Women’s Health Clinic: Balancing Organizational Priorities to Manage Access

Case Study

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Introduction

Managing change in a healthcare setting requires careful consideration of many factors, and the issues are often accompanied by multiple priorities. This was the case for a small women’s health practice within the Thomas Koritz Clinic, a United States Air Force clinic in Goldsboro, North Carolina, where a series of challenges resulted in the clinic’s inability to provide adequate accessibility to its population of approximately 3,200 patients. With an unanticipated provider staff shortage, a recently published study calling for new protocols, and a primary care clinic that was unable to quickly assume the workload, clinic leaders faced a multi-faceted problem that would require sequential solutions. Due to the staff shortage, the clinic faced patient care delays and upsurges to urgent care and emergency room visits, the latter of which results in additional costs to the Defense Health Program, which are funds specifically allocated for medical care for Department of Defense beneficiaries. Therefore, the clinic leadership set out to formulate a plan to better accommodate patient demand and establish a new framework for women’s health and cervical cancer screening protocols. In doing so, leadership had to weigh the priorities of improving access, maintaining patient continuity, and improving clinical currency.

The catalyst of limited access in the Women’s Health Clinic was a sudden decrease in provider staff. The specialty clinic was originally staffed by two full time nurse practitioners, supported by one nurse, two medical technicians, and one receptionist for front desk operations. An enterprise-wide staffing shortage in women’s health providers caused the Thomas Koritz Clinic to lose one full time provider, leaving one sole women’s health nurse practitioner. Support staff also decreased from four personnel to two, which were medical technicians who had to take on a shared role of managing front desk operations. Already a small clinic, the loss of one provider and two support staff was a significant impact. Clinic leadership measured and assessed access for every clinic with a rate – the number of appointments booked (within an established time standard) divided by the total number of booked appointments of that appointment type. There were three observed appointment types based on the patient’s need – acute, routine, and
established. The access standard for booking a patient into an acute appointment is one day, or 24 hours. For a routine appointment, it is seven days, and for a follow-up appointment for an established patient, it is four weeks. Prior to the staff shortage, the Women’s Health Clinic averaged 99% access. The loss of one provider resulted in reduced access of 63%, 85%, and 78% over the next quarter.

Just prior to the staff shortage in the Women’s Health Clinic, the United States Preventive Services Task Force (USPSTF) published an article recommending less frequent cervical cancer screenings, depending on the patient’s screening criteria (Moyer, 2012). The new protocols would be a significant change to a medical specialty that had routinely emphasized annual well women exams as a preventive measure. In fact, the sole women’s health provider that remained was somewhat wary of adopting the new protocols. However, leadership also realized that the new recommendation could help alleviate the high demand for women’s health appointments.

The final issue at hand was that the primary care providers at the Thomas Koritz Clinic were not accustomed to performing well women’s exams. Approximately ten years prior, the local community advocated for a specialty clinic designated for women’s health care. As a result, the Thomas Koritz Clinic stood up the Women’s Health Clinic, and in doing so, centralized the women’s healthcare services and streamlined the tracking of follow-up care due to abnormal lab results or other conditions requiring further treatment. From that point on, the primary care clinics rarely performed women’s health exams since patients had direct access to the specialty clinic. Patients also preferred direct access, since the separate area and specialized providers offered increased privacy. However, an unintended consequence of this setup was that the primary care clinics were not immediately prepared to conduct women’s health examinations due to inexperienced clinical staff and unequipped exam rooms.

The clinic leadership stood up three objectives to deliver a broad solution to the women’s health access issues. The first objective was to improve access by conducting an analysis of the
clinic’s appointment capacity and utilization. The second objective was to reduce excessive or unnecessary utilization of women’s health appointments by realigning appointment protocols with recently published guidance, in an effort to reduce the frequency of cervical cancer screening appointments. The third objective was to enable the nine primary care providers in the Family Health Clinic to accomplish women’s health exams, which would improve clinical currency and distribute workload away from the sole women’s health provider. It is the third objective in which this case study will explore the alternative courses of action and the results of the final decision.

