different types of measures. Distinguishing between them and understanding which should be focused upon by the managers of the system is therefore critical.

One level of differentiation is distinguishing between measures of outcomes of performance and measures we use as indicators. Systems and processes result in outcomes. A system that improves its outcome may increase scores on patient satisfaction. A program that's launched may yield a process outcome that reduces the number of patients who are smokers. Outcome or performance measures tell us how well systems and processes are doing.

Outcome or performance measures tell us how well systems and processes are doing.

The best way to understand indicators is that they are measures we use for control or monitoring progress. Indicators are essentially gauges. If clinic wait times creep upward over time, they may indicate the need for another resource (in the constraint area).

Indicators are essentially gauges we use for control or monitoring progress.

Sometimes we use the terms interchangeably but they technically mean different things.

One critical set of measures are those that provide information about the system's success. Let's think of these as organization wide or system measures. Specifically, the most important measures are those of system performance in relation to its goal. They cannot be defined until you clearly define the goal.

One critical set of measures are organization wide or system measures.

The goal of the system is to increase the rate at which it generates its throughput. Thus, one measure you want to improve is the growth rate of the clinic's throughput.

another organization wide measure of throughput is patient satisfaction

In reality, there are multiple measures for any important item. In the case of the primary care clinic, another organization wide measure of throughput is patient satisfaction – or on dimensions that are surrogates for or correlated to patient satisfaction.

This is where understanding your organization as a system pays off most. If you're looking at your organization as a system, the correct organization wide measures are in the systems' feedback loop.

Helpful Hint: Think of it in the following way:

IF your system is achieving its goal of successfully treating its veteran patients, THEN what would you expect to see?

- Improvement in reported levels of patient satisfaction
- Reduction in complaints or in factors related to complaints (such as excessive wait times and delays).
- Reduction in errors (such as in billing, unnecessary revisits, etc.)

This is why VHA emphasizes Customer Satisfaction. If you are not satisfying veteran patients, system throughput is jeopardized. Customer Satisfaction means you must define the system's customers and what is important to them.

additional organizational measures associated with waste and inefficiency are expected of clinical practice managers as well.

It is important to bear in mind, however, that the system's stakeholders and executive management have other responsibilities as well. This has to do with resource utilization. As a result, additional organizational measures associated with waste and inefficiency are expected of clinical practice managers as well.

Another critical set of measures entities and/or individuals in the system.

Another critical set of measures are those that provide information about the performance of entities and/or individuals in the system.

Measures of entities in the system can be department-level measures such as staff competence (i.e. percentage of employees who meet performance standards), quality of medical care (i.e. percentage of nosocomial infections), timeliness (i.e. percentage of patients waiting longer than departmental time standards for test results).

Measures of individuals in the system could include (for nurses) number of patients inadequately prepared for tests, (for schedulers) adherence to protocols for routine same day requests, (for housekeeping), proper removal of trash, etc.

"tell me how you measure me and I'll tell you how I will behave".

There is an adage of unknown origin that states "tell me how you measure me and I'll tell you how I will behave".

The purpose of these unit and individual measures should be to induce the system's parts and individuals to do what is good for the system. You should be aware that many of the measures currently in place for departments and individuals do not necessarily do so.

A "Watch Out": If you hold people responsible for measures that benefit only their unit or themselves and if these measurements are in conflict with what improves or sustains the system, the system will undoubtedly suffer.

The difficulty that exists in nearly all organizations and systems are conflicts or misalignments between organization wide measures and individual or unit performance measures. It is probably beyond your ability to resolve all these conflicts – and certainly beyond the scope of this chapter and guide, but rethinking what you emphasize as important can mitigate the "disconnect".

VHA Performance Measures

Our business is healthcare, not hospitals.
Dr. Kenneth Kizer

Network Director Performance Measures

The Network Director Performance Measures are a set of data definitions formulated to measure the progress of the organization towards the achievement of its global objectives. They represent specific measurable components of various VHA strategies intended to help realize the current VHA Strategic goals. (2)

Clinical Performance Measures (CPM)

The Clinical Performance Measures (CPM) are clinical interventions that are designed to facilitate VHA-wide implementation of health care practices that enhance health promotion and disease prevention. They are part of the strategy linked to the VHA Strategic Goal to "Put quality first until first in quality". (2) The implementation of VHA's Clinical Performance Measures (CPM) is an important undertaking for VHA, in general, and every VHA primary care practice, in particular.

Both of the above are more organization or system wide performance measures as described earlier in this section.

Prevention Index

The Prevention Index is composed of interventions that have been culled from the US Preventive Services Task Force and Healthy People 2010 recommendations.

Clinical Practice Guidelines

The Clinical Practice Guidelines measures are derived from clinical practices that have extensive documentation of clinical effectiveness in the medical literature. (4,5) The implementation of clinical practice guidelines is one strategy VHA has embraced to reduce variation in practice and systematize quality of care. Guidelines, as generic tools to improve the processes of care for patient cohorts, serve to reduce errors, and provide consistent quality of care and utilization of resources throughout the system. Guidelines also are cornerstones for accountability and facilitate learning and the conduct of research.

External Peer Review Program (EPRP) survey

The Prevention Index (PI) and Clinical Practice Guideline (CPG) measures are tools for the application of effective healthcare interventions.

The External Peer Review Program (EPRP) survey scores reflect how well (or poorly) the clinic is applying these tools. They are a means to an end. *In and of themselves, the EPRP scores have no meaning.* What a good survey score does signify is that the clinic

staff are applying effective tools of disease prevention and health maintenance to the patients that they see.

The PI, CPG and EPRP are more for process evaluation types of measurements.

The successful implementation of these performance measures in primary care and other practices throughout the VHA system will ensure a consistent quality of healthcare delivery to our veterans across the country.

> **Note:** If the staff views the CPM as an activity to simply obtain "good scores", any improvements in compliance will likely be temporary. The reason why a system has to be developed for the implementation of the CPM is not to get good EPRP numbers. The performance measures need to be there because they will facilitate the consistent delivery of quality healthcare services to the veterans that we serve. If the clinic staff can focus on that perspective then a positive impact can be made on the health status of the veteran population.

A Process for Planning, Implementing and Monitoring Improvement

This section of the chapter will focus upon "the process stuff". Thus, it will reiterate what is meant by the term "process" and present a set of characteristics and sequence of a sound process for evaluating programs and improvement initiatives. Improving systems (and departmental/unit or individual performance in them) in order to do so must be planned, implemented and evaluated with a process for improvement. A question raised in Chapter 1 was "what is a good problem-solving process to use for your improvement efforts?" The answer was that it must carry the essence of the scientific method.

Recall that Chapter 1 summarized two approaches that satisfy the criteria of being customer (patient)-driven – a critical focus for improving system throughput. Table 1.1 provided an example of the Plan-Do-Study-Act (PDSA) methodology. Table 1.2 presented the system constraint (TOC) based Process of On-Going Improvement (POOGI). The steps for both remain true to the essence of the scientific method.

From these, you can extract the critical features of an effective improvement process.

Determine the system's goal:

1. *Determine the system's goal:* There is no way to evaluate and monitor if the system is performing well if you do not have this defined. It will affect the system performance measures.

Define the "problem" in relation to the goal that the

From the primary care standpoint, the goal must signify the main reason why our practices and clinics exist. When a veteran comes for a visit, his/her main purpose is often to see the clinician provider. Until that particular interaction has taken place, the purpose of the veteran's clinic visit has not been satisfied.

2. *Define the "problem" in relation to the goal that the improvement should address*. A problem in PDSA-based methods could be a host of items ranging from staff

turnover, patient complaints, errors, etc. The Theory of Constraints (TOC) gives us a practical and powerful conceptual framework to focus and prioritize our efforts. An analogy may help: a chain is only as strong as its weakest link. In order to increase the ability of the chain to bear weight, we must strengthen the weakest link. Your objective should be to improve the constraint to improve the system.

determining the system's constraint is critical.

This is why determining the system's constraint is critical. Activity 1-B provided a way to identify it fairly quickly and accurately in clinical practices.

Formulate a hypothesis based upon why a step is a constraint to drive the planned change and the measures.

3. *Formulate a hypothesis based upon why a step is a constraint to drive the planned change and the measures*. This hypothesis drives the intervention or action plan to eliminate the constraint. In essence, the plan is an experiment to test the validity of the hypothesis. (7)

The planned change should be focused on the constraint. How can you best exploit its capacity?

The planned change should be focused on the constraint. How can you best exploit its capacity? Many of the ideas contained throughout this guide, if focused on the constraint, could be used. For example, if the provider time is the system's constraint – what should be done by nurses performing intake to remove unnecessary load from the constraint? What can or should a support area like IS do to make it easier for the provider to enter notes or reminders?

The planned changes must also focus on ensuring "subordination" of non-constraints to making the constraint work better, faster, more accurately. This is where aligned measures are critical for subordinate units and individuals are critical. If a clerk is measured on volume, not accuracy, the latter may suffer. If s/he is measured on both, one will suffer. But if accuracy is critical to ensuring the constraint can work to increase system flow, the latter is the only one that should be measured.

Some ideas to consider include:

- Activities which can be done well by non-clinician staff (NCS) should not be delegated to clinicians
- Clinic workflow should ensure that patients are ready to be seen at the scheduled appointment time
- There is advantage to the patient and the system to maximize work done at each visit and minimize the number of visits
- If the patient's needs can be satisfied by telephone care, then doing so is the most efficient means to deliver needed care
- There is no advantage to postponing work that can be done today

Determine and take baseline, interim and outcome measures.

4. *Determine and take baseline, interim and outcome measures.* The measurements must include system performance and milestones or small steps that are indicators of progress toward the goal. The former will provide your organization or system wide performance. The latter will serve as indicators and/or unit and individual progress.

Baselines are needed to quantify your starting point. Outcome measures will be taken at the end of the planned improvement ... use of the interim measures is as indicators that staff and units are performing in ways to achieve the desired outcomes.

Baselines are needed to quantify your starting point. Outcome measures will be taken on those same items at the end of the planned improvement so that a determination is made as to its effectiveness. The use of the interim measures is as indicators that staff and units are performing in ways to achieve the desired outcomes.

VHA Performance measures are based on applying current medical knowledge to clinical practice. They can be valuable in fostering timely, comprehensive care[8]. However, as demonstrated in item 3 above, if the clinician has to personally accomplish all actions needed to satisfy performance measures, less of the clinician's time will be available to attend to the patient's current concerns and those chronic problems for which no performance measures exist.

Implement the change.

5. *Implement the change.* The improvement has been planned (based upon the system – and ideally its constraint) to enable increased system throughput. Appropriate measures that reflect system performance – and those required to drive the correct behavior (subordination) of departments and staff have been determined. Implementing these changes for the required time has to be done in order to improve performance.

Repeat your outcome measures.

6. *Repeat your outcome measures.* Taking measures again is the best way to verify that the effect of the improvement or planned changed. Your goal is to determine – did it have the desired effects or not?

Discontinue those initiatives that did not work – and capture what was learned.

7. *Discontinue those initiatives that did not work – and capture what was learned.* This is where process evaluation becomes important. It's not enough to simply try and trash change after change. Process evaluation can help in refining future efforts or building a knowledge base of continual learning into your efforts to improve the clinical practice.

The discussions should focus on analysis of trends and patterns. Where are we improving? Are the results consistent? Where are we not improving? Are we up and down with compliance in certain parameters (i.e. inconsistent)? For those measures we are not improving on or are inconsistent, where is the breakdown?

Continually repeat the improvement process while monitoring to "hold the gains".

8. *Continually repeat the improvement process while monitoring to "hold the gains".* The performance monitoring results are a measure of our progress or lack thereof. As the raw data come in they should be organized into tables and graphs to detect patterns and trends. The information must be shared promptly with all who are involved in the process. Discussions must focus on looking at new bottlenecks or unforeseen events. Watch out in particular for unintended consequences brought about by the changes that were introduced. (The use of Tool 1 from Chapter 2 to untangle unintended, negative effects can be useful here.) During deliberations, concentrate on the process/processes and not on individuals. It is only through regular data-driven interaction with "process owners" that we can tease out the real implications of the information we have collected.

It is only through regular data-driven interaction with "process owners" that we can tease out the real implications of the information we have collected.

regular feedback to the staff ... is a very powerful motivator

The importance of regular feedback to the staff of performance information cannot be overemphasized. Being able to see incremental progress, no matter how small, is a very powerful motivator. Likewise, lack of progress, if handled constructively, can bring about a wealth of insight into the current improvement process which can add greatly to the chances for success of subsequent efforts.

Do not allow inertia to become the constraint.

9. *Do not allow inertia to become the constraint.* When compliance scores consistently hit the 90-100% mark further improvements may be hard to come by. This is when inertia may set in (i.e. when the CPM process starts to negatively impact other aspects of patient flow) or there is a staff let-down. It if does occur then the patient flow and related events must be re-examined using the performance improvement methods described earlier. Staff let-down is a real phenomenon. It can be expected that the clinic staff will breathe a little after spending so much effort in achieving the excellent results.

