Increasing the Efficiency of Clinical Operations in a Multi-Discipline Pediatric Academic Practice

Professional Paper Topic and Outline: FOCUS

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August 30, 2017

This paper is being submitted in partial fulfillment of the requirements of Fellowship in the American College of Medical Practice Executives.
Introduction

Access to comprehensive, quality health care services is important for promoting and maintaining health, preventing and managing disease, reducing unnecessary disability and premature death, and achieving health equity for all Americans. According to Healthy People.gov, the delay in time between identifying a need for a specific test or treatment and actually receiving those services can negatively impact health and costs of care. For example, delays in getting care can lead to:

- Increased emotional distress
- Increased complications
- Higher treatment costs
- Increased hospitalizations

which are especially traumatic in young children and children with anticipated special needs (https://www.healthypeople.gov).

As patients and their families become increasingly well-informed and empowered to make health-related decisions – and increasingly responsible to bear the cost of care – healthcare providers cannot afford to overlook patients’ expectations of timely access to care, and patients’ needs to be guided through the process of scheduling tests and follow-ups. Today, it is in providers’ best interests to not only make their patients feel good about their experience at their facility, but to work to ensure that patients schedule follow up appointments, tests, and imaging. Not only does increased patient access help to achieve better clinical outcomes, but it can also increase revenue and resource efficiency at the practice. Practices that fail to meet their patients’ expectations of timely access to care often suffer from reducing patient volumes and decreased practice revenue. Several factors contribute to patient access problems and lead to patient dissatisfaction, such as lack of standardization, poor scheduling processes, and lack of
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actionable alerts and follow-up notifications. Together, these three factors lead to disruptions in patient flow, unnecessary costs, and lost revenue (http://www.etransmedia.com).

Creating and maintaining a clinical operative system that is efficient and effective in allowing reasonable access to the demand for pediatric specialty care is imperative to sustain the health and wellbeing of the community and also the practice. This paper shares the highlights one pediatric multi-discipline academic practice undertook to reduce the length of time patients waited for an appointment.

**Understanding the Importance of Patient Access**

New Medical Group Management Association (MGMA) data find that medical practices focus on patient experience and access as patients face more options in how their care is delivered. The first-of-its-kind Practice Operations Survey analyzes a range of important benchmarking data that’s never been available before, including patient portals usage, wait times, call volumes, hours of operation, appointment length, scheduling and other nuts and bolts of running a medical practice.

“From what time the doors open to how long a patient waits in an exam room, operations affect a practice’s bottom line as well as its ability to deliver quality care to patients,” said Halee Fischer-Wright, MD, MMM, FAAP, CMPE, President and CEO of the Medical Group Management Association. “As patients increasingly have more options for receiving care, it’s essential for practices to have benchmarking data to identify tactics that best improve patients’ experiences.” Many of the operations metrics in the new survey focus on patient access. For example, of all responding practices, the MGMA data show that 61 percent of practices have taken action to improve wait times. These findings further underscore the results of an MGMA Stat poll – a real-time, text-based polling initiative – from April of more than 100 health
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professionals finding that more than 80 percent of the respondent practices changed or were in the process of changing processes to improve patient access (http://www.mgma.com).

**Background**

Effective data management plays an important role in improving the performance of an organization’s health care systems. Collecting, analyzing, interpreting, and acting on data for specific performance measures allows health care professionals to identify where systems are falling short, to make corrective adjustments, and to track outcomes (https://www.hrsa.gov).

The institution the practice resides in developed the following benchmark expectations for all practices to adhere to several years ago:

- Patients/Families will be contacted by phone within two days of the receipt of a referral for a healthcare visit
- Patients/Families will receive an appointment to be seen by a healthcare provider within four days of the receipt of a referral
- Patients/Families will be seen by a healthcare provider within fourteen days of the receipt of a referral

Expectations for each of these metrics for all practices is to maintain a minimum adherence of 80% at all times. Unfortunately upon review, the pediatric practice had almost no statistics reported over the previous years in which to gauge performance albeit a series of excel spreadsheets tracking the patient waiting lists. It was eventually discovered that the referral and scheduling staff did not understand how to utilize the electronic health record system to choose appropriate referral and scheduling statuses which were the trigger points for obtaining reports on the adherence to the metrics.

Training the referral and scheduling staff to use the electronic health record correctly in order to obtain accurate data on referral management and scheduling efficiency became
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imperative. Additional analysis revealed that the referral pathway through the electronic health record was impeded by broken work queues that would not funnel referrals to the respective programs and the referral and scheduling staff were unable to view the work queues themselves.