For the first objective, analyzing access and increasing productivity, the Women’s Health Clinic Director expanded the clinic work hours and schedule, increasing the number of available appointments. The Director also worked with the Access Manager, appointment staff, and the Medical Operations Commander, to propose and implement a new schedule. This included adding acute and routine appointments to the schedule so that the clinic could accommodate demand for more urgent requests. These changes went into effect as soon as possible to avoid any further impact on patient access, and they resulted in a short-term improvement to access rates, revealed by an increase to 100% and 96% in the subsequent two months.

To address the second objective, managing appointment utilization by revising protocols for annual women’s health appointments, the Access Manager met with the Medical Director and the women’s health provider to review the new criteria and discuss how the appointing protocols should change. The women’s health provider expressed her concern that the updated protocol would potentially result in patients not seeking a preventive exam at all, and therefore miss other elements of an annual physical, such as the breast exam and discussion of topics such as birth control, family planning, and other important issues. Clinic leadership came to a compromise, which was to allow patients to book their next annual preventive exam if desired, and it would be the provider’s responsibility to educate patients on the updated protocol during the visit. The Access Manager and appointment staff soon used a new script for patients requesting an annual
preventive women’s health appointment, which provided a brief amount of education on the new protocol and offered the patient with the appointment according to their needs and concerns. According to the appointment line staff, very few patients opted to delay their planned annual exam.

The third objective would require the clinic leaders to discuss the alternatives on whether to continue direct and centralized access to the Women’s Health Clinic or to direct patients to the Primary Care Clinic and require that patients access the Women’s Health Clinic on a referral basis. The Medical Operations Commander, Access Manager, Women’s Health Clinic Director, and Primary Care Clinic Director, reviewed an analysis of the historical performance of the clinic, patient demographics, and similar women’s health clinic models in other practices. Also involved in the decision-making were the Chief Medical Officer, Medical Director, Patient Safety Manager, and Appointment Line Supervisor.

Alternatives Considered

The proposal’s first alternative to keep the existing construct of the Women’s Health Clinic of streamlined and direct access, while giving priority to Active Duty patients. To clarify this concept, military medical services must give priority to those on Active Duty. Other patient categories, such as family members and military retirees and their families, are provided medical services as long as the capacity is still available. This is outlined in Health Affairs Policy 11-005, TRICARE Policy for Access to Care (Assistant Secretary of Defense, 2011). Additionally, it is somewhat common for specialty clinics, such as Physical Therapy, Optometry, or Mental Health, to only treat Active Duty military patients due to a limited amount of resources; the primary care provider will refer non-Active Duty patients to an off-base civilian medical practice. In addition to prioritizing Active Duty patients, primary care providers would perform one half-day per week in the Women’s Health Clinic. The benefit of this course of action would be the ability to maintain the already centralized, patient-centric process of tracking all women’s health lab results, and it would sustain direct access to the Women’s Health Clinic for Active Duty patients,
the population with the highest priority. In this scenario, patient continuity and access were prioritized, and clinical currency would improve amongst the primary care providers.

In the second alternative, leadership considered a pilot initiative, where one primary care provider would regularly conduct women’s health exams and services in the primary care clinic. After the pilot was complete, the clinic would evaluate the benefits and challenges of the transition. Depending on the outcome, the clinic could later decide to expand the program to other primary care providers and their staff. The advantage with this course was the ability to gradually transition the process for all clinics and parties involved. Risks and unforeseen problems could be addressed in a smaller environment. In this alternative, a pilot initiative that prioritized clinical currency of the primary care providers would provide a gradual approach, as it left room to consider patient concerns before a full change.