One way to counteract this is to continue to feed the EPRP survey results back to the staff. The more they hear about this and the discussion that follows, including praise for maintaining results, the more they will internalize the system that was introduced. If the letdown persists the next step is to profile the percentage compliance of each primary care team (specific for their panel of patients abstracted for each survey period) and present the data just like the general data for the clinic except that the performance of each team per parameter is also shown for each survey month. The intent is not to embarrass a particular team (*this must be emphasized*) but to allow the clinic staff to share experiences and to see if they can work out the kinks on their own. There should not be any negative consequences to this exercise. The basis for this technique is that health care personnel (especially physicians) have an extreme distaste to being an outlier. They usually find means of coming back towards the norm.

The true key lies in keeping everyone focused on the system's constraint and instilling a culture of continually improving it.

Common Questions and Concerns

This final section to the chapter attempts to anticipate the most likely questions and problems you will encounter as you attempt to improve and measure performance and evaluate your processes. In this way, many of the barriers to effectively improve should be identified. Ideas and guidelines to address each increase the likelihood that your effectiveness as a clinic manager in ensuring your operation learns to perform well is improved as well.

What do we do about the number of initiatives and improvements in process or planned?

What do we do about the number of initiatives and improvements in process or planned?

One of the reasons this occurs is because programs and improvement initiatives are rarely chosen from the perspective of a system's focus – and because many managers espouse the belief that an improvement anywhere is an improvement to the system.

The best recommendation is to make a list of all current and planned improvements. Apply the following questions to each:

If the responses are all "no" … consider dropping the initiative altogether.

If your only "no" response is to the third bulleted question, re-evaluate the measures and align them

We're really focused on efficiency and productivity – is this bad?

If you have balanced capability – and "Murphy" strikes … system's throughput for that day will be at the rate of the slowest producer.

How do we integrate clinical performance measures into the clinic flow?

You should now realize this is not the case.

The best recommendation is to make a list of all current and planned improvements. Apply the following questions to each:

- Is this initiative focused on the clinic's constraint area?
- Does it primarily focus on ways that will enable us to improve or use the constraint's valuable capacity better (faster, more efficiently, increase its productivity)?
- Are the primary measures used to evaluate non-constraint areas (whether they are in the throughput-generating flow or support) reinforce the use of constraint capacity (i.e. time and effort)?
- Does the initiative increase the capacity of the system because it increases the constraint's capability?

If the responses are all "no" to the above questions (and to the first bullet point), consider dropping the initiative altogether. You might have spent/lost time and energy in planning it and even executing parts of it – but it probably will not improve the system.

If your only "no" response is to the third bulleted question, re-evaluate the measures and align them so they incent the non-constraint sectors to do what is good for the constraint.

We're really focused on efficiency and productivity – is this bad?

The only entity in the throughput-chain that must be 100% efficient and productive is the constraint area. Trying to make all entities efficient and productive all of the time can create delays and excess patients/work-in-process – which has the direct effect of increasing waiting time. Unless the capability in each is essentially the same (i.e. the number of patients who can be checked-in = the number of patients going through intake, etc.).

But recall that all links in system chains have variability. If you have balanced capability – and "Murphy" strikes ay one link, the system's throughput for that day will be at the rate of the slowest producer. Having "excess" capability in non-constraint areas allows the system to absorb normal variations in rates of performance.

How do we integrate clinical performance measures into the clinic flow?

The clinical performance measures are best utilized within the framework of processing patient visits in the primary care setting. Intelligently distributing the multiple tasks associated with these functions to the clinical staff – especially if they are non-constraint links in the chain can expedite the process without jeopardizing flow. (For purposes of this discussion clinical staff will mean nurses, pharmacists, social workers, dieticians, licensed vocational nurses, nursing assistants, health technicians, and patient health educators.)

Prevention Index screens and education components can be readily performed by clinical staff, during initial intake

The Prevention Index screens and education components can be readily performed by clinical staff, as can screening for completion of specific clinical practice guideline measures (e.g. annual retinal exams and HgbA1c for diabetics, blood pressure guidelines, lipid guidelines, medications for congestive heart failure and post-myocardial infarction, and so forth). These can likely be performed during initial intake of the clinic flow.

The clinical reminders package developed for the VA electronic medical record (8) provides excellent cues for interventions that are due and allows for prompt documentation of items that have been addressed during the clinic visit. Documentation in the medical record should be done by the clinical staff member or provider who performed the intervention.

Areas of concern identified can be annotated and forwarded to the primary care provider (PCP)

Areas of concern identified during intake can be annotated and forwarded to the primary care provider (PCP) for appropriate action during the actual patient encounter. At this point, the PCP (especially if s/he is the constraint area) must quickly review the clinical reminder screen, then spend time to educate the patient, and address the patient's medical complaints as well as identified deficiencies in performance measure compliance.

This system allows the clinic support staff to "prep" the patient properly so that the clinician can make maximal use of his/her expertise in the limited time spent with the patient. It allows the incorporation of the CPM process into the clinic flow, minimizes disruptions in patient transit through the clinic, places emphasis on education and preventive healthcare interventions for the patient, and offers an excellent chance for compliance with stated VHA goals.

Staff involvement is best achieved if the primary care team members are made jointly responsible for their panel of patients.

Implementation of the CPM is a concerted effort between the primary care providers and all other clinic personnel. It is important that this system is discussed in depth to obtain insight and buy-in from the staff. Staff involvement is best achieved if the primary care team members are made jointly responsible for their panel of patients. It gives the team a clear focus for their efforts.

Active involvement by the clinicians is indispensable for the success of implementation.

Active involvement by the clinicians (especially physicians) in this activity is indispensable for the success of implementation. Clinician fervor practically guarantees success.

The system outlined above must not be construed as an external process. It is critical that it be integrated into the clinic flow. It must be considered "another vital sign". Only by adopting such an attitude can we ensure that the CPM will be implemented in a systematic, regular, and consistent fashion.

delineation of responsibility among clinic staff must be clear but everyone must share in ensuring that all the appropriate steps in the CPM are performed during the clinic visit.

The delineation of responsibility among clinic staff must be clear but everyone must share in ensuring that all the appropriate steps in the CPM are performed during the clinic visit.

It is often helpful to have standing orders for subspecialty referrals whenever a patient is found to not meet certain criteria. These are particularly helpful for diabetic eye exams, podiatry referrals for compromised diabetic feet, cervical cancer screening, and mammography.

We're received our initial performance feedback and the results look bad. What do we do now?

We're received our initial performance feedback and the results look bad. What do we do now?

It is clear that parameters need to be tracked. Compliance with the clinical performance measures (CPM) is easy to monitor because the interventions themselves are amenable to measurement by numbers. There is also an independent tracking mechanism already in place (the EPRP). (2) In short, percentage compliance can be tracked for each of the Prevention Index (PI) and clinical practice guideline (CPG) measures, and the EPRP will be the monitor.

The clinic staff must treat the EPRP survey results as an outsider's comment on how well (or poorly) the clinic is doing in its implementation activities.

It is important to ensure that the actual compliance review by the EPRP abstractor be as spontaneous as possible. There should not be a pre-survey in-house review of pulled charts (i.e. sanitation review). This will take away from an honest assessment of the CPM process in the clinic. The clinic staff must treat the EPRP survey results as an outsider's comment on how well (or poorly) the clinic is doing in its implementation activities.

Once the data is in, it must be broken down and organized by measure with tabulated comparisons of the most recent results with the previous surveys (by month initially, then by quarter as more data points are accumulated). Graphs provide a visual presentation of data and are recommended. These must be presented to the staff promptly.

Do not be discouraged by the initial reports.

Do not be discouraged by the initial reports. It may take a few months for noticeable improvements to occur. Clinical staff needs to know this.

Reiterate what is important:

Reiterate what is important:

- the data is analyzed for what it is (do not discount the accuracy of the survey results);
- do not make excuses;
- look deep into how the clinic is doing things;
- think process and not "person";
- take prompt action where needed;
- stay the course if that is what the discussion has concluded; and
- have confidence in the capabilities of the clinic staff.

What are some things we can look at to help the constraint improve?

What are some things we can look at to help the constraint improve?

- Exam space gives opportunity to address multiple patients within a given time period. While one patient is having vital signs recorded, another is being examined and another is having a treatment performed. The Ambulatory Care Infrastructure Space and Patient Flow Assessment Guide[4] reports that efficiency increases when at least 2.5 (but preferably 3) examination rooms per clinician are available.

- Support staff provide opportunities to address multiple patients within a given time period. Many preventive medicine evaluations and some clinical practice guideline evaluations may be performed prior to the patient being seen by the clinician. Clerical personnel, nursing staff, or team associates can assist with appropriate portions of these activities. Other support staff can

contribute greatly to clinic efficiency. Clinical pharmacists can assist with monitoring of many patients (e.g. many patients on warfarin or lipid lowering agents). Nutritionists, clinical psychologists, social workers and other disciplines can serve important roles in providing care to ambulatory patients, while freeing the clinician to see other, more complex or acutely ill patients.

- Staffing Models. Addressing the primary system constraint while delivering integrated care is the goal. What types of staffing models are used to achieve this? The functional cornerstone of efficient clinic operation is cooperation of a nurse or team associate and a clinician. Other clinic functions are oriented around and integrated into this fundamental operating unit.

  In the Team Associate model, a patient is served by the team associate, who completes check in, vital signs and those portions of preventive medicine and clinical practice guidelines that are within the scope of their training and ability. The clinician assesses the patient, including the information generated by the team associate, and devises a plan of care (with patient input and understanding). The team associate then reviews the clinician's note, assists with requisite interventions (including education within their level of expertise) and checks the patient out. Many variations on this basic patient flow have been used successfully. The key issue is that teamwork among well trained support staff present in ***sufficient numbers*** allows efficient patient flow while maximizing time for the patient – clinician encounter.

What barriers are there to Effective Process Evaluation?

What barriers are there to Effective Process Evaluation?

Understanding clinic processes can be a daunting task. A list of some of the more common barriers to understanding processes includes:

- Mistaking a small piece of the process for the whole (Division of responsibility and authority for clinic processes often limits input (e.g. clinicians, nurses and clerks may all report problems to different managers) which makes seeing the big picture more difficult)
- Allowing our understanding to be limited by unacknowledged assumptions such as "Past practices will continue to work", "Past demands reflect current and future demands", "My view is representative of the views of others", "My view is sufficiently complete to allow evaluation of clinic processes"
- Each day is busy – we don't have time to collect information and digest it
- Lack of appropriate measures and consistent definitions for key clinic characteristics (staffing, waiting times, panel sizes, etc.)
- Limited dialogue with stakeholders (e.g. patients, clerks, nurses, clinicians, specialists, pharmacists, top administration, etc.)
- Limited ability to recognize a lesson learned in one context when the same basic problem arises in another setting

The barriers above should not be discouraging. Many times our best efforts in process evaluation do not immediately result in dramatic improvements. Process improvement is by nature cyclical. We walk in the light we have at the time, then reevaluate and take

another step by the light of the new learning gleaned from the previous cycle. An essential element is the "freedom to fail" which liberates us to take reasonable risks and views failure as disappointing, but rich in practical lessons to be used in the next cycle of process evaluation and change.

Like the student learning to drive, as we advance in our practice of process evaluation, we will be helped by several attitudes: an open mind; the humility to know we really do need to listen to others; the commitment to be certain we understand before judging; and an appropriate confidence in our own experience and intuition. Most practical solutions are simple and intuitive. Our willingness to pursue such solutions with openness and persistence will be rewarded with a clinic that cares for patients efficiently and capably.

Summary

The keys to success in performance improvement are a clear focus on the goal of the clinic, an intimate knowledge of the processes involved in the clinic visit, setting of reasonable intermediate goals, choosing relevant and correct monitoring parameters, and prompt in-depth discussion of performance information with the process owners.

Process evaluation is an essential component of understanding and improving clinic efficiency and clinical care. In order to effectively understand clinic processes, we should think big picture, consider key principles of efficiency (IHI), and organize information in order to prioritize and align our efforts (TOC). The plan must address staffing, space, and performance measures (including panel size). The staffing model must maximize the time for the patient – clinician encounter while avoiding fragmentation of care. By working together, with openness and persistence, practice managers can make a huge difference in clinic performance. Patients, staff, and the VA will ultimately benefit.

CHAPTER 12
Data Collection and Validation

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Goals:

To provide an overview of outpatient data collection and validation systems overall and detail the specific processes used.

Objectives:

1. Provide a summary and review of current process (how data regarding patients, procedures and providers is collected, stored, validated, integrated, transmitted (to Austin Automation Center) and retrieved)
2. Provide a summary of reports and tools for patient updates and recommended "best-practices" to run and review in the clinical practice weekly vs. monthly
3. Provide a comprehensive list of warning signs, bulletins, etc.