In addition, the patient/family satisfaction survey through vendor Press Ganey had been abandoned five years prior by the practice based on “the structure of the survey not providing applicable data for a multi-disciplinary team approach.” The bottom line: the practice had no idea the current level of efficiency or whether or not patients and families were satisfied with the pathway to their care.

Call to Action & Stakeholders

The School of Medicine (SOM) was highly concerned about the increased patient wait lists and lack of data to pin point the performance challenges of the practice. Along with the Chair and Senior Administrator of the Department of Pediatrics, the SOM discussed the ways and means of productive improvement in a practice that provides the only type of specialized care in the state. Options included:

1. Do nothing and continue to lean on physicians and administrative leadership to make improvements.
2. Cut some of the clinical programs to balance the budget
3. Invest in additional resources to optimize the clinical programs

The decision resulted in a one-time investment into better understanding the complexity of the situation and to put the necessary infrastructure, operational platforms, and processes in place to better serve the community.
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**Methodology of Initial Investigation & Trends Discovered**

A well-renown consulting firm for pediatric hospitals was engaged to complete a four day survey into the clinical operations of the pediatric practice in early 2016. The themes of opportunity identified included the following:

1. Leadership & Governance
2. Organizational Infrastructure
3. Operational Processes
4. Financial and Productivity Indicators

While the survey presented valuable insight and recommendations, it was apparent from administrative review that a deeper analysis into the platform the practice operated on needed to be investigated further. A senior project leader was identified, a team assembled, and a deep dive survey tool developed to query each of the 21 programs that were part of the pediatric clinic, including the largest off-site location (please see example in appendix).

For the purposes of this paper, the primary elements of focus will be operational in regards to patient access, although leadership and organizational infrastructure will also be addressed. The following trends were discovered:

**Organizational Leadership & Infrastructure**

- Lack of physician, clinic, and scheduling supervisory leadership

**Personnel Resources**

- Medical Assistant resources, 2.0 FTE is extremely low for an average of 185 patients per day, unable to touch all patients needing vitals and basic management, shifting the work onto MDs and NPs. The current institution ratio of pediatric patients to medical assistants is 13-20 patients for every medical assistant.
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- Social Work resources, 1.0 FTE is very low for 21 multi-discipline clinical programs, unable to provide necessary support shifting the work onto MDs and NPs. The current institution ratio of pediatric patients to social workers is 2.0 FTE social workers for general pediatrics and 1.0 FTE social workers for each pediatric subspecialty.

Electronic Health Record (EHR)

- Significant use of paper or “work arounds” rather than using the EHR system
- Lack of training and comprehension of EHR for both staff and providers

Operational Processes & Standardized Workflows

- Care coordination tasks, i.e. completing paperwork, faxing documents, connecting families with community resources are done by MD and NP providers—reducing the number of patients seen
- Medical Assistant task performance is not consistent and scope of work performed is at the bottom of the certification
- Referral management, scheduling, and managed care lack standard work processes and promote duplication of effort, excessive paper, and EHR avoidance
- Patient wait lists vary from 3 months to 1.5+ years
- Appointment durations are too long for the younger children to maintain decorum
- Providers spend time coordinating the schedule for the day rather than trusting the EHR which delays clinic start times
- Not every patient wants or needs a full-team visit, especially with a follow-up appointment, resulting in last minute cancellations
- Need a better organizational strategy on filling last minute cancellations
- Scheduling templates do not have set standards & providers make last minute changes resulting in needless reschedules
- Significant out of template and overbook appointment scheduling
New patient questionnaires for each program lack standardization, continuity of look and feel, institution branding, and read at high level resulting in delayed receipt from families

Scheduling templates are not available for appointments beyond one to two months from current date of service

Website does not list and describe all programs available for referrals

Lack of meaningful and understandable provider productivity standards to incent efficient patient throughput

**Clinic Facility & Space Management**

- Lack of management oversight in space utilization and perceived lack of space
- Bottle necks at patient check-in at the front desk
- One area for vitals that creates constant bottle necks

**Policies & Procedures**

- Some programs experience chronic last minute cancellations or no-shows with no guiding policies or procedures
- Provider sick call notifications are often not sent to the appropriate individuals, no policies in place
- Provider pre-planned vacation or academic conferences often a last minute discovery
- No policies for front end revenue cycle collection
- Non-standard algorithm ratio of provider clinic to administrative time