The third proposal was to require that all appointment requests for a preventive women’s health exam will be directed to the patient’s primary care provider. In this model, the Women’s Health Clinic will only see patients that are diagnosed with dysplasia, require birth control procedures, or those that are referred from the primary care provider for any other reason. The advantage was that it would ensure that all primary care providers are fully practiced in conducting women’s health exams. Also, more providers would be able to conduct women’s health exams, thus alleviating pressure on the sole provider in the Women’s Health Clinic. The disadvantage was that it would likely result in a decrease to patient satisfaction because of the break in continuity. Some apprehension was expressed by the Chief of the Medical Staff and the women’s health provider, who were concerned that the changes could pose risks to patient safety and continuity of care. The Patient Safety Manager also expressed that female staff members working in the clinic would be disappointed about losing the ability to see the women’s health provider directly as their privacy would be perceived as diminished in the primary care clinic. This is because the women’s health provider was an older and more experienced female contracted civilian employee, while the primary care providers were of varying levels of
experience, gender, and familiarity within the staff. According to one study, only 52.2% of females in a health maintenance organization preferred a female provider for routine gynecological care, while 42% had no preference; however, the study also concluded that previous patient experience and familiarity leads to a strong influence of a specific provider type (Schmittdiel, Selby, Grumbach, & Quesenberry, 1999). Furthermore, the clinic could anticipate an increase in leakage by civilian female patients, who were able to visit a civilian provider for a preventive women’s health exam without a referral once per year under TRICARE policy. This scenario prioritized access, as it would provide the biggest impact to alleviating demand on the Women’s Health Clinic, and it prioritized clinical currency, since all primary care providers would be expected to care for women’s health issues.

**Chosen Solution**

The ability to hire a second women’s health provider was not in the clinic’s foreseeable future. Due to the immediacy of the access issue and the high prioritization for ensuring provider currency, the Medical Operations Commander decided to implement the third proposal, which was to direct all patient requests for annual women’s health exams to the primary care clinics, excluding patients that were part of the dysplasia treatment group or those with a referral. This solution would accomplish the desired outcome of dispersing requests for women’s health exams amongst multiple providers and ensure that the primary care clinic can treat patients with women’s health concerns, as required by their provider credentials. The cost of this solution was creating a break in continuity for the women’s health provider and her patients, time and money required to train and equip the primary care clinics, time to train the appointment line staff to redirect patients to their primary care provider, and time addressing anticipated patient complaints due to the change in structure. The leadership also considered concerns for patient safety and quality of care during the transition; however, it was decided that having more providers accomplish women’s health exams was more beneficial in the long term to the group, patients, and staff.
After the decision was made, the Women’s Health Clinic Director initiated several actions to take place in order to fully address all aspects of the changes:

- The women’s health provider and the Medical Director will set up initial refresher training for all primary care providers on accomplish women’s health exam processes and referral options as seamlessly as possible.
- The senior medical technician in primary care will build and monitor a lab results tracking database.
- The senior medical technician will also identify appropriate exam rooms and procure required equipment.
- The women’s health provider, Medical Director, and Access Manager will update the affected clinic policy documents – Provision of Care, Pap Smear/Dysplasia Program, and Continuum of Care – to reflect the change in protocols and address the responsibility for tracking of pap smear lab results.
- The Quality and Patient Safety Managers will establish an audit program to ensure standards of care are maintained during the transition.
- The Access Manager and senior primary care clinic nurse will advertise the upcoming changes to the patient population and clinic staff.