Introduction

This chapter provides navigation guide and overview of outpatient data collection and validation processes.

Accurate and complete data collection for outpatient encounters is necessary for a number of reasons. First, patient treatment and demographic data must be accurate so it can be retrieved your own clinicians and by other sites for any requisite further treatment. Second, the information provides feedback for you regarding patterns and trends in supply and demand (thus you can make supported budget requests). Third, that same data is used to calculate reimbursement to your Medical Center within the VERA (Veterans Equitable Resource Allocation) model.

This chapter is organized to explain the following topics:

1. How to correctly get data INTO the VistA information system (and where it goes once it gets there).

2. How to validate (through the use of reports that can or are automatically generated) both data quality and whether the data was successfully transferred to the Austin Automation Center.

3. How to get data and information and information back out of the system (and the various reasons/reports you could find useful).

As shown in Figure 12.1 Software Relationships, the Ambulatory Care Reporting Project (ACRP) software is the vehicle for the collection and storage of encounter-based clinical, diagnostic, and administrative outpatient data. The software enables daily transmission of outpatient encounters to the National Patient Care Database (NPCDB), which resides at the Austin Automation Center (AAC).

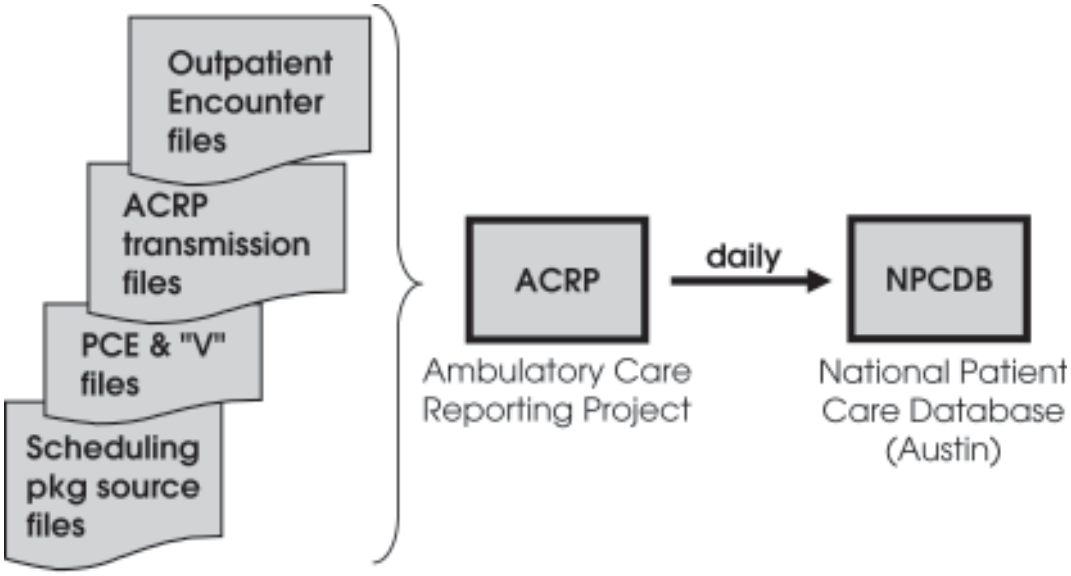

Figure 12.1 Software Relationships

ACRP in concert with the PCE (Patient Care Encounter) software captures and records:

- Selected demographic data about the patient,
- the date and time services were provided,
- Identifies what was done, why it was done, and who provided the services, and
- Moves the information from VistA to the NPCDB via an Event Driven Reporting mechanism for the purpose of workload credit.

The three steps above essentially mean you must get the data INTO PCE and ACRP (collection), make sure its been transmitted properly to NPCDB (validation) and how to use reports back from the database to improve the quality of your data and provide critical feedback regarding your clinic's performance.

Outpatient practice managers must be familiar with all VistA software used in the Ambulatory Care setting.

Getting Data Into the Software (and Where it Goes)

Required demographic information is entered via either the Load/Edit Patient Data option or the Registration option. This is stored in two places: with the encounter data files as well as in the Patient file.

(More information can be found in the User Manuals of the VistA software applications. These are available on the VHA Intranet in the VistA Documentation Library at http://vista.med.va.gov/vdl/).

The key to data collection for outpatient encounters lies in the Check-out process.

The key to data collection for outpatient encounters lies in the Check-out process. There are numerous ways to conduct patient check-outs. These include the Patient Information Management package (PIMS), the Patient Care Encounter package (PCE), through Progress Notes, Event Capture, and a number of methods within the Automated Information Collection Systems (AICS).

one method should be chosen as the preferred method by each clinic to ensure consistency and ease of training.

Because the key for data collection lies in the Check-out process and because the checkout process for the patient's appointment can be done from several different packages, one method should be chosen as the preferred method by each clinic to ensure consistency and ease of training. You know that the accuracy and consistency by which the data is collected is vital. Thus, regardless of method you select – choose one method and stick with it.

A summary of each method *(excerpted from "MAS ADPACs Survival Guide" available through John Derderian)* including some tables that will organize key items on which to focus about each which may help you determine which method you should use are presented next.

To see unscheduled visits, you must select Add/Edit to review them.

Check-Out via Appointment Management

The Appointment Management option in the Patient Information Management (PIMS) package allows *staff* to check out patients after their appointments. Data captured includes providers, diagnoses, and CPT codes. Appointments can be selected for checkout by either the clinic location or by individual patient.

All required information MUST be entered for the checkout to be complete and ready for transmission to the Austin Automation Center for processing.

When you look at the Appointment Management screen, only scheduled visits for the patient are displayed. To see unscheduled visits, you must select Add/Edit to review them.

This latter point is sometimes sufficiently cumbersome and subject to error that some clinics choose to use Patient Care Encounter (PCE) over Appointment Management to complete Check-Out because it allows the user to see both scheduled and unscheduled encounters on the encounter screen.

Table 12.1 provides details about those items within Appointment Management. All required information MUST be entered for the checkout to be complete and ready for transmission to the Austin Automation Center for processing. Failure to answer these prompts will result in an incomplete encounter and your facility will not receive credit for that encounter.

Required Items for Check-Out	Restrictions	Pertinent Detail
PROVIDER	≥One	Can have more than one provider involved
PROVIDER MARKED AS PRIMARY	One and only one	
DIAGNOSIS	≥One	Can have more than one provider involved
DIAGNOSIS MARKED AS PRIMARY	One and only one	
PROCEDURE CODE	≥One	Can be and Evaluation and Management (E&M) code and/or a CPT Code
Service Connection Status	Service Connected (SC) or Not Service Connected (NSC)	
Exposure to	MUST be answered	Agent Orange Ionizing Radiation Environmental Hazards

Table 12.1 Requirements for Proper Check-Out of PIMS' Appointment Management Option

Check-Out via Patient Care Encounter (PCE)

The Patient Care Encounter (PCE) package captures the essential clinical data on a patient's appointment. PCE ensures that every encounter has associated provider(s), procedure code(s) and diagnostic codes(s) documented.

Check out through PCE is done the same way for each of the four options listed below. Which option you select depends upon which type staff you use to perform this responsibility.

Check out through PCE is done the same way for each of the four options listed below. Which option you select depends upon which type staff you use to perform this responsibility.

Check-Out Options	When Used
PCE Encounter Data Entry without Delete	Users CAN document a clinical encounter by should not be able to deleted entries - including ones they have created.
PCE Encounter Data Entry	Users CAN document a clinical encounter in PCE and able to delete but only the entries they have created.
PCE Encounter Data Entry and Delete	Users CAN document a clinical encounter in PCE and delete any encounter entries, including those created by others
PCE Encounter Data Entry - Supervisor	Users (intended to be supervisor or staff member who performed encounter data entry) CAN document a clinical encounter in PCE and allows deletion of encounter entries created by others.

Table 12.2 Differences in PCE Check-Out Options

Table 12.2 illustrates the differences in the four options for PCE check-outs. The difference between the third and fourth items is that the latter is the only option that allows the user to see data that has passed to PCE from other packages, such as Laboratory, Radiology, and Surgery. ***If*** *it is necessary for staff (such as coding staff) to see this type of information, this is the option you should suggest.*

Diagnosis can be added to the patient's Problem List at this time if desired.

The "Checkout Interview" is done for all outpatients and prompts will require entry of Provider (and to designate if Primary Provider), Service-connection status, CPT codes, Diagnosis, Stop Codes, etc. Diagnosis can be added to the patient's Problem List at this time if desired.

Check Out via Progress Notes

Use of Progress Notes for checking out the patients is another alternative. The primary difference in how the check-out is to be done depends on whether the site has Graphic User Interface (GUI) available to the staff of not.

Note: If the clinic does not plan to complete the checkout through the progress note, the **Clinical Application Coordinator should set the appropriate parameters and indicate this in the setup of the progress note titles**. *If this is not done, you will be prompted for workload data.*

you need to assign the progress note to the scheduled clinic.

To capture workload using this method, you need to assign the progress note to the scheduled clinic. Look at the choices that are available on the screen. The first listing you see are scheduled appointments only. If you do not see the clinic displayed, select U for unscheduled visits to see if an unscheduled visit is already available. If not, select N for adding a new visit. The date may be the same, but there must be a difference in the time, even if it is only 10-15 minutes.

Event Capture provides a mechanism to track and account for procedures and services that are not captured through any other VistA package.

Check Out via Event Capture

Event Capture provides a mechanism to track and account for procedures and services that are not captured through any other VistA package. The procedures and services tracked through Event Capture are associated with:

- The patient who *received* the service,
- The clinician *requesting* the service or procedure, and
- The DSS (Decision Support System) unit *responsible for delivering* the service.

DSS Units typically represent the smallest identifiable work unit in a clinical service at the medical center and are defined by the VAMCs. A DSS Unit can represent any of the following:

- An entire service,
- A section of a service,
- A small section within a section,
- A item of medical equipment used in patient procedures

Many sites use Event Capture only for inpatient workload but there are others that also use it in the outpatient setting.

Note: Event Capture can also be set up to pass data to PCE. Many codes used by services in Event Capture are designed for DSS capture of staff workload and are not CPT codes used in Appointment Management and PCE. If the data is passed to PCE, there is a conversion process that changes the data to the appropriate codes so the encounter data can be processed at the Austin Automation Center.

Many codes used by services in Event Capture are designed for DSS capture of staff workload and are not CPT codes used in Appointment Management and PCE.

PIMS' Appointment Management option, PCE, Progress Notes or Event Capture are check-out methods for data collection that are essentially individually and manually performed. We now turn to automated forms of data collection

Check Out via Automated Information Collection System (AICS)

The AICS package contains the software necessary to design, edit, and assign encounter forms to clinics, print forms with patient data for patients with appointments, and print (with or without patient data) forms for patients without an appointment. Because it

Because it enables computer generation of the forms, the software enables collection of that outpatient clinical and administrative data. It also provides a more systematic and less obtrusive method of data collection

enables computer generation of the forms, the software enables collection of that outpatient clinical and administrative data. It also provides a more systematic and less obtrusive method of data collection for the clinician and clerical support staff.

AICS Scanning Encounter Forms

The scanning of encounter forms may be a method some clinics opt for in order to complete the patient's checkout process. There are several points of differentiation between the automated methods of check-out, (i.e. getting data collected in) AICS. These are: Levels of scanners, modes of work stations and "manual" AICS data entry models.

There are several points of differentiation between the automated methods of check-out, (i.e. getting data collected in) AICS. These are: Levels of scanners, modes of work stations and "manual" AICS data entry models.

There are essentially two types of scanners: high-end vs. low-end scanners. High-end scanners are able to scan two-sided encounter forms. Low-end scanners can only scan one side at a time. As a result, the latter are somewhat slower thus more useful in areas with a lower volume of checkouts.

> **Note:** If scanners are used, an attendant is still required to monitor the scanning process to assure the data transfers (i.e. gets into the system) and that all checkouts are completed. As such, it is not necessarily a seamless process that enables you to free up staff. It can be a useful approach however as scanners can frequently be used for other scanning needs as well.

Work Station Mode refers to whether the workstations are centralized, decentralized, or "Scan Only". The major distinctions have to do with the number of forms scanned into AICS at a time – and whether the data is validated immediately or deferred to a later time.

The specific differences are explained below.

Centralized Work Station Scanning Mode: This mode optimizes operations for workstations that are set up as a centralized scanning area. Thus, a stack of forms is processed through the scanner with each one being scanned, 'acknowledged', and validated.

Centralized Work Station Scanning Mode: The data from the form will be transmitted to VistA only if it passes the validation stage. If it does not for any reason, the form is saved as an image file and dealt with as described in the section entitled Validation Workstation.