**Statement of Goals**

With the additional insights from the deep dive surveys, the guiding principles of the project were defined. The overarching goal of the clinical optimization is to improve the access efficiency of the pediatric practice to better meet the needs of the patient population. This will be accomplished through the following areas of focus:
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- Assess the practice operations and identify opportunities to enhance efficiency, reduce cost, and grow volumes
- Evaluate the effectiveness of the current organizational and leadership structure, reporting relationships, and decision-making authority
- Compare performance across a wide range of metrics in key operational areas to available national and institutional best practices and highlight areas of underperformance and opportunity.
- Explore options for an optimized multidisciplinary clinic model
- Create a prioritized set of recommendations that identifies immediate actionable items and longer-term items of significant impact.
- Put recommendations in place in a staged approach via training, systems, and monitor for feedback and results.

**Implementation**

As mentioned earlier, a senior project manager was identified to lead the effort and a project team assembled that metamorphosed over time as resource needs were identified, approved, and recruitment complete. Please see the types of roles included in the project team and supportive structure below:

*Project Team Members*

- Senior Project Manager
- Administrator
- Outside Consultant(s)*
- SOM Performance Improvement Consultant
- Children’s Hospital Project Coordinator
- Practice Managers^
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- Scheduling & Managed Care Supervisors^  

Management Committee

- Department Chair of Pediatrics  
- Senior Administrator of Pediatrics  
- Practice Medical Director^  
- Children’s Hospital Ambulatory Director^  
- Senior Project Manager  

Medical Director Task Force

- Practice Medical Director^  
- Autism Program Director  
- Neo-Natal Intensive Care Follow-Up Program Director  
- Occupational Therapy Discipline Director  
- Practice Manager^  
- Ad hoc as needed  

Sponsors

- SOM Senior Associate Dean of Finance & Administration  
- Vice President of the Children’s Hospital^  
- Department Chair of Pediatrics  
- Senior Administrator of Pediatrics  

*As needed for specific skill sets such as EHR support, limited duration  
^When hired  

Progress Report-out

The following meetings are held to report progress, address challenges, strategize next steps, and obtain approval when necessary from senior leadership:

- Project Team meetings held twice a month for two hours at each occurrence
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- Management Committee meetings held twice a month for an hour at each occurrence
- Medical Director Task Force meetings held weekly for an hour at each occurrence
- Program & Discipline Directors meetings held monthly for an hour at each occurrence
- Sponsor Report-Out held once a month for 30 minutes at each occurrence

**Communication Strategy**

The practice encompasses many different disciplines of providers from pediatricians, nurse practitioners, dieticians, physical and occupational therapists, speech language pathologists, psychologist, to geneticists. To engage and inform the various providers and support staff, a unique branded clinical optimization communication platform was designed and communication updates encompassing accomplishments, recognition of individual and team achievement, and notification of upcoming changes or requests for feedback were sent out monthly to the entire group.

**Clinical Optimization**

With the deep dive survey results compiled, a four-phase project was developed to address the goals of the project. Please see the elements below of each phase, highlighted accomplishments, and lessons learned through the process.

**Phase One**

**Elements**

1. Clinical operation metrics: establish incremental goals
   I. Phone call abandonment rate
   II. Patient satisfaction percentage
   III. Patient access by next available appointment
   IV. Referral adherence to institution expectation
2. Electronic Health Record (EHR) Optimization
   I. Use institutional standard colored dot system for patient flow/communication
   II. Exam room assignment by room number

3. Medical Assistants
   I. Standardize position description and scope of work across all individuals
   II. Train on revised standard work to ensure consistency
   III. Determine the need for additional resources

4. Appointment Scheduling
   I. Review and revise intake center flow and processes to be lean and better leverage existing technology
   II. Revise new patient questionnaires to be standard in look and feel, reduce redundancy among programs, and reduce the reading level

5. Front Desk
   I. Pilot three individuals to check-in from 8:00am to 9:30am
   II. Review standard operating procedures and explore the addition of a standard check-out and one discipline follow-up scheduling

6. Provider Clinical Documentation
   I. Request review from EHR analyst team
   II. Review provider documentation in EHR for efficiency
   III. Increase use of Smart Text and Note Writer macros

7. Policies
   I. How long to keep a referral active
   II. Patient no-show and cancellation
III. Provider pre-planned time off

*Noted Accomplishments*

Each of the 21 program directors along with the associated scheduling and managed care staff met to review their performance against monthly institution benchmark expectations for phone call abandonment rates (2.5%), referral communication and scheduling rates (80%), and patient access for next available appointment (two weeks). Questions were asked about what was currently working well, barriers to success, and additional needs to meet expectations. Three themes emerged:

- The practice received a significant amount of phone calls that required triaging to the rest of the university
- The scheduling staff were not properly trained on how to manage the referral process in the EHR
- The medical review process for many programs was not addressed in a timely manner

With just deploying additional EHR training and program director awareness of sluggish medical review processes, 53% of the programs met referral benchmark expectations within a short time period and continued to improve rapidly from there.