Lessons Learned

The action plan was implemented and resulted in several positive and negative outcomes. All three objectives of improving access, educating patients about the new protocols, and establishing a new framework for conducting women’s health exams in the clinic, were accomplished. The first two objectives were able to be implemented without much risk to patient perceptions, as the end result simply added more appointments to the schedule and provided education to the patient at the time of booking a women’s health exam. However, a lesson learned involved with the new protocols is that changing patient behavior is a gradual process, as most patients still opted to schedule their annual exam. It was not ideal to ask the appointment line staff
to educate patients at the time of booking the appointment (although in the end it was the patient’s choice), because it added time to the phone call and did not usually result in the desired effect. Additionally, it placed the decision-making responsibility on the patient, who may not know or understand fully how to apply the new protocols to their medical status. According to one article, “active communication along the pathway is also critical, because frequent feedback encourages behavior change,” and 76% of patients in one survey failed to accurately assess their own health status (Sundiatu, Gandhi, Pellathy, & Spatharou, 2012). Providing education over the phone at the time of booking an appointment may have been a good starting point to change patient behavior, but it was not the quick fix solution that the clinic was hoping for when trying to reduce appointment utilization.

The third objective required leadership to decide whether to maintain existing processes, implement a pilot program, or to redirect all preventive women’s health exams to primary care, the latter of which was the final decision. These alternatives had to balance three main priorities - improving access, maintaining patient continuity, and improving clinical currency. A positive result of the chosen design was the increased motivation, teamwork, and preparation that followed. The primary care clinic staff was eager to expand their skills and experiences into more complex procedures and health care interventions. There was one provider who expressed apprehension to the plan, and this was addressed individually with the Medical Director. Another positive outcome was the improvement to access in the Women’s Health Clinic for patients that met criteria for direct access, such as those undergoing dysplasia treatment or requiring birth control-related procedures. This resulted in swiftly addressing the issue of access in the Women’s Health Clinic and subsequently, clinical currency in the primary care clinics.

What can be seen as positive to some can be negative to others. In this case, leadership was focused on alleviating access issues and made the most sweeping decision to achieve immediate success. However, to the women’s health provider and the patients already being seen in the specialty clinic, they perceived that their access and care continuity were discounted.
Patients expressed increased frustration and confusion when calling to book an appointment, as they were now not only being educated by the new cervical cancer screening protocol, but also being scheduled with a different provider. This caused extra time spent on the phones with patients, as some dissatisfied patients chose to file a complaint with the Patient Advocate. The women’s health provider perceived the situation as losing patients. Prior to the change, she averaged 171 visits per month in the previous 6 months; her productivity in the month following the changes was 128 visits. This signaled and contributed to an unanticipated effect, which occurred approximately one month later – the women’s health provider decided to leave the practice. It was known that she was having a hard time with the changes, as mentioned earlier, and was further frustrated by the sense of losing patients. Although access improved, productivity declined and her patients no longer had direct access to her clinic. She expressed amongst colleagues that she was not a part of the decision-making process as much she would like to have been. Although clinic leadership expressed understanding of her concerns and tried to convey the benefits of the new design, it was clear that she felt her sense of ownership was lost. One month after the change, the access problem shifted fully to the primary care clinics. A major lesson learned by these outcomes is that perceptions can differ and vary greatly even in terms of what is successful or beneficial. When it comes to changing processes that affect patient and provider continuity, there is almost no quick fix or immediate solution without negative effects.

Conclusion

The benefits of innovation and change may outweigh risks; however, it is difficult to anticipate all of the future challenges. The question is whether the risks and challenges are enough to deter clinic leadership from executing a vision and whether the decision-making process must change or petition for additional investigation and research. The first objective, to improve access, was perceived as being met by the staff and clinic leadership, but this was not the case for patients who preferred direct access to the Women’s Health Clinic. This highlights the
importance of considering the patient’s perspective of access to medical services and balancing the priorities of the organization with patient-centered care. This case also provides lessons learned about the importance of stakeholder involvement. In the end, the one and only women’s health provider in the clinic decided to leave. The position was not filled with a new provider for at least another six months. Innovative solutions to meet short-term goals may have unforeseeable long-term effects; therefore, designing and implementing solutions that value patient-centered care and stakeholder involvement can help ensure more successful outcomes. Most importantly, healthcare organizations must carefully balance the priorities that drive decision-making and be prepared to mitigate the risks or negative impacts as much as possible, along with the successes.
Bibliography