The data from the form will be transmitted to VistA only if it passes the validation stage. If it does not for any reason, the form is saved as an image file and dealt with as described in the section entitled Validation Workstation.

Decentralized Scanning: The decentralized mode is very similar to Centralized Scanning Mode. The essential difference is that the operations are designed for use where only one form is scanned at a time. Each form is scanned, recognized, and validated. Just as is the case with centralized scanning the data from the form will be transmitted to VistA

only if it passes the validation stage. If it does not for any reason, the form is saved as an image file and dealt with as described in the section entitled Validation Workstation.

Scan Only Workstation: As the name implies, the "Scan Only" mode is designed for those workstations in clinic areas where the processing time of patients is most critical.

"Scan Only" mode is designed for those workstations in clinic areas where the processing time of patients is most critical. the workstation scans the form and automatically saves it in an image file for validation later.

In this mode, the workstation scans the form and automatically saves it in an image file for validation later. Sites running a PC network can use Scan Only workstations to save images to a network drive and then use a centralized validation workstation to complete the process. This allows them to maintain the encounter form with the patient's medical record and is the fastest scanning process in the outpatient area.

Validation Workstation: This mode is used to validate previously saved image files whether they come from any of the prior modes.

Image files are saved in one of three ways.

- The Save Image parameter is checked.
- The Attended Operation parameter is not checked (and the form failed the validation process).
- Images are automatically saved if the form has a scan-able page block but the form design number, the form ID, or the page number printed on the form cannot be read or are not validated with their check sum values as unrecognizable forms.

In validation mode, the workstation will check the paths specified for the three types of images. A dialog box will appear to select the type of images to process and a specific form specification. Images are automatically deleted after validation if the Options/Ask When Deleting menu bar command is not checked; otherwise, a dialog box will appear after each form

Check Out via AICS Data Entry Menu (MANUAL)

Clinic based Data Entry: This option allows manual entry of encounter data by clinic staff. All forms that have been printed for appointments will be prompted for data entry. If forms were not previously printed for an appointment, the Clinic based Data Entry option will default to the form(s) defined for the clinic.

Errors indicate the data was NOT accepted by PCE, and should be fixed and resubmitted.

PCE may occasionally return errors and/or warnings on any encounter submission. Errors indicate the data was NOT accepted by PCE, and should be fixed and resubmitted.

Data Entry by Form: This option allows you to select a single encounter form for data entry. To utilize this option, a form must be printed for the encounter. Data entry is based on the Encounter Form ID, which is located in the upper left hand corner of the printed Encounter Form. Input is designed to mirror the design of the form.
Once data entry is completed, it is immediately passed off to the PCE package. Once again, the data sent to PCE may or may not be displayed on the screen, depending upon the set up of the ENCOUNTER FORM PARAMETERS file. PCE may return errors and/or

warnings on any encounter submission. Errors indicate the data was NOT accepted by PCE, and should be corrected and resubmitted.

data entry is completed, it is immediately passed off to the PCE package.

Group Clinic Data Entry: This option allows manual entry of encounter data for a group clinic. It is designed for clinics where the diagnosis and procedure (evaluation and management code) would be identical for all patients in the group. You can exclude specific patient(s) for the group. After completing data entry for the first patient, the data will then be entered for all patients with the same appointment date/time and who had an encounter form printed for the appointment will be included unless specifically excluded. If no forms were printed for the appointment, you can select the form for data entry without having to print the form.

designed for clinics where the diagnosis and procedure (evaluation and management code) would be identical for all patients in the group.

Whether you use Clinic-based Data Entry, Data Entry by Form or Group Clinic Data Entry, once data entry is completed, it is immediately passed to the Patient Care Encounter (PCE) package. The data sent to PCE may or may not be displayed on the screen, depending upon the set up of the ENCOUNTER FORM PARAMETERS file.

Pre-Printed Form Data Entry: This option allows you to enter data on forms that are pre-printed without patient data. Entry of this data creates a stand-alone encounter (the equivalent of what is known in appointment management as Add/Edit).

Whether you use Clinic-based Data Entry, Data Entry by Form or Group Clinic Data Entry, once data entry is completed, it is immediately passed to the Patient Care Encounter (PCE) package. The data sent to PCE may or may not be displayed on the screen, depending upon the set up of the ENCOUNTER FORM PARAMETERS file.

Data Feeds from Clinical Packages:

There are a number of clinical packages that feed data to the PCE files. Some store the encounter data and others only store their package data and the links to the outpatient encounter. The various clinical packages and where data in the package is stored or placed as well as what happens (hence, what to check for) to it are summarized in Table 12.3.

> Data does not get INTO the system until Check-Out is performed. There are a number of ways to accomplish check-outs. The more of these ways you use the greater the chance that variation inherent in individuals and the subtle but distinct differences in the various software tools will increase the chance for error. The greater the number of errors, the more difficult it is to know with confidence what is happening in the clinic, what the clinic may need, and the greater the likelihood that any decisions driven off that data are affected negatively.

Clinical Package	Where data is stored/placed	What happens/What to Check for
Surgery	Surgery package	Links to PCE (passes provider, diagnosis and CPT codes) IF the site turns on/activates parameters to allow for it.
Radiology	Radiology/Nuclear Medicine package	CPT codes and provider data passed to PCE NO Diagnosis data is stored in the package
Laboratory	Laboratory package	CPT codes and provider data passed to PCE NO Diagnosis data is stored in package
Event Capture	PCE (if linked to an outpatient location)	Passes provider, diagnosis and CPT codes
AICS Scanning	PCE	Passes provider, diagnosis and CPT codes AND Electronically performed check-out of patient from appointment.
Progress Notes	PCE	Links to outpatient visits/locations as scheduled or unscheduled (historical/events) User enters provider, diagnosis and CPT codes Data passes to PCE but it NOT stored in Progress Note. Note MUST be linked to proper location for credit in PCE
Consults	Progress Note package	Reply to the consult is done via Progress Note package as works as it does with them
Integrated Billing	PCE*	Data entered manually in billing package will populate the PCE

Table 12.3 Comparison of Data Feeds to Clinic Packages

ACTIVITY 12-A

Activity 12-A is designed to help you do a little diagnosis and plan improvements to the data collection phase of your operation.

Goal: To evaluate data collection processes to identify ways to reduce errors and/or improve it.

Steps:

1. Using the table below, place a check (√) in the column labeled "USED' if the data collection method is being used anywhere in your clinic.
2. Make an estimate of the total volume of checkouts done in a representative time frame and place it in the space provided at the top of the column labeled "% method is used". Then make an estimate in that, for each item checked in step 1, of the % of time check-out is performed via this mode.
3. Estimate (or, if you actually use the data in the reports summarized in the latter half of this chapter) the % of overall data errors occur within each checked method of data collection.

Check-Out Method	Used	Total Checkouts: _____ % method is used	% of data errors
Appointment Management Option in PIMS			
PCE			
Progress Notes			
Event Capture			
AICS - Scanned Centralized Workstation			
Decentralized Workstation			
Scan Only			
Validation Workstation			
AICS - Manual By Form			
Group Clinic			
Pre-Printed Forms			
Validation Workstation			
Clinical Package Data Feed			

4. Generate, evaluate and select from options for Improving Data Collection. Some ideas:
   - If you use several methods and the % of errors is equal, review the pros and cons with (as well as the circumstances to which each is best suited) and consider eliminating those that are inappropriate and/or prone to errors.
   - Target those that trigger the largest percentage of errors
   - Focus your training on your biggest culprits…

Where is the Data Stored? *(Source for this section is the MAS ADPACs Survival Guide)*

As stated and shown in Figure 12.1 the Ambulatory Care Reporting Package (ACRP) contains a vast collection of files to store encounter related information and manage the transmission of that information to the National Care Database (NPCDB) in Austin.

As you frequently experience, many packages are used to enter data that passes to these files. Although they form a single entity, the files can be conceptualized as falling in the following four major categories: scheduling package "source" files, Outpatient Encounter files, ACRP transmission files, and PCE Visit and "V files".

A bit more explanation about what is stored in each may help you make the connections between them – and understanding how to improve the valid collection of data.

Scheduling package "source" files

The *Scheduling package "source" files* category consists of most of the traditional scheduling and outpatient workload file structures that existed prior to development of ACRP and the Outpatient Encounter database. (The typical dilemma that information system developers' face is the challenge of efficiency and effectiveness: how to make sure the system meets emerging needs without having to consume significant resources to design and get it working correctly. The compromise solution is they frequently re-use "legacy" code and build "add on's" to it).

Scheduling package data generally pertains to appointments and registration/ disposition transactions. Its critical elements are the:

- PATIENT file
  - o DISPOSITION (multiple)
  - o APPOINTMENT (multiple)
- HOSPITAL LOCATION file

Patient Care Encounter (PCE) files

The *Patient Care Encounter (PCE) files* are where clinical information related to outpatient care workload is placed.

However, they may also contain data that reflects inpatient and historical (non-facility) encounters which is not transmitted as a part of outpatient workload.

However, they may also contain data that reflects inpatient and historical (non-facility) encounters which is not transmitted as a part of outpatient workload.

The interrelated, associated PCE files are:

- VISIT file
- V CPT file
- V EXAM file
- V POV file
- V PROVIDER file
- V IMMUNIZATION file
- V PATIENT ED file
- V SKIN TEST file
- V HEALTH FACTORS file
- V TREATMENT file

After the changes to the Scheduling package, database, diagnosis and procedure information are now stored ONLY in the PCE "V file".

The *Outpatient Encounter database* originally stored encounter, diagnosis, procedure(s) and treatment classification information.

After the changes to the Scheduling package, database, diagnosis and procedure information are now stored ONLY in the PCE "V file".

Outpatient Encounter files now consist of:

- OUTPATIENT ENCOUNTER file, and
- OUTPATIENT CLASSIFICATION file

Storage of data in the ACRP transmission files is the basis for triggering the nightly transmission of data to Austin.

Storage of data in the ACRP transmission files is the basis for triggering the nightly transmission of data to Austin.

Recall why you want and need accurate and complete data collection for outpatient encounters: high quality, integrated patient treatment by any portion of the VHA system, ability to review and improve clinic performance (as per material discussed in Chapter 11), and reimbursement to your Medical Center within the VERA (Veterans Equitable Resource Allocation) model. (The VA corporate files used in calculating the VERA allocations by the way are the Patient Treatment File, Outpatient Encounter File, Fee Basis File, and the Patient Assessment Instrument (PAI) File. In the future, VERA will be based on DSS data. (See Chapter on Budget and Finance for more information on VERA.))

How to Better Validate Outpatient Data

The question now becomes how to put together a straight-forward process to determine that the data is valid.

So where are we now with respect to data collection? You know "the big picture" of how many of the packages fit with respect to each other and where related sets of get stored. You should at least have some belief that the accuracy and validity of the data is crucial for achieving the desired system outcomes. The question now becomes how to put together a straight-forward process to determine that the data is valid.

This section attempts to answer that question by summarizing the various packages and reports that are essentially designed to tell you what was correct – and what wasn't AND by providing a process that you can use or modify.

Figure 12.2 illustrates what is required to ensure you have valid data.

Conceptually, Figure 12.2 illustrates what is required to ensure you have valid data. The data (whenever it's collected) must be done correctly. The reality is that sometimes it isn't. Thus, the second requirement is that any errors must be corrected. And, as is inevitable in any system, changes occur: patients move, providers determine another medication is required, diseases evolve, etc. This means any updates must be made. Finally, even with all of the three prior elements, you don't necessarily have valid data unless it goes from the point of entry to where it's supposed to go (the NPCDB) – and VA corporate files.

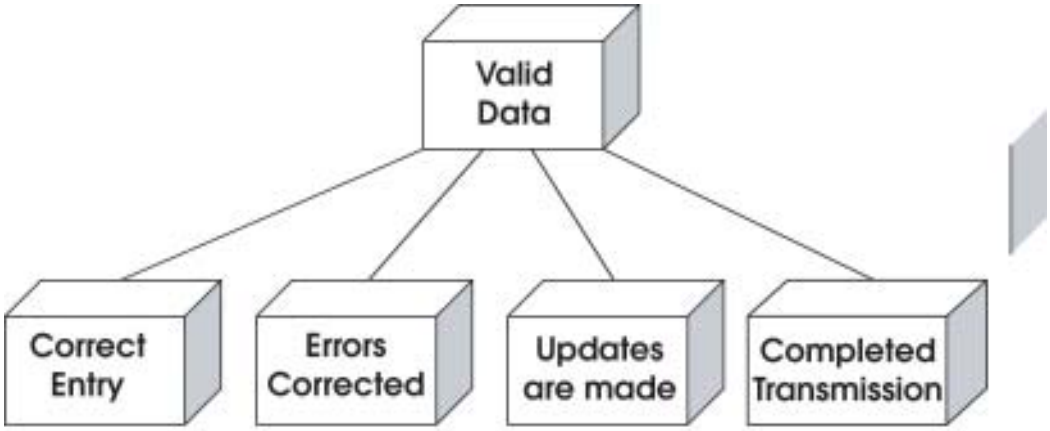

Figure 12.2 Required Components for Valid Data

Your process for validating data collection has to ensure that all of the required bases are covered.