New patient questionnaires were reviewed with the provider task force and scheduling team and completely revised to pin point priority information, reduce the length and duplication, and also adopt a standard across all programs that would match the EHR documentation template structure for easy review and translation. New patient policy and procedures were added to a standard welcome letter in an effort to reduce chronic appointment no-show, cancellation, and rescheduling (please see example in appendix).

The hiring of a practice medical director from a pool of internal practice candidates provided the project with additional decision making authority and leverage. Once this occurred
the practice leadership and reporting structure was finalized and a clear pathway of communication triage in effect.

**Lessons Learned**

The practice implemented the use of the EHR’s colored dot communication system which appears next to a patient’s name and informs the staff and providers where they are at in their visit. Please see the structure below:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient is checked in/MA needed</td>
<td>![Blue Circle]</td>
</tr>
<tr>
<td>MA Rooming patient</td>
<td>![Red Circle]</td>
</tr>
<tr>
<td>Patient out for testing/lunch</td>
<td>![White Circle]</td>
</tr>
<tr>
<td>Patient ready for provider</td>
<td>![Green Circle]</td>
</tr>
<tr>
<td>Patient has checked out</td>
<td>![Black Circle]</td>
</tr>
</tbody>
</table>

The hope was to adopt this mechanism and discontinue the use of paging providers every time a patient checked in. However, some of the patients do not need to be roomed by a medical assistant due to therapy only appointments and those that did, the medical assistants could not keep up with the flow. While addressing the limited medical assistant resources is part of the
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overall optimization plan, changing the location of the medical assistant computer stations became apparent so they could have closer proximity to the waiting area, vitals station, and front desk. The use of the dots was recently abandoned in favor of setting an auto-page algorithm that would trigger a page once a patient was checked in to the EHR instead of requiring a manual colored dot change. Once receiving the page, the provider would look at their schedule and be able to see when the patient had a room number assigned next to their name and were ready to be seen.

**Phase Two**

*Elements*

1. Electronic Medical Record (EHR)
   
   I. Referral work queue functionality resolved
   
   II. Appointment visit type reconciliation & reduction
   
   III. Appointment length standardization—program and discipline specific
   
   IV. Scheduling template multi-discipline panel builds
   
   V. Review & revise provider documentation workflow for efficiency

2. Positions
   
   I. Scheduling Supervisor—main campus (replace)
   
   II. 2 Practice Managers—one for main campus, one for central campus (new)
   
   III. Scheduler—main campus (replace)
   
   IV. 2 Medical Assistants—main campus (new)
   
   V. Care Coordinator-CFD—main campus (new)
   
   VI. Social Worker, LCSW—main campus (new)
   
   VII. Social Worker, MSW—main campus (new)
   
   VIII. Psychologist—central campus (new)
   
   IX. Dietician—central campus (replace)
X. Physical Therapist—central campus (new)

XI. Audiologist—main campus (new)

XII. Rehabilitation Aid—main campus (new)

XIII. Review Psychology resource utilization—main campus

3. Clinical Operations

   I. Scheduling group work duties re-organized, evaluate for resource needs

   II. Fractionation with hospital centralized scheduling and managed care remedied—main campus

   III. Standards employed

       a. Referral matrix program spreadsheets completed/revised and submitted to referral intake

       b. Scheduling standards

       c. Managed care standards

       d. Medical assistant standards

       e. Referral work queue clean up

IV. Expand use of mini-teams to see more patients

V. Pediatric Neurology to exit current exam room pod—main campus

VI. Standardize provider clinical full time equivalent breakdown (FTE)

       a. Establish standards for provider productivity

       b. Match productivity expectations to schedules, scheduling templates, and exam room assignment

VII. Continue to monitor clinical operations metric incremental goals and performance against university benchmarks

VIII. Update referring provider instructions on website to include all programs

IX. Develop strategy on program growth vs status quo
X. Identify and create a second vitals area—main campus

XI. Both main and central campus clinic space addressed to meet safety and quality standards

XII. Create huddle boards in clinic spaces and schedule morning huddles to review the day and address any short or long term challenges

4. Policies
   I. Providers calling in sick
   II. Patients who show up late

Notable Accomplishments

A significant accomplishment in Phase Two was the hiring and training of two seasoned practice managers and one scheduling supervisor. All three joined the project team and were immediately able to jump into the heavy lifting of this phase. Referral intake, scheduling, and managed care workflow standards were created and staff provided with training (please see example in appendix). The central campus group had the largest gap in EHR skills and referral efficiency was impeded by not only this, but new patient packets circa 1990 and no policies on how long to keep a referral active. Once training, standards, new forms, and policies were in place, the scheduling staff reported being positively overwhelmed at the number of new patient packets returned in a couple of weeks rather one to two months.

