INSTITUTE OF MEDICINE (IOM)

Transforming Health Care
Scheduling and Access

Getting to Now

IOM COMMITTEE ON
OPTIMIZING
SCHEDULING IN HEALTH CARE
Committee on Optimizing Scheduling in Health Care

- Gary Kaplan, (Chair) Virginia Mason Health System
- Jana Bazzoli, Cincinnati Children’s Hospital Medical Center
- James Benneyan, Northeastern University
- James Conway, Harvard School of Public Health
- Susan Dentzer, Robert Wood Johnson Foundation
- Eva Lee, Georgia Institute of Technology
- Eugene Litvak, Institute for Healthcare Optimization
- Mark Murray, Mark Murray & Associates, LLC
- Thomas Nolan, Institute for Healthcare Improvement
- Peter Pronovost, Johns Hopkins Universities
- Ronald Wyatt, The Joint Commission
Presenters

1. MICHAEL MCGINNIS, Executive Director, Leadership Consortium for Value & Science-Driven Health Care and Senior Scholar, National Academy of Medicine

2. SUSAN DENTZER (Report Committee Member), Senior Health Policy Advisor, Robert Wood Johnson Foundation; Former editor-in-chief of *Health Affairs*; Former health correspondent, PBS

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Briefing Flow

1. Committee Approach

2. Committee Findings and Recommendations

3. Conceptual Reference Points
   1. Systems approaches
   2. Anchors
   3. Patient and family-centered focus

4. Learning from Examples

5. Committee Recommendations
Committee Charge

1. **Review the literature** on patterns, standards, and strategies for timely health care provision nationally.

2. **Characterize the variability** in needs and practices and the implications for scheduling protocols.

3. **Identify organizations and examples** demonstrating best practices in the timely delivery of care.

4. **Organize a public workshop** to inform the committee on the evidence of best practices and issues to be considered.

5. **Issue findings, conclusions, and recommendations** for practices and standards to improve scheduling and access nationwide.
Committee Approach

• Held 7 Committee meetings
• Examined evidence from published studies, including those related to the VA experience
• Held public meeting to hear expert testimony
• Commissioned IOM Discussion paper by field leaders
• Examined relevant findings from related systems-level approaches in other sectors
Innovation and Best Practices in Health Care Scheduling

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Report Chapters

1. Improving Health Care Scheduling
2. Issues in Access, Scheduling and Wait Times
3. Systems Strategies for Continuous Improvement
4. Building from Best Practices
5. Getting to Now
Committee Findings

- Limited evidence
- Substantial variability
- Significant consequences
- **Multiple contributors**
- Lack of systems strategies
- Need for reframing the concept of supply and demand
- No validated standards
- Emerging best practices
- Paucity of leadership
Multiple Contributors

- Supply and demand inattention
- Provider-focused approach
- Outmoded workforce models
- Priority-based queues
- Care complexity
- Reimbursement complexity
- Financial access
- Geographic access
Basic Access Principles for All Settings

• Supply-demand matching
• Immediate engagement
• Patient preference invited
• Need-tailored care
• Surge contingencies
• Continuous assessment
10 Recommendations

• 6 National Leadership

• 4 Health Care Facility Leadership
Conceptual Reference Points

Systems Strategies

- Patients and families
- Systems strategies and culture
- Clinicians and services
- Leadership and organization
- Supply and demand assessment
- Performance assessment
Patient and family-centered care is designed, with patient involvement, to ensure timely, convenient, well-coordinated engagement of a person’s health and health care needs, preferences, and values; it includes explicit and partnered determination of patient goals and care options; and it requires ongoing assessment of the care match with patient goals.
Conceptual Reference Points

Engagement Framework

1. **Query**: Patient presents health question
   - Patient can access system 24/7: system responds immediately
   - Patient’s concerns are respected

2. **Engage**: There is a collaborative process to answer question
   - Communication is provided in an understandable and convenient way

3. **Schedule**: Patient can easily/quickly schedule consultation
   - Patient can schedule care 24/7 and can do so online
   - Rescheduling is easy and readily available
   - New appointments can be synchronized with existing ones

4. **Prepare**: Patient can make preparations in the interim
   - Needed prior approvals and forms are obtained automatically
   - Needed lab tests are arranged and scheduled automatically
   - New appointments can be synchronized with existing ones

5. **Meet**: Patient has encounter with health care provider
   - Encounter takes place in person, online or by telemedicine
   - Encounter takes place on time; patient is given alternatives to waiting (when delays occur)
   - Staff is respectful and courteous; exam space private and comfortable
   - Team goes to patient