Your process for validating data collection has to ensure that all of the required bases are covered.

VHA's information system has a number of modules and reports that provide feedback as to how well you're system is completing these required components. These are identified and explained in the remainder of this section.

Monthly Closing of Austin Databases: Review your monthly closeout dates for VA Ambulatory data. The rule is that your data is to be transmitted by the closing date and time (5:00 PM, Central (Austin) Time).

Helpful Hint: Transmit your data at least 3 days prior to close out. This will allow time to correct and retransmit any rejections based upon the feedback and status reports.

Table 12.3 summarizes various reports that should be run weekly.

What it is (called)	Where it is	What it does	Usefulness
IEMM (Incomplete Encounter Management Module)		Keeps a record of an INDIVIDUAL encounter's transmission history	Enables you to track and manage transmissions and rejections from Austin
EARR (Encounter Action Required Report)	ACRP Menu	Identifies Outpatient Encounters that did not transmit and WHY (i.e. Missing DX, CPT, Provider, Classification, etc.)	Flags what is required to fix encounter data NOTE: Review for possible duplicate encounters created by Scheduling and Add/Edit CPRS TIU
Incomplete Encounters by Error Code	IEMM Menu	Identified encounters that did not transmit by reason (i.e. eligibility, missing means test data, etc.)	Let's you identify where to focus improvement (i.e. are the reasons more clerical errors at a particular link in the chain?)
OEWS Outpatient Encounter Workload Statistics	VistA	Identifies data that has been acknowledged, that has action required, or still pending transmission.	If report is reviewed for Unique patients, outpatient visits, and encounters, you can validate your workload by Division
Retroactive Visits List	ACRP menu	Gives you Outpatient Encounters entered in VistA past closing dates	Sort by Clinic, by Stop Codes and by Division and audit monthly to identify lost data.
Rejected Outpatient Encounters due to Demographics	ACRP menu (Selective Retransmission of NPCDB Rejections)	Gives a list of patients rejected by the National Patient Care Database	You know patients you treated but are not currently marked for retransmission
Check Transmitted Outpatient Encounter Files	ACRP menu	Searches patient encounters with the status of checked out, it is added to the transmission file.	Missing outpatient encounters re-flagged for transmission.
Batch Update Comp Gen Appt Type for C&Ps	Computer Generated Menu	Gives you the computer-generated Outpatient activity	Use after visits which have an appointment type of 'Computer Generated' have been reviewed AND any possible C&P visits which are not C&P related edited (see next item) to reflect the appropriate appointment type
Edit Computer Generated Appointment Type		Enables you to edit appointment types with a value of Computer-Generated to a valid appointment type	Ensures that your clinic and your facility will receive credit.
Surgery - PCE Filing Status Report	PCE	Identifies ambulatory care surgeries that were not "checked out" thus not passed to PCE.	Ensures the surgical specialty has a clinic assigned to it can pass to PCE (properly).
Outpatient Encounters without status of "Transmission Accepted"	ACRP Menu (Ad Hoc Report)	Identifies outpatient encounters that have any status other than "Transmitted, accepted."	Allows you to detect problems when transmission errors occur

Table 12.3 Commonly Needed Reports and Modules for Weekly Data Validation and Workload Credit

The reports summarized above are normally completed by an HAS ADPAC (ADP Application Coordinator) level staff member at your facility. As the clinical practice manager – you need to understand and review these to help diagnose WHERE to focus improvement effort and clues as to what could be done to insure data quality as well as successful transmission to the Austin Automation center (Austin AAC).

Data validation must be a continuous process.

MONTHLY TRANSMISSION VERIFICATION

Data validation must be a continuous process. The list below contains common reports (some of which are explained in Table 12.3) and the sequence in which each should be done monthly in order to verify transmission.

the sequence in which each should be done monthly

1. At the end of each month, *run the Encounter 'Action Required' Report*.

Purpose: ensures there are no outstanding encounters.

2. *Run the Incomplete Encounters by Error Code* Report.

Purpose: ensures there are no encounters outstanding on that report.

3. *Run the Outpatient Encounter Workload Statistics Report*. The status on this report should only show numbers in the Checked Out portion called Transmitted, accepted.

Purpose: encounters for patients with Required Means tests will show as Rejected for transmission.

   a. If you do have encounters that have not been transmitted and accepted, you should run an ACRP AD HOC report by the Outpatient Encounter Transmission Status.
   b. Include those showing on your report to verify and validate the information for each encounter.

4. *Track* (check sheet data in them, frequency, etc.) the following *standard, post-transmission daily messages*.

   a. The "*Transmission of data to NPCDB completed*" report shows the total number of Outpatient Encounters that were sent and a total number of Outpatient Encounters that were not sent. It will also tell you to review the IEMM Error Listing for further detail.

   Purpose: you have required details regarding reasons for Outpatient Encounter records that were not sent.

   b. *OPA message regarding the daily processing of data* Austin has received from your station. This report shows the facility/division, the number of encounters received, the number of encounters rejected, the number of duplicates that were dropped, the encounter additions, updates, deletions received and the encounter cumulative fiscal year to date totals.

   Purpose: Your staff can validate the statistics displayed on this report.

   c. *If there is a problem with one encounter during the transmission to NPCDB*, a message is sent to the IRM person that has scheduled the nightly NPCBD background job to run. The message states on which patient the data has stopped. Operator must use the Edit Outpatient Encounter option from the Ambulatory Care Reporting Menu (under the Supervisory options) and correct

the type of visit. Look up the patient's eligibility code before going to the option.

5. Using the System Link monitor, *check the status of the system to assure the AMB-CARE data shows as being sent*:

6. There may be times when a *progress note* is linked to the wrong visit and these have to be *corrected* so there is no duplication of workload. The notes can be *re-linked* and the problem resolved by using the Text Integration Utilities (MIS Manager Options) menu. This menu is usually controlled by a selected person on site (the Chief, HIMS or CAC).

Patient Pre-Registration and VHA Directive 98-042

The most desirable process is to update administrative and financial data before the patient comes in for a visit.

Historically, keeping patient demographic and insurance information current has been difficult. Obtaining this information from the patient during his or her clinical visit often gets in the way of providing patient care in an already limited timeframe. Getting the patient to update his or her information after seeing the clinician is not always successful. The most desirable process is to update administrative and financial data before the patient comes in for a visit.

use of *VistA* Pre-registration software

VHA Directive 98-042, published September 23, 1998, mandated the use of the VistA Pre-registration software at all Medical Centers. It provides guidance on the mandatory implementation of a patient Pre-registration process for updating important patient demographic data, including up-to-date health insurance information for all active patients.

entails calling patients prior to their appointment and obtaining any updates for demographic and insurance data over the phone.

The software entails calling patients prior to their appointment and obtaining any updates for demographic and insurance data over the phone. Receipt of more accurate data prior to the appointment should occur because any information the patient has (especially when providing insurance coverage information) is more likely to be at home and therefore accessible.

Flow of the Pre-registration software:

- Daily call list of upcoming patient appointments based on parameters established by the facility is generated.
- The call list should be provided to a clerk/user with a List Manager interface.
- The clerk should work through the list, reviewing and updating each patient's information while editing in "real time".

> **Note:** A "timestamp" can be added which ensures the patient is excluded on subsequent call lists if he or she has another appointment in the near future (as determined by the site).

Three management reports can be generated from the Outputs for Pre-Registration menu as summarized in Table 12.4.

Pre-Registration Software Reports	What it provides or tells you	What this enables you to do
Calling Statistics	Breakdown by call status, (such as busy, no answer, change information etc.) of the entries in the PRE-REGISTRATION CALL LOG File	Can track how many patients were contacted, what information was updated, etc. This report can also provide totals by one, many or all divisions.
Pre-Registration Source	Pre-Registration patients who had insurance data entered within a selected date range with a source of information	See bills created, payments received in defined date ranges, etc.
Print Pre-Registration Audits	History of changes in the patient file that have to do with Pre-registration.	See information on fields in PATIENT File #2 Note: other fields listed in section 4b of Directive 98-042 must be activated by IRM.

Table 12.4 Management Reports from Pre-Registration Outputs

Many of these reports are part of your feedback loop regarding where trouble spots or areas of consistently-good performance can be tracked.

Parameters

Parameters are set when the MAS PARAMETER ENTRY/ EDIT option is selected. This option is located in the ADT System Definition menu.

There are several parameters related to the Pre-registration software which need to be set. The parameters affect the decision criteria as to which patients are included in the call list (such as clinics, eligibility, etc.), how long entries remain on the call logs, how far out in terms of appointments the system should look to include individuals, etc. It essentially affects who gets included on the call list versus who gets excluded. Parameters are set when the MAS PARAMETER ENTRY/EDIT option is selected. This option is located in the ADT System Definition menu.

Table 12.5 Parameter Settings for Pre-Registration Software summarizes the parameters, the choices (and what each means) as well as the recommended setting or choice (and why.)

Pre-Registration Parameter	Choices (Explanation)	Recommended Setting or Action
PRE-REGISTRATION SORT	PATIENT NAME or MEDICAL SERVICE	P (Patient name is generally more useful and needed than medical service)
DAYS BETWEEN CALLS	180// (Fields helps determine how many days from the latest DATE CHANGED Field, #1, in PRE-REGISTRATION AUDIT File, #41.41 before patient is added to the call list again. If the patient has another appointment within x number of days of the date in the DATE CHANGED field, he or she will not be added.	Use a number between 180 and 365.
BACKGROUND JOB FUNCTION	D DELETE ALL ENTRIES P DELETE CALLED PATIENTS DA DELETE ENTRIES AND ADD NEW PA DELETE CALLED PATIENTS AND ADD NEW AO ADD NEW ENTRIES ONLY N NOTHING (Field determines actions the background job performs when it runs nightly. The background job is the tool which generaties the call list for each day.)	DELETE CALLED PATIENTS AND ADD NEW
DAYS TO MAINTAIN LOG:	120//	Set number between 60 and 120
DAYS TO PULL APPOINTMENT	14// (Field sets advance date range for pulling patients with appointments.)	14 seems good enough
RUN FOR WEEKEND	NO// (If field is set to 'Y'es, then background job will run and add call list entries on weekends.)	No
Select CLINIC EXCLUSION	Clinics in this list will not be checking fo patient appointments when adding new patient entries to the call list.	Adding administrative or non-count clinics here.
Select ELIGIBILITY EXCLUSION	Patients with eligibilty codes listed here will not be added to the call list during the nightly process when new patients entries are being added to the call list.	Reviewing list of eligibility codes with Management at your facility to see if any should be excluded.

Table 12.5 Setting Parameters for Pre-Registration Software

Transmission Validation Warning Signs

Occasionally, errors will occur.

Occasionally, errors will occur. The list below includes warning messages regarding the data.

HELPFUL HINT: Don't fall into the trap of perpetual firefighting here. Monitor how frequently each is received (use a simply tally sheet)

☹ DAILY SUMMARY Bulletin Not Received
- Background job did not run
- Background job still running

☹ OPA Message from Austin
- All zeroes
  - Data not leaving station
  - HL7 filers/LLP stopped
  - Background job did not run or is still running
  - Mailman problems
- DRASTIC difference in number sent and Cum Totals updated
  - Retransmission
  - No Acknowledgements being received
- Number received by Austin different from Summary Bulletin number
  - HL7 filers/LLP stopped
  - Mailman Problems

☹ No Acknowledgements Received
HL7 parameter changes

☹ HL7*1.6*33 patch installed
IEMM - No Austin Errors

☹ Disk Space Problems
- Retransmission
- Acknowledgement not being Accepted by VISTA
- LAG time parameter
- Local users in mailgroup that receives HL7 messages going to Austin

Associated Bulletins:

<u>Outpatient Encounter Status Update:</u> ***provides outpatient activity on action required scheduled appointments that have not been checked-out the prior day***.

There are four daily bulletins and one monthly bulletin that should be monitored over time. If the daily are reviewed weekly, and the monthly bulletin monitored monthly – address the patterns.

<u>Outpatient Encounter Status Update:</u>

This bulletin is generated daily and *provides outpatient activity on action required scheduled appointments that have not been checked-out the prior day*. Taskman has this job listed as 'SDAM BACKGROUND JOB' and runs daily (1D@0001).

- Vista Mailgroup: APPT.UPDATE
- Use VistA option 'Appointment Status Update' to identify action required for a selected date range after the weekly review.
- <u>Validate against the EARR Report under the ACRP Menu</u> and to obtain patient listing

Data Transmission to NPCDB: provides outpatient activity listing the number of outpatient encounters that were sent and the number of encounters not sent to the NPCDB.