The institution embarked on a centralized referral, scheduling, and managed care service team at an offsite location to streamline processes and positively impact patient access. A small portion of the pediatric practice was part of the pilot and left with the group for the years following. Unfortunately, the service provided was sub-par in terms of accuracy and timeliness and required a duplication of effort from the practice to avoid disaster. Since transitioning this back to the practice, both programs impacted are now beating the referral benchmark of 80% in appointing patients within 4 days of the receipt of a referral—something that had not be previously achieved.
Lessons Learned

Establishing a standard approach to provider FTE breakdown, more specifically for clinical time versus administrative time, can be a hotly debated topic in the academic arena. This practice was no different in that each provider prioritizes clinical work, teaching, and research in different ways. Delicately balancing the need for financial solvency with the fact that academic clinicians are typically paid less than private practice clinicians, a group meeting was held to review the need to scrutinize how time is spent. In reviewing the data leading up to this meeting, it was discovered that many providers spent very little time seeing patients in clinic relative to unpaid administrative, teaching, and research endeavors. The culture had evolved over many years to be a “specialize in what you would like to do and see.” Unfortunately this resulted in many clinicians seeing only a very small subset of patients and created a significant wait list. The new model approach for a clinically dedicated full-time provider is to spend 32 hours of scheduled and slotted patient time with the remaining 8 hours to be protected administrative time. There were many provider champions who welcomed the change as they felt the burden of carrying a heavy load from their less engaged colleagues. But there were also notable senior program leaders who not only refused to be part of the solution, they created additional resistance with negativity and claims that no one could ever take vacations in this new model. Collectively with leadership, meetings were held with each discipline director (i.e. physical therapy, psychology, ect.) and each individual pediatrician and nurse practitioner. By the end of the process, the resistance had been mitigated, there was significant appreciation for better organization, and only one casualty who chose to self-select out of the practice.

Applying dramatic changes to scheduling algorithms in an EHR and expecting it to carry through for the indeterminate future ended up being a naïve expectation. As changes were applied to each of the providers and programs templates and spot checks for accuracy completed, it became apparent that there were many inconsistencies. Significant re-work was required which
slowed the anticipated go live by a couple of months and audits continue to this day based on this lesson learned.

**Phase Three**

*Elements*

1. Continued monitoring from Phases One through Two
   
   I. EHR work queue function
   
   II. EHR scheduling templates and multi-discipline panel builds

   III. Referral, scheduling, and managed care standard workflows

2. Operations
   
   I. New scheduling & managed care team structure to go live—main campus

   II. Mitigate and re-route 2000+ monthly phone calls that should be coming to central hospital operators instead of practice—main campus

   III. Create & develop key performance indicator boards for both main and central campus locations

3. Finance
   
   I. Revenue Cycle
      
      a. Develop & deploy front end revenue cycle policy at patient reminder call and check-in

      b. Establish EHR billing work queue goals and track visit denial patterns

      c. Non-covered services will no longer be offered for free

   II. Create monthly finance & metric dashboard for clinical leadership
Notable Accomplishments

Creating key performance indicator boards for the main and central campus locations of the practice was a tremendous help in visually displaying the areas of focus that roll up to patient access. In addition, front line staff and managers were much more engaged with senior leadership because every individual knew what the metrics and their associated benchmarks were and where we were at in the process of making improvements. Many staff members commented that they felt like they could “own” the metrics associated with their work and truly felt a sense of family pride as progress ensued. For example, appointment slots that are unfilled are reported each day and the schedulers work hard to make sure these are few because they know the expectation is to explain why. The managed care team works hard to keep denials underneath the set monthly threshold so they can remain at “green status” on the board, though they know that each denial that comes through will be reviewed for cause.