6. **Act**: The patient and provider take follow-up action
   - Understandable visit summary is provided on patient portal and hard copy
   - Team uses teach-back to insure patient understands critical information
   - Rest of care team fully informed about visit
   - Prescriptions are e-prescribed

7. **Communicate**: Patient has ongoing care from care team
   - Any follow-up appointments are scheduled
   - Care team checks in to answer questions or ensure follow-up care

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Learning from other sectors

• Integrated perspective
• Analysis and measurement capacity
• Emerging technologies anticipation
• Culture of service excellence
Learning from experience and evidence

The Committee identified examples of systems-level approaches in individual settings that improved scheduling and wait times.

- Scheduling strategy models
- Reframing supply and demand
  - team-based workforce strategies
  - technology-based alternatives to in-person visits
- Lean processes
- Simulation models
Case Studies

- St. Thomas Community Health Center: smoothing scheduling flow model to target patient flow variability.
- Cincinnati Children’s Hospital: smoothing scheduling flow model to improve outpatient clinics scheduling.
- Group Health: team-based care to improve scheduling in primary care and chronic care management.
- Southcentral Foundation’s Alaska Native Medical Center and Baylor Family Medicine: advanced access model to improve scheduling and reduce wait times.
- Thunder Bay Regional Medical Center: co-located mental health & primary care for timely mental health.
- Teladoc: round-the-clock consultations with licensed physicians via telephone or secure Internet video.
- Kaiser Permanente Northern California: provider access via secure e-mail, telephone, web-based video.
- Virginia Mason Medical Center: telephone triage tool to facilitate access for headache symptoms.
- Mayo Clinic, Florida and Cincinnati Children’s Hospital: smoothing scheduling flow model to improve surgical capacity.
- UPMC Health System: multidisciplinary teams to address wait times for cervical spine collar clearance.
- Boston Medical Center: nurses and clinical pharmacists to improve discharge processes.
- Grady Memorial Hospital: systems engineering techniques to re-engineer hospital ER.
- Mayo Clinic, Rochester: Lean and Six Sigma methods to improve surgical processes.
- Seattle Children’s Hospital: patient/family preferences incorporated to design scheduling approach.
The VHA Polytrauma Telehealth Network

Rehabilitation center hub sites that support 21 regionally based polytrauma network sites

The PTN:
• Supports videoconferencing and peer-to-peer networking of rehabilitation teams across the VA
• Links care across VA sites and DoD counterparts
• Allows patients to access distant VA sites
• Supports clinical and education activities (e.g., grand rounds)
• Facilitate ongoing outpatient care with the same providers while allowing the patient to live in his or her local community
• Allows access to specialty care in their local communities
• Facilitates care coordination across treatment teams
Representation Benchmarks

- **Primary care**: Same or next-day engagement
- **Primary care backup for urgent services**: referral if cannot serve
- **Specialty care**: 10 days or less for specialty care new visits
- **Emergency departments**: 10-minute door-to-provider time
- **Hospital admissions from emergency department**: holding time less than 4 hours
- **Hospital discharge assessment**: begins immediately on admission
Basic Access Principles

• **Supply-demand matching** through formal ongoing evaluation.
• **Immediate engagement** and exploration of need at time of inquiry.
• **Patient preference** on timing and nature of care invited at inquiry.
• **Need-tailored care** with reliable, acceptable alternatives to clinician visit.
• **Surge contingencies** in place to ensure timely accommodation of needs.
• **Continuous assessment** of changing circumstances in each care setting.
Recommendations

For National Leadership leading to:

• Basic access principles spread and implemented.
• Federal implementation initiatives with multiple department collaboration.
• Systems strategies broadly promoted in health care.
• Standards development proposed, tested, and applied.
• Professional societies leading application of systems approaches.
• Public and private payers providing financial incentives and other tools.
Recommendations

For Health Care Facility Leadership leading to:

• Front-line scheduling practices anchored in the basic access principles.
• Governance commitment to leadership on basic access principles.
• Patient and family participation in designing and leading change.
• Continuous assessment and adjustment at every care site.
Moving ahead

Since the report’s release on June 15, 2015:

- Committee members conducted:
  - Briefings to the VA
  - Briefings to the Hill:
    - Senate HELP (Bi partisan)
    - Senate VA Committee (Bi partisan)
    - House VA Committee (Bi partisan)
- Media mentions: *Health Affairs*, *JAMA*, *Fierce Healthcare*, etc.
- Distribution: 300 stakeholder organizations