Data Transmission to NPCDB:

This bulletin is generated daily and provides outpatient activity listing the number of outpatient encounters that were sent and the number of encounters not sent to the NPCDB.

- VistA Mail group: OPC GENERATE
- Weekly reviews/audits are recommended to identify any possible transmission errors.
- Use the `IEMM Menu' for detailed reporting and patient listing.

IEMM Summary Report Bulletin: provides outpatient encounter activity listing the number Incomplete Encounter Mgmt Summary Error Report for the day prior.

IEMM Summary Report Bulletin:

This bulletin is generated daily and provides outpatient encounter activity listing the number Incomplete Encounter Mgmt Summary Error Report for the day prior.

- VistA Mailgroup: SCDX INCOMPLETE ENCOUNTER MGMT
- Weekly reviews/audits are recommended to identify any possible transmission errors.
- Use the `IEMM Menu' for detailed reporting and patient listing.

Ambulatory Care Data Capture (OPA/LSO Bulletin)

This bulletin is generated daily and provides outpatient activity received by Austin listing by Division the number of encounters received, rejected and totals FYTD.

- VistA Mail group: OPA
- Daily reviews/audits are recommended to identify any possible transmission errors.
- Use the `OEWS Report under the ACRP Menu for detailed reporting.

Ambulatory Care Data Capture (OPA/LSO Bulletin) provides outpatient activity by Division the number of encounters received, rejected and totals FYTD.

Austin OPA Reports and VistA OPA Comparison

Austin transmits monthly OPn reports in several formats as listed under the ACRP Menu, `Data Validation Menu'. These menus can be used for producing reports from the local database that match the Austin `OPn' reports in format. The statistics produced by all of the reports on this menu are based on OUTPATIENT ENCOUNTER records that have a `checked-out' status.

- Select Data Validation Menu Option:
  - `Enc. by DSS ID/DSS ID by Freq. (OP0, OP1, OP2)': Produces statistics by DSS Identifier in a format that matches the Austin OP0, OP1 and OP2 reports.
  - `Means Test Visits & Uniques (OP3, OP4, OP5)': Produces a summary of Means Test visits and uniques in a format that matches the Austin OP3, OP4 and OP5 reports.
  - `Most Frequent 20 Practitioner Types (OP8)': Produces practitioner type frequency statistics that matches the Austin OP8 report in format.
  - `Most Frequent 50 CPT Codes (OP6)': Lists the 50 most frequent ambulatory procedure codes with associated provider type frequency in a format that matches the Austin OP6 report.

Austin OPA Reports and VistA OPA Comparison can be used for producing reports from the local database that match the Austin 'OPn' reports in format.

- `Most Frequent 50 ICD-9-CM Codes (OP7)': Lists the 50 most frequent diagnoses with associated provider type frequency in a format that matches the Austin OP7 report.
- `Visits and Unique SSNs by County (OP9)': Produces counts of encounters, visits and unique patients by state and county in a format that matches the Austin OP9 report.

Reports from Austin AAC:

KLF Menu Systems and Reports

The KLF Menu System provides access to the Austin Automation Center mainframe computer and allows one to use both current and historical data for information, validation, analysis and comparison without having to be a programmer or obtain programmer access. The KLF Menu System draws its data from the VA corporate databases at the Austin Automation Center. In some sections of the menu system, raw data is converted into pre-formatted reports. In other areas, the operator is given the opportunity to control the design of reports. Another feature is that reports produced through the KLF Menu System are immediately available for downloading to a local PC.

The KLF Menu System continues to evolve as data needs are identified. It is rapidly transitioning to a web-based interface in order to make report generation even easier.

Using the KLF Menu System is quite easy. Data is organized by purpose and then by fiscal year. You use a menu to first select the type of data you want. Next, you select what portion of the data will be included in your report. And finally, you select the report design options, and the computer will produce your report.

Using the KLF Menu System is quite easy first select the type of data you want. select what portion of the data will be included in your report select the report design options,

Some of the data available through the KLF Menu System include:

- Bed Control Reports
- FMS Financial Data,
- the Medical Care Cost Distribution Report,
- MCCF collections data,
- a medical center specific financial management overview,
- quality management reports,
- demographics reports,
- VERA data,
- traditional workload databases,
- performance measures and planning data.

Helpful Hint: Training is provided twice a year (generally scheduled during the months of January and July). The training is one week long and covers introductory through intermediate level exercises. Notification of this training is sent to each Network to nominate participants. In addition, the VHA KLF Menu training is also conducted at Network level. It is recommended that users download the Introductory and Intermediate training material from the VSSC - Information Management web site. To request KLF Menu access, obtain VA Form 9957, Timesharing Request. This form is used to process the access for the requesting user. Ask your IRM service to provide you with a copy. Requests may also be faxed to Austin Automation Center at 512.326.6069.

SAS Reports

Statistical Analysis System (SAS) is a statistical software package that can be used to analyze medical, financial, personnel and workload management files that are located at the Austin Automation Center (AAC). Differences in health care programs from fiscal year to fiscal year or activity between programs such as PTF, OPC, CDR and NPCD are examples of analysis that can be done using SAS. Time Sharing Option (TSO) is the computer access method designed for the remote customer to utilize SAS and the data files available for SAS. The Austin Automation Center provides a variety of services ranging from Clinical, Demographics, and Financial Systems. The listed web address(s) provide an explanation on Dataset Use and Management and steps to follow when connecting to the Austin Automation Center.

http://vaww.aac.va.gov/operations/PDFfiles/Cust8Med.pdf

http://vaww.aac.va.gov/operations/PDFfiles/Cust7BgData.pdf

A number of excellent SAS report "shell" programs have been authored and compiled by Mr. Juan Garcia of the El Paso VA Healthcare System in the form of an Austin reports "Cookbook." This collection is comprehensive and easy to use, and contains all the needed reports for monitoring your station's progress. The cookbook may be downloaded from the Office of Primary & Ambulatory Care web site.

Summary

This chapter has provided a review of the outpatient data collection and validation processes. It provided general information where the data is stored and a synopsis of the tools available to managers. Useful information for daily operations and troubleshooting has been provided. For more information, please obtain the associated VistA User manuals from the VistA Documentation Library at http://vista.med.va.gov/vdl/ .

CHAPTER 13

The VHA Compliance Program

Sara J. McVicker, RN, MN Clinical Program Manager VACO

Goal:

To provide a comprehensive review of what the compliance program is, why it exists and programs or tools used in it.

Objectives:

1. Review the medical center organizational structure including the Compliance Officer as the "point person" and other key individuals.
2. Explore the importance of data coding for health information management, billing and collections, accreditation.
3. Provide a thorough description of resources, units and location of guidelines for the capture/entry, use and access of that data (will include "best-practices").

Introduction

VHA's Compliance Program provides an oversight process to ensure that employee actions and character are consistent with VHA core values of Trust, Respect, Commitment, Compassion, and Excellence.

compliance is an important way to ensure you use feedback loop of your system and continuously seek to improve your clinic's ability to deliver health care when and where needed with VHA's core values.

The Compliance Program provides a number of policies and procedures intended to "prevent and detect activities, practices, or behavior that is not consistent, or in compliance, with existing regulatory, ethical, or legal requirements." (VHA Directive 99-052, Compliance Policy, November 10, 1999)

Because compliance programs tend to sound so comprehensive and rather ominous, human resources, information systems, providers and other facility staff tend to fear them rather than understand their value. Thus, many activities related to compliance are relegated to the "back burner" coupled with a frenzied push when a review deadline appears (much as JCAHO re-accreditation efforts in hospitals tend to be.)

The value of such programs is not just internal assurance that facilities and clinics do what they are supposed to do the way they're supposed to be done. Rather, compliance is an important way to ensure you use feedback loop of your system and continuously seek to improve your clinic's ability to deliver health care when and where needed with VHA's core values.

The sections in this chapter focus less on "how to" specifics. Rather it attempts to concisely summarize to whom you should turn and where you can look to get what you need. Much has already been developed – your challenge is to ask the right questions, use what's available to do it and to understand and communicate what these programs are about in ways that their value can be realized.

A Compliance Program Primer

One obstacle to overcome is figuring out how to properly plan and successfully launch processes to ensure required compliance data gathering and report generation is performed. The best resource for clinics is the Medical Center's designated Compliance Officer. Other individuals typically involved with the compliance effort include the Medical Center's Chief, Health Information Management Service (HIMS); the Chief, Medical Care Collections Fund (MCCF—formerly Medical Care Cost Recovery – MCCR); and the Director of Quality Management. All have expertise and insights to help you plan and carry out required education of staff.

The best resource for clinics is the Medical Center's designated Compliance Officer.

Use them all.

Part of their responsibilities is to help you in evaluating your existing systems and processes to pinpoint areas for improvement. They can also assist in reviewing previously identified deficiencies and corrective actions to determine their effectiveness.

Coding

One of the goals of the Compliance Program is to have processes that will ensure you have complete and accurate diagnostic and procedural coded data. The data that is generated as a result of patient care is typically used for multiple purposes including:

- providing patient care
- medical and health-related research
- evaluation of clinical care
- evaluation of our performance as a health care system.
- resource allocation through VERA
- billing and collections from third-party insurers
- measuring clinical and financial outcomes
- strategic and financial planning

The people in HIMS are the experts in coding.

It is essential that the data be accurate, complete and timely. This is where coding comes into the picture.

The people in HIMS are the experts in coding. You will need to work with them to be sure the codes on your encounter forms are up-to-date. Revisions to the diagnostic codes, CPT codes and HCPC Level II codes are issued annually but it is your responsibility to make sure the forms you are using are accurate.

it is <u>your responsibility</u> to make sure the forms you are using are accurate.

Tip #1: Create an annual "to-do" calendar if you do not have one already (some of you are better organized than others, some are flat out busier). Post the reminder to "revise Dx, CPT and HCPC Level II codes" on it and think through a way to make required changes.

Some suggestions are: friendly pre-warnings to staff that will be making the updates; creating temporary workload responsibility shifts so it can be done with minimal interruption. (Contrary to popular belief, multi-tasking is not good. It tends to delay timely completion of all tasks being juggled.); developing a little cause-effect diagram showing where and how not doing them costs them time due to rework, etc.

Develop good relationships with the Chief, HIMS and the outpatient coders

Develop good relationships with the Chief, HIMS and the outpatient coders so you know whom you can call when questions arise. One way to use their capabilities more fully include:

- *Brainstorm a list of common problems* experienced with coding in the past.
- Provide the list to and *schedule an "education session"* with one of the above personnel where they can provide tips, tools and insights on how to improve, on what the changes imply and entail, etc.

YOU do not have to do all the work – you just have to put the pieces in place.

Coding is not easy, nor straightforward, so it's important to use these resources.

Compliance with respect to coding means more than making updates and training your people on doing it however. Another important aspect of your responsibilities is ensuring the data you enter is valid.

Chapter 12 on Data Validation section provides detailed actions and "how to" pointers about what you can do to verify and validate your data.

bills and collects payments, non-service connected conditions and illnesses, co-payments.

Medical Care Collections Fund (MCCF)/Billing

Medical Care Collections Fund is the office that **bills and collects payments** due the VA from third-party insurances or from the individual veteran for health care services related to **non-service connected conditions and illnesses**. This office also has responsibility for billing and collecting the **co-payments** that certain veterans are required to make.

Appropriate and <u>legal</u> billing requires accurately coded data regarding the patient's visit.

Since mid-1997, VHA has been allowed to retain these collections and they are returned to the facility where the patient was seen. Thus, there's an incentive that this be done well. **Appropriate and <u>legal</u> billing requires accurately coded data regarding the patient's visit.** There are VA manuals that contain guidance regarding documentation. M-1, "Operations", Part 1, "Medical Administration Activities', Chapter 5, "Patient Records" (available at www.va.gov/publ/direc/health/) is one particularly definite source. Your medical center may also have specific policies so be sure to check with HIMS and MCCF personnel for those items.

HIMS and MCCF personnel can also help you with reviews to ensure you are in compliance. Third party payers often conduct audits of billing practices. It is essential that the codes used to reflect the care provided to the patient be substantiated by the documentation in the medical record in order to successfully survive such audits.

In addition, VHA has some unique requirements not found in the private sector. For example, there are several factors that determine whether VHA may bill or charge co-payments for services. The most common requirements include:

- whether the care is provided for a service-connected (SC) or non-service connected (NSC) condition,
- the veteran's eligibility status,
- the veteran's means test status.

It is therefore essential that the clinicians in the system accurately record if the condition being treated is service connected or not.

More information on eligibility status can be found on the Intranet at www.va.gov/health/elig/eligbility.html. Patient information brochures on billing of health insurance and co-payments are also available for download at http://vaww.rev.lrn.va.gov/revenue/publications/publications.html.

JCAHO Accreditation

ask what specific expectations are there for your facility to meet in order for the facility to maintain its accreditation status.