Many of the practice providers want to provide as many services to patients and their families as possible. However, some of these elements of care are not covered by Medicaid plans, the primary payer in the practice. Instead of alerting families to the situation and offering a self-pay option and subsequently removing the service if refusal to pay, the historic process is to perform it free of charge. This not only resulted in longer appointment lengths which were not being reimbursed, but also reduced the number of patients that could be seen on a given day or template. With free services no longer being allowed along with standardized slot lengths, the practice is beginning to see a reduction in denied services due to providers no longer attempting to carry out and bill for uncovered elements.

Lessons Learned

One of the early discoveries in practice inefficiency was the significant number of phone calls that came into the practice that did not belong. Initial conversations with the institution telecom department resulted in the practice needing to collect additional data on how many and what types of calls were coming into the practice that resulted in heavy triage or problem solving.
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The result was that the three FTE logged into the practice phone queue fielded twice as many phone calls as necessary. For every 4,000 calls answered in a month, 2,000 should have come through the main hospital operator. Unfortunately, there was no easy switch to flip and send the erroneous calls elsewhere. The telecom system of funneled calls is currently being examined to determine where the disconnect lies and has not been discovered yet. We are diligently working to remedy this, but will not be at optimal phone efficiency until this is resolved, thus impacting the ability to answer calls within benchmark standards consistently.

Front end revenue cycle strategies did not previously exist for this practice, though the managed care team did mark appointments that needed a co-pay collection. In observing the front desk at our two largest locations, the requirement of a co-pay was rarely initiated and when prompted, the staff appeared very uncomfortable with asking for fear that the family would say they couldn’t pay and be embarrassed. One tactic that was witnessed was a family offering to pay cash for a co-pay and the front desk individual stating not to worry about it now, they would be billed.

Hospitals and medical practices share a growing problem with those they treat: Patients aren’t paying their bills. As more people come under high deductible health plans, the ratio could settle around 70-30 — with patients paying nearly a third of their bills, said Ken Kubisty, senior vice president at Advisory Board Consulting and Management. There has to be a collective mindset shift, said Larry Van Horn, executive director of health affairs at Vanderbilt University's Owen Graduate School of Management. Hospitals have to be more transparent in billing and pricing while patients have to be prepared to set money aside to pay for health care. “People are not saving and people are going to need to plan for health care expenses just like they do for all kinds of services they already (pay for) out-of-pocket,” said Van Horn. Nearly a quarter of the U.S. has a $2,000 deductible, said Van Horn. We’ve made choices and become accustomed to a level of consumerism, without setting aside money for health care,” said Van Horn. “It’s
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going to take time for people to get their head around it, to understand they have to prepare for it." Van Horn said “the move toward high-deductible health plans is unstoppable.” He thinks that in 15 years that’s all people will have. The old system was designed to send past due accounts to collection agencies or write them off. But as patients are billed for more of the cost of their care, a new system balancing their responsibility with their ability to pay has yet to emerge. But it should reflect the necessity of care as well as the necessity of payment. “Patients have to adapt to a new reality. That’s true. But so are providers. So are hospitals. They are chasing more dollars from patients,” said David Frederiksen, CEO of PatientFocus. “It’s important to be persistent and polite with patients” (Fletcher, Holly “Why More Than Half of Hospital Bills Don’t Get Paid,” Tennessean.com Part of the USA Today Network).

For this practice, the managed care staff are now trained to not only include co-pays, but co-insurance, and non-met deductible amounts in the appointment notes as needing collection. New patient welcome letters also let families know that payment is expected at check-in and appointment reminder calls will alert families to the amount they need to be prepared to pay. The schedulers and front desk staff have been trained with scripting on how to ask politely, but firmly on the amount that is owed and if met with “I cannot pay,” to ask for a minimum of 50% of the amount owed. Many families are able to contribute something toward their balance due, but unless asked, the practice may never collect it.

**Phase Four**

*Elements*

1. Growth in Pediatric Specialty Services
   
   I. New southwest and eastern community locations in metropolitan area
   
   II. New western community location to pair with new Family Medicine location
   
   III. Additional services to be added to the central campus location
   
   IV. Additional services to be added to the southern campus location
2. Clinical Facilities

   I. Pull all central campus services together into one building
      a. Retrofit existing shelled space for programmatic needs

   II. Pull all southern campus services together into one building
       a. Retrofit existing building for programmatic needs