The Director of Quality Management can help you learn about the JCAHO Standards that apply to you. One important place to begin is to ask what specific expectations are there for your facility to meet in order for the facility to maintain its accreditation status. You don't have to research it –access Quality Management to provide you with the right one and what your facility is expected to do (or was expected to have done) in order to maintain your status.

Types of Information or service available from the QM Director that you should request are:

- Results of the last triennial survey – which should help pinpoint areas for improvement;
- Checklists of on-going activities that can be used to pinpoint them
- Having the Quality Management office conduct "mock" surveys to help your staff remain current in their knowledge and practices.

Copies of the JCAHO standards are available in your medical center library.

Ethical Conduct

The National Center for Ethics of the Veterans Health Administration (VHA) had a produced a book entitled *Challenges and Change*. It is a compendium of fourteen reports produced by VHA's National Ethics Committee during the last several years. It is a good resource of what matters and why with respect to ethical standards and how to maintain them.

A major focus of ethical concern in VHA is in the area of coding. A resource that is specifically focused on this topic is Standards of Ethical Coding, on the VHA Intranet at http://vhacoweb1.cio.med.va.gov/cfocompliance/resource.htm

Ethical behavior essentially boils down to doing the right thing. Determining what this means in primary care clinics and health care facilities boils down to protections regarding information about patients, diagnoses and treatment –how it is used and by whom.

Ethical behavior essentially boils down to doing the right thing. Determining what this means in primary care clinics and health care facilities boils down to protections regarding information about patients, diagnoses and treatment –how it is used and by whom.

Each Medical Center has Medical Staff Bylaws that govern the operation of the medical staff. You should become familiar with the portions of your bylaws that pertain to your clinic operations.

Information Security/Release of Information/HIPAA

VHA Directive 6210 (Automated Information Systems AIS Security, March 7, 2000, available at www.va.gov/publ/direc/health/) contains current requirements regarding Information Security.

In a clinic it is essential that patient information be protected and secured. This means that clinic procedures must include:

- Physically shielding it from the view of others (whether these are their own families, visitors, but also from other patients and unauthorized staff)
- Secure computer access to prevent unauthorized use or duplication.

Tip #2: An occasional walk-around inspection may reveal a surprising number of inadvertent lapses of security.

The first-ever federal privacy standards to protect patients' medical records and other health information provided to health plans, doctors, hospitals and other health care providers took effect on April 14, 2003. The standards, developed by the Department of Health and Human Services (HHS), provide patients with access to their medical records and more control over how their personal health information is used and disclosed. They represent a uniform, set of privacy protections for consumers.

The "privacy rule" sets limits on how covered providers may use individually identifiable health information. It does not restrict the ability of doctors, nurses and other providers to share information needed to treat their patients but does attempt to ensure that only the minimum amount of protected information needed for a particular purpose is involved.

It does restrict its use in situations and purposes not related to health care. In addition, patients must sign a specific authorization before a covered entity could release their medical information to a life insurer, a bank, a marketing firm or another outside business for purposes not related to their health care.

Release of Information

VA Manual M-1, "Operations", Part 1, "Medical Administration Activities', Chapter 9, "Release of Medical Information" (available at www.va.gov/publ/direc/health/) provides detailed information on the requirements of the Privacy Act and the provisions of the Freedom of Information Act. In addition to information on how patients may obtain copies of their records, this Chapter of the Manual includes release of information:

- for legal proceeding
- to Members of Congress
- for recovery of costs of medical care
- to non-VHA physicians, hospitals and clinics
- for research
- to news media

contact your designated Privacy Officer

You should contact your designated Privacy Officer if you have questions regarding the procedures you must follow and the documentation required.

> **Watch Outs:** In particular, familiarize appropriate staff regarding special provisions governing release of medical record information related to drug abuse, alcoholism or alcohol abuse, tests for or infection with the human immunodeficiency virus (HIV) and sickle cell anemia.

HIPAA

Administrative Simplification... assure health insurance portability, reduce health care fraud and abuse, guarantee security and privacy of health information,

The Health Insurance Portability and Accountability Act of 1996, PL104-191 (also known as the Kennedy-Kassebaum Act) contains a section called **Administrative Simplification**. (Don't even go there…) The intent of the law is to **assure health insurance portability, reduce health care fraud and abuse, guarantee security and privacy of health information**, and enforce standards for health information.

Specifically HIPAA calls for:

- standardization of electronic patient health, administrative and financial data
- unique health identifiers for individuals, employers, health plans and health care providers
- security standards protecting the confidentiality and integrity of "individually identifiable health information", past, present or future
- privacy and confidentiality standards.

Electronic Transactions

The Final Rule on Standards for Electronic Transactions was published in August 2000 with a compliance deadline of October 2002. The Final Rule on Standards for Privacy of Individually Identifiable Health Information was reopened for public comment in March 2001 that pushed the compliance deadline for it to April 2003. The Final Rule on Standards of Privacy has a compliance deadline of April 2003. The Final Rules on Security

Standards, National Provider Identifier and National Employer Identifier were to be published in the third or fourth quarter of 2001. It is unclear at the time of this writing if Congressional action may delay implementation of some of these rules.

As a rule, you will receive further information on any necessary changes that will affect you as VHA develops implementation plans. Further information and updates on VHA activities related to implementation of HIPAA can be found at http://vaww.va.gov/hipaa/HIPAA_workgroup.htm. Additional information on HIPAA may be found at www.hcfa.gov/hipaa/hipaahm.htm.

As a rule, you will receive further information on any necessary changes that will affect you as VHA develops implementation plans.

Resident Supervision/VHA and HCFA PATH

(Physicians at Teaching Hospitals) Guidelines

VHA Handbook 1400.1, Resident Supervision, March 21, 2000 provides **information on the level of supervision required for residents in inpatient, outpatient, and long-term care settings** (available at www.va.gov/publ/direc/health/).

information on the level of supervision required for residents in inpatient, outpatient, and long-term care setting

The Resident Supervision Handbook provides standards for educational supervision of residents. It does not address the separate issue of compliance with HCFA Medicare billing regulations. It also should be noted that many insurance carriers use HCFA regulations as their requirements for non-HCFA coverage.

At the time of this writing, VHA has not issued guidance regarding implementation of those guidelines.

> **Note:** You should consult with your local Compliance Officer to discuss VHA's current stance and how to insure insurance carriers are not erroneously billed for resident-provided services if the attending supervision does not meet the required criteria.

Summary

Many of the requirements of VHA's compliance program are not new; they are simply a restatement of legal, regulatory and VHA policy requirements. The increased scrutiny that VHA has received as a result of billing/coding issues has placed increased attention on compliance with these "rules". While VHA's Compliance Program is very similar to compliance programs in the private sector, the points of departure are your responsibility to identify and your compliance with them is your responsibility to achieve. The resources summarized in this chapter should be sufficient to help you do so.

CHAPTER 14

Shared Healthcare Decision Making

Rose Mary Pries, Dr.P.H., CHES

Goals:

To provide a detailed and comprehensive explanation of what shared decision-making is, its benefits, processes and programs and ideas to ensure it.

Objectives:

1. Clarify and further enhance the important distinction between decision-making and problem-solving
2. Explore the process of shared decision-making – identify behaviors on the part of both clinician and patient that promote its successful use.
3. Provide a detailed description of the VHA policy and reviews programs and resources available to support shared decision-making.
4. Provide examples of innovative local VA medical center initiatives to support shared decision-making.

Introduction

Shared decision making is a strategy for achieving improved quality and accessibility of care and for meeting VHA customer service standards.

The heart of shared healthcare decision making is the process of communication between a clinician and a patient regarding the patient's health, between the clinician and clinic support staff and the patient regarding implementing a plan that is mutually agreeable to all.

Although shared decision making is frequently viewed as an episodic event (such as a decision between surgical or medical management for a newly diagnosed problem) it is grounded in a much larger context that encompasses the relationship between the clinician and patient and the full spectrum of health from prevention to treatment of disease.

Shared decision making is embedded in the relationship that develops between the clinician and patient, and it is expressed through the multitude of decisions that they make over time in managing the patient's health. Through the process of shared decision making, the clinician and patient together create a management plan tailored to the needs and desires of the patient and aimed at achieving the maximum health benefit for that patient.

A number of studies have demonstrated substantial benefits to both clinician and patient when this partnership approach to care is used. Improved health, adherence to treatment regimens; reduced exposure of clinicians, patient satisfaction, more effective use of health care resources

Veterans Health Administration (VHA) explicitly encourages shared decision making in the context of clinician-patient partnerships as a strategy to achieve the goals of improving quality and accessibility of care and meeting its customer service standards. Clinicians must now be aware of the importance of involving patients in their own healthcare. You, as practice managers, now must ensure that resources and processes work to support this.

A number of studies have demonstrated substantial benefits to both clinician and patient when this partnership approach to care is used. These benefits include improved health outcomes[1,2,3,4] ; greater adherence to treatment regimens[5]; reduced exposure of clinicians to malpractice litigation[6,7,8]; higher levels of patient satisfaction[9,10,11], and more effective use of health care resources[12]. It's clearly a "win-win" – if it's achieved.

Interest in shared decision making varies among patients, and may change with the seriousness of the health problem or the age of the patient. Attempts to predict interest in shared decision making have produced widely discrepant results, from both clinician and patient perspectives. Further analysis of the variables that influence a patient's desire to participate in shared decision making is needed. One approach to this task is described below.

Understanding the Shift

The problem with descriptions of strategies such as shared decision making ... we understand them in theory

The problem with descriptions of strategies such as shared decision making is that we understand them in theory, and because they are logically sound, the case for their adoption is compelling. But **we** often **struggle with translating the concept into practice and into the practice**.

So let's try to put some structure into it.

It is clear that there are three big players involved in shared decision making: patients, providers and clinical administrative support staff. Figure 14.1 Episode-Based Patient Care illustrates one, perhaps more traditional view of how these entities interface.

we struggle with translating the concept into practice and into the practice.

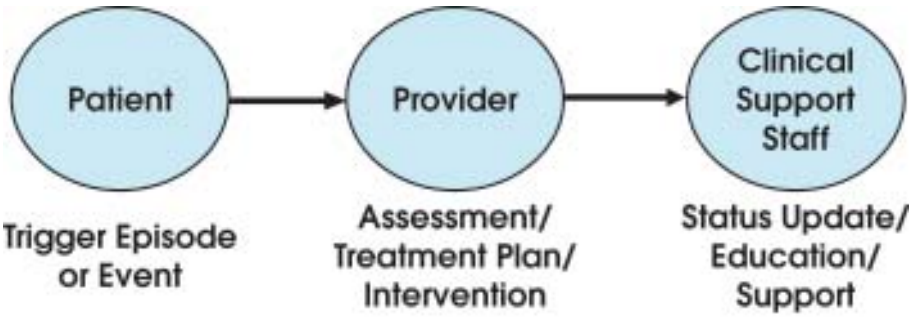

Figure 14.1 "Episode-Based" Patient Care

there's a flow and interaction, but decision-making is more focused on the specifics associated with the immediate problem.

As the figure illustrates, a common model of health care is the patient has a problem or event that motivates them to seek medical care. The next major phase of the flow is the assessment, the plan of care that the provider determines is necessary and occasionally, directly providing some of what is required. Clinical support staff become involved with post-procedure care, education and advice, etc.

In other words, there's a flow and interaction, but decision-making is more focused on the specifics associated with the immediate problem.

Shared healthcare creates a different picture represented by Figure 14.2 Shared healthcare decision making.

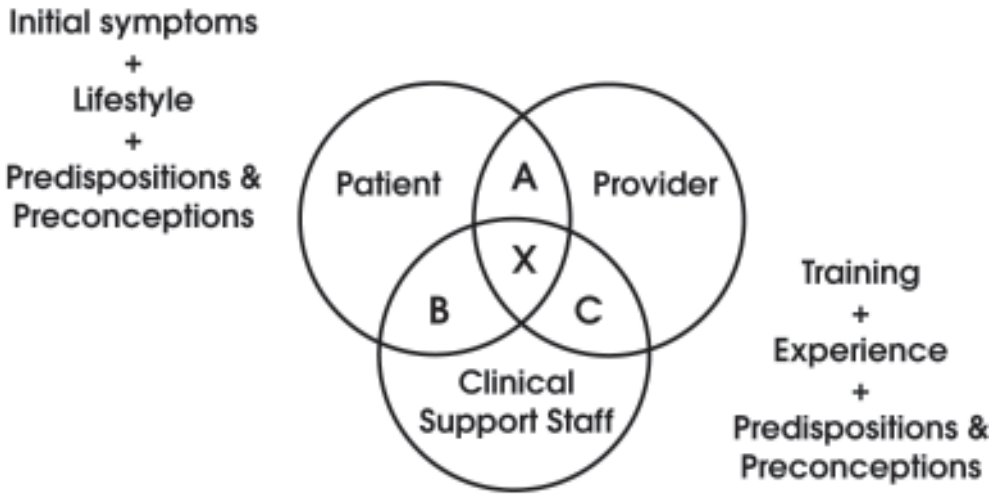

Figure 14.2 Shared healthcare decision making

patients ... carry with them the legacy of lifestyle choices that affect their current overall health status as well as preconceptions and predispositions regarding how they view health, illness, roles they and practitioners play,

There is still an underlying system as discussed in Chapter 1, but what is happening within that system shifts to one with much more synergy and a much broader perspective about the interaction between the key entities involved in health care.