   III. Retrofit existing buildings as necessary for metropolitan expansion

3. Provider & Staff Resources

   I. Plan, budget, recruit, and onboard additional provider resources as needed

   II. Plan, budget, recruit, and onboard additional staff resources as needed

4. Continued Monitoring from Phases One through Three

   I. EHR work queue function

   II. EHR scheduling templates and multi-discipline panel builds

   III. Referral, scheduling, and managed care standard workflows

   IV. Adherence to policies, procedures, benchmark expectations

Accomplishments

The practice is currently engaged in Phase four of the Clinical Optimization, which based on the elements involved, will be a longer term effort. Of the work currently underway, the focus is on procuring and working through the design phase of the clinical facilities for the central campus location. The space for the western metropolitan community and southern campus locations are up and running with next steps of the expansion of services along with obtaining additional provider and staff resources.
Lessons Learned

Some of the pediatric senior leadership desired to expand service areas and service elements offered at the same time the clinical optimization effort was in its initial stages. With the knowledge of the deep dives and uncovering limited staff training, skill sets, and available resources, the concern was to overburden an already taxed system. But due to the significant amount of planning involved in setting up new arenas of care, some of the work needed to be accomplished earlier, such as setting up new scheduling departments in the EHR, recruiting for supplemental providers and staff, and preparing the appropriate infrastructure to support from a leadership and administrative standpoint. The lesson learned: it never hurts to start early in planning for clinical expansion, it allows for nimble problem solving and better execution.

Summary

“Change is hard at first, messy in the middle, and gorgeous at the end, Robin Sharma, writer,” (Biles, Simone, Courage to Soar). At 10 months into the clinical optimization project, the practice not only accepted the need for change, but the culture is shifting to one of more flexibility and engagement. Although still experiencing a slow emergence from the “messiness” in some elements, the practice is simultaneously enjoying some of the benefits of the hard work accomplished by all.

While this paper did not expressly focus on financial objects as part of the highlighted accomplishments, the need for improved financial performance was a significant undercurrent running throughout. The comprehension and attitude of many providers toward seeing a full templated day of patients coupled with a lack of appropriate operative oversight put the practice’s financial solvency at risk. A single unused appointment slot per day can cost practices more than $25,000 per year per provider or resource (http://www.etransmedia.com). Opening the eyes of the project sponsors and newly acquired leadership to the realities of the clinical practices along with the aversion to the EHR and a “you do not understand our complicated practice” response to previous standardization attempts was significant. However, finding the right balance of detailed
Increasing the Efficiency of Clinical Operations in a Multi-Discipline Pediatric Academic Practice

analysis, consistent time spent in clinic with staff and providers to experience the good, the bad, and the ugly, and communicating thoughtfully, transparently, and frequently helped to establish trust and a sense of teamwork.

Upon reflection of the distance achieved by the practice, the recommendation for others embarking on similar journeys is to take the time to go all the way to the very bottom of a system. Where there is smoke, there is usually fire burning below the surface and in some cases, process breakdowns are often caused by a lack of training or understanding of the larger picture, not being held accountable for well-defined and measurable standards, and a lack of an appropriate resource support system. Finding champions in each function of the practice to come along side, help drive decision making, and rally the rest of the team helped create this project to move quickly, positively, and demonstrate the value of the investment to the stakeholders.
References


2. Etransmedia, “Patient Access Technology Can Increase Your Revenue”,

3. Fletcher, Holly “Why More Than Half of Hospital Bills Don’t Get Paid,” Tennessean.com Part of the USA Today Network, March 7, 2016,

4. Fischer-Wright, Halee, “First-of-its-kind MGMA survey of day-to-day operations in medical practices shows an increased focus on patient experience,” October 31, 2016,
   http://www.mgma.com/


Appendix

1. Deep Dive Survey Tool (see excel file)

2. Clinical Policy Example on Patient No-Show and Cancellation

**Clinical Policy Example on Patient No-Show and Cancellation of Appointments**

## Patient Cancellation and No Show Policy

### Related Definitions

- **No Show:** When a family/patient does not appear for a scheduled appointment.
- **Late Cancellation:** When a family/patient cancels an appointment with *less than 24 hours’ notice.*
- **Cancellation:** When a family/patient cancels an appointment with *more than 24 hours’ notice.*

### New Patients

- The family/patient has the responsibility to contact the scheduling team if there is a need to cancel or reschedule their appointment.
- The first appointment that is a Cancellation, a Late Cancellation, or a No Show will only be rescheduled once more.
- The scheduling team will offer to reschedule if the family/patient does not keep their first appointment.
- The scheduling team will not reschedule if the family/patient does not keep their second appointment. Instead, the team will send a letter to the referring provider stating the family/patient did not keep their original and rescheduled appointment.
- If the family/patient is re-referred by their primary provider, the process will be reinitiated with the family/patient placed at the end of the waiting list. A request for re-referral will only be honored one time.

### Return/Follow Up Patients for Team Clinics

- The scheduling team will not reschedule a family/patient if there are two consecutive No Shows or three cumulative missed appointments (for any reason) within a nine month period, even if these were Cancellations.
- The scheduling team will send a letter to the family/patient and the referring provider after the first No Show letting both know that the scheduling team will not reschedule the family/patient again if there is a second consecutive No Show or three cumulative missed appointments within the nine month period.
The scheduling team may decline to schedule a family/patient under these circumstances without getting explicit permission from the provider(s).

The scheduling team will inform the provider(s) for informational purposes only, but not to negotiate the No Show Policy.

The Program Director or Discipline Director may override this policy under special circumstances.

Return/Follow Up Patients for Therapy

The scheduling team will not reschedule a family/patient if there are two consecutive No Shows or three cumulative missed appointments (for any reason) within a 3 month period, even if these were Cancellations.

The scheduling team will send a letter to the family/patient and the referring provider after the first No Show letting both know that the scheduling team will not reschedule the family/patient again if there is a second consecutive No Show or three cumulative missed appointments within the three month period.

The scheduling team may decline to schedule a family/patient under these circumstances without getting explicit permission from the provider(s). However, if a patient/family is receiving mental health services, the scheduling team will notify the mental health providers (psychiatry, psychology, social work) before efforts at rescheduling appointments are discontinued.

The scheduling team will inform the provider(s) for informational purposes only, but not to negotiate the No Show Policy.

The Program Director or Discipline Director may override this policy under special circumstances.

Referral Management Standard Work Document

Registration/Referral Intake Standard Workflow

The role(s) of registration and initial patient intake for the practice serves as the first point of contact for patients and/or referring providers. Adhering to standard policies and expectations and explaining our processes and timelines to families is a key element of this workflow.

Receipt, Review, and Processing of Referrals

a. Monitor and process incoming referrals from Right Fax (paper or electronic), phone, or other valid source. Review referral information and contact referring provider if key information is missing such as patient contact.
b. Contact patient’s family by phone within two days of receiving the referral and register their demographic and insurance information directly into the EHR. Do not duplicate this information onto paper face sheets or in a paper chart. Create a medical record number and referral shell and select the referral status as New Request. If you are missing information and need to contact the referring provider for an external referral, leave the referral status at New Request and reach out to obtain the needed information. If the referral is an internal provider, document in the referral shell what you need and change the referral status to Incomplete which will transfer the referral from your WQ. The referring practice will make the necessary changes and change the request to New Request and it will transfer back into the WQ. Scan the referral information and chart notes and populate the following details into the referral shell: referring provider name, phone, fax, insurance name and phone number, diagnosis code and/or reason for visit, and whether records received or not. Keep chart notes for 7 days and shred afterwards.

c. If you are able to reach the family on the first try, change scheduling status to Patient Notified of Referral Received. Leave the referral status as New Request.

   i. If you are able to leave a message for the family please instruct them to call back. Even when leaving a message, please change the scheduling status to Patient Notified of Referral Received. If no response in 3 business days from message left, please call the family again.

   ii. If you are not able to leave a message for the family, do not change the scheduling status and attempt to call the family again within 24 hours.

   iii. If contact cannot be made after the second attempt regardless of a message left or not, please send a letter through the EHR alerting them of our receipt of a referral, our attempts to contact them, and should they be interested in being seen in our clinic, our policy is for them to contact us within 30 days of the date of this letter. A copy of this letter is to be sent to the referring provider. Please change the referral status to Closed and scheduling status to Scheduling Letter Mailed to Patient.

d. While speaking with the family, explain the required forms to be completed prior to the appointment being scheduled and mail the new patient packet. Once the forms have been dispatched, change the scheduling status to Waiting for Patient Action. This role is responsible to monitor the paperwork due into the office by reviewing the referral WQ statuses daily.

   i. At 30 days from sending or directing families to download the forms from the website, please call the family and let them know we haven’t received the forms and explain that our process is to given them an
additional month to get the forms in. At 2 months from sending the initial forms, a letter will need to be sent to the family stating that with no received forms in 2 months, our process is to close their referral. If they would like care in the future, a new referral will need to be initiated. A similar letter will need to be sent to the referring provider. Change referral status to Closed and Scheduling Status to Scheduling Letter Mailed.

e. When the paperwork returns please scan it into the EHR under outside records. Update the referral status to Medical