Understanding what this perspective is can be done by explaining the portions of Figure 14.2 that are separate and the points of overlap labeled A, B, C and X.

Providers ... Clinical practice variation, Experience, Preconceptions and predispositions

Most patients will still likely enter the system based upon an episode. They present with set of symptoms sufficient to trigger the system into action. But they also carry with them the legacy of lifestyle choices that affect their current overall health status as well as preconceptions and predispositions regarding how they view health, illness, roles they and practitioners play, etc.

Providers have a similar though slightly different legacy. Clinical practice variation is well documented (e.g. DRG reimbursement rates are adjusted for variation in regional practice patterns). Experience affects treatment plans (e.g. positive outcomes get repeated). Preconceptions and predispositions in terms of how they view health, illness,

and the roles they, staff and patients play influence how they approach what they do in healthcare.

clinical support staff have a different level and extent of training

Though clinical support staff have a different level and extent of training, they too are the product of experiences and thus preconceptions and predispositions on all of the above.

That is the "starting point" that exists.

The challenge of shared healthcare decision making lies in correctly defining what can and should happen in the different areas of intersection.

The challenge of shared healthcare decision making lies in correctly defining what can and should happen in the different areas of intersection. For example, at interface Point A, the provider skills in extracting both the immediate and overall status of the patient depends upon the dialogue and the extent to which the patient conveys pertinent information, background and needs. At interface Point B, clinic staff has a unique opportunity to capture an understanding of the host of other concerns and needs that patients have that will affect the success of immediate intervention and the attainment of the longer term goal of patient care management. At interface Point C for example, providers and clinic staff establish requisite understanding of what each can and should do overall – but it is at the "sweet spot", X, that the synergy occurs.

The key lies in what actions or behaviors each takes in this picture. Some elements that seem to enter into this picture are presented next.

specific characteristics of the process, and specific behaviors of clinicians and patients that facilitate shared decision making.

Shared Decision Making Behavior

A closer look at the descriptions of shared decision making in the literature reveals specific characteristics of the process, and specific behaviors of clinicians and patients that facilitate shared decision making. From a clinic manager's perspective, it is important to educate clinicians, patients and staff about shared decision making – and to ensure the structure the clinic environment and its processes facilitate this aspect of healthcare delivery.

Shared Decision Making Process

elements of shared decision making

Key elements of shared decision making include:

- both patients and physicians share knowledge and expertise through open dialogue, exploration of values, honest sharing of perspectives, and suspension of judgement[15,16,17]
- both parties take steps to build a consensus about the preferred treatment by collaborating to find the best course of action[15,16,17]
- the framework for the process is win/win vs. win/lose[17]
- patients and physicians have joint responsibility for the patient's outcomes.[15]

The test of a shared decision making process is if both parties interact as indicated above and both are satisfied with their level of involvement. [15]

Clinician Behaviors

Clinician behaviors that promote shared decision making

Clinician behaviors that promote shared decision making include:

- establish a conducive atmosphere so that the patient feels his/her views about various treatment options are valued and needed[16]
- encourage the patient to discuss concerns in detail, and express concern about the patient[1]
- elicit patient preferences so that treatment options discussed are compatible with the patient's lifestyle and values[1,16,1,18,19]
- inform the patient about treatment options, risks, and probable benefits in an unbiased, clear, and simple way, and ask whether information about the condition or treatment was understood[1,16]
- help the patient conceptualize the weighing process of risks vs. benefits in a way that ensures that patient preferences are based on fact and not misconception[16]
- include both clinical facts and personal experience when discussing recommendations with patients, and share his/her own treatment recommendations with the patient[15,16]
- focus first on goals of therapy, not technical options of management;[15]
- in the face of disagreements, initiate a process of mutual exchange to explore areas of agreement as well as differences[15]
- acknowledge that final choices belong to fully informed patients[15]
- give patients a sense of control over medical care[18,19]
- ask patients to take some responsibility for care[18,19]
- work to refine his/her own communication skills, especially in direct and honest dialogue and negotiation.[15]

Patient behaviors that promote shared decision making

Patient Behaviors

Patient behaviors that promote shared decision making include:

- identify relevant medical decisions in their care and management issues warranting discussion with the physician[2,3]
- share beliefs about the health problem, and disclose preferences[1,16]
- discuss topics not related to the current visit, including interpersonal relations or the emotional state of the patient or family[1]
- ask questions[1,2,3,16]
- weigh and evaluate treatment alternatives and formulate a treatment preference[16]
- negotiate decisions with physicians.[2,3]

It is clear that these shared decision making behaviors are what generate the substantial benefits to all involved. The positive effects of improved health outcomes, greater adherence to treatment regimens, reduced exposure of clinicians to malpractice

litigation, higher levels of clinician and patient satisfaction, and more effective use of health care resources.

From a clinic management perspective, it is important to promote shared decision making via interventions for clinicians and patients, as well as creation of an environment that supports these behaviors.

The challenge lies in finding tools or processes that enable these behaviors to be exercised.

The challenge lies in finding tools or processes that enable these behaviors to be exercised.

Tools, Processes and Resources for Shared Healthcare Decision Making

The behaviors presented in the prior section indicate that a good methodology with tools would be helpful in ensuring the win/win outcomes and the positive effects of shared decision making.

Some providers and staff intuitively have or have developed such skills. Those who don't must be given tools in order to engage in the desired behaviors.

Some providers and staff intuitively have or have developed such skills. Those who don't must be given tools in order to engage in the desired behaviors. Chapter 2 presented two tools that may be helpful here. The two scenarios that follow exemplify how these could be used.

Example 1:

During the patient-provider –staff interface, it is may become clear that the patient has a chronic condition that requires a level of vigilance and discipline from the patient – yet staff have noted a number of instances (through emergency appointments, repeat calls, etc.) where this has not been done.

Working through a cause-effect negative branch that enables the patient to participate in seeing what the staff does and the choices that are being made that are contributing to negative outcomes being experienced can be a way to engage the patient in making the requisite commitment to change. The communication process, because it prompts the patient to find ways to prevent the negatives, is a non-threatening but effective way of building consensus.

Example 2:

A familiar dilemma occurs when patients are in conflict with family caregivers over issues ranging from dietary habits, exercise, or even disputes over transporting patients to clinics. The conflict diagram shown in Chapter 2 is an easy to use tool for clinic support staff to use to quickly clarify each side's need and the source of the conflict.

Surfacing the assumptions (with the staff person providing input as to how other services such as patient education, sources of funding for equipment, etc.) allows the patient and caregivers to identify those they are willing to pursue to achieve the desired objective. The key is that the staff uses the tool to facilitate the patient and caregiver to derive the solution.

In both situations all of the requisite behaviors can be achieved.

In addition to tools, there are a number of VHA resources to promote and provide additional information for shared decision making.

In addition to tools, there are a number of VHA resources to promote and provide additional information for shared decision making.

VHA Policy & Program Support for Shared Decision Making

VHA Directive 98-023 on primary care included specific attention to sustained partnership between clinicians and patients.[20] *The directive states:*

> "Primary care is the provision of integrated, accessible healthcare services by clinicians who are accountable for addressing a large majority of personal healthcare needs, developing a sustained partnership with patients, and practicing in the context of family and community. It consists of intake, initial assessment, health promotion, disease prevention, emergency services (commensurate with the facility capability), management of acute and chronic biopsychosocial conditions, referrals for specialty, rehabilitation, and other levels of care, follow-up, overall care management, and patient and caregiver education."

VHA Information Notice on Shared Decision Making[21] highlights benefits and opportunities for VA medical facilities to implement shared decision making, promotes system-wide implementation of shared decision making, and describes educational resources and potential strategies to support shared decision making.

The Employee Education System also offers training to physicians, nurse practitioners, clinical nurse specialists, and physician assistants to improve the quality and quantity of communications between clinicians and patients. Some workshop titles include: *Clinician-Patient Communication to Enhance Health Outcomes; Difficult Clinician-Patient Relationships; Choices and Changes; Clinician Influence and Patient Action;* and *Communication: A Risk Management Tool.* A workshop for non-clinical staff in direct contact with patients, *Treating Veterans with CARE,* is designed to enhance the communication skills of these staff in their interactions with patients.

A two-day program, *Enhancing Patient Education Skills,* helps clinicians establish healing relationships with patients, assess patient learning needs, communicate effectively, and facilitate patient behavior changes. The program offers a variety of techniques that clinicians can use in time-limited encounters to foster partnerships with patients around management of their health problems.

There are also pamphlets for patients on shared decision making developed within VHA. At the Tampa VA Medical Center, the pamphlet, *Teamwork: Be Your Doctor's Partner,* is distributed in clinics and waiting areas. It advises patients on how to prepare for the visit with their health care provider, offers communication strategies to use during the visit, and it makes suggestions on what patients can do after the visit to help themselves. Anecdotal reports indicate that patients and clinicians find the pamphlet very useful.

The VISN 13 Patient Education Council created the pamphlet, *You and Your Appointment: How to Make the Most of Your Visit,* for use in all the network facilities. The

pamphlet contains four sections that help patients: get ready for the appointment, follow specific instructions for the day of the appointment, communicate with the clinician during the appointment, and get answers to questions about follow-up care. Space is also provided in the pamphlet for patients to take notes. The pamphlet itself serves as the reminder for the next appointment; the date and time of the next appointment are written on the front of the pamphlet instead of on a separate card. Inpatients receive copies at discharge, and outpatients receive copies at the end of each visit. Copies are also available in waiting areas, at health fairs, and in the Patient Learning Center.

VISN 13, in conjunction with the VA Learning University Task Force on Shared Decision Making, developed a videotape and print package, *The Decision Diner: Is Shared Decision making on Your Menu?* The 13-minute video portrays three styles of decision making and allows viewers to recognize the impact of the different styles on clinicians and patients. The companion facilitator's guide offers suggestions for using the video and print materials with VHA clinicians in a number of formats and settings.

The Patient Health Education Coordinator at the Amarillo VA Medical Center created a 14-minute videotape, *It's OK to Ask,* which portrays three scenarios of physician-patient communication. In each scenario an unsuccessful encounter unfolds, followed by a replay of the same scenario but this time with the patient asking more questions, playing a more active role in the communication, and having a more successful experience. The videotape runs on the hospital's closed-circuit television system every two hours.

At the Richmond VA Medical Center, the Patient Health Education Coordinator developed a health promotion program called *Healthy Lifestyles.* During each weekly 3-hour session, patients participated in personal health risk assessments and learned about modifiable risk behaviors. As needed, they received referrals to programs and clinics at the medical center. The session also provided an orientation to primary care at the medical center and helped patients prepare for clinic visits. Recently, the program was expanded and transformed into a prevention clinic that now meets six times a week. New enrollees to primary care are sent letters asking them to attend the clinic as their first contact with primary care at the medical center.

VISN 8 has contracted with the Stanford University Patient Education Center to train clinicians and lay leaders to conduct the program, *Chronic Disease Self-Management*, which is designed to teach persons with chronic disease the skills needed for self-management [22].

A published study among veterans in a primary care practice evaluated a notebook for patients to carry with them to all appointments. The health organizer, with sections for medications, past history, questions, and educational materials among others, was shown to increase patient and clinician satisfaction with the clinic visit, and to improve the patient's sense of control and knowledge about their health. The Personal Health Organizer is available commercially.

Summary

Shared decision making is a process of communication between a clinician and a patient regarding the patient's health. It is grounded in a much larger context that encompasses the relationship between the clinician and patient and the full spectrum of health from prevention to treatment of disease. Shared decision making is embedded in the relationship that develops between the clinician and patient, and it is expressed through the multitude of decisions that they make over time in managing the patient's health. Through the process of shared decision-making, the clinician and patient together create a management plan tailored to the needs and desires of the patient and aimed at achieving the maximum health benefit for the patient. Shared decision making is a strategy for achieving improved quality and accessibility of care, and meeting VHA customer service standards.

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Chapter 2 Effective Decision Making and Problem Solving for Clinic Managers

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www.inurse.com/~AAACNA

AAACN Telephone Nursing Practice Special Interest Group:
www.phonern@aol.com

Nursing Spectrum/ Telephone Advice:
www.nursingspectrum.com

Telephone Nursing Telezine-a monthly electronic magazine
www.katsden.com/tnt/index.html

TeleTriage System, Sheila Wheeler
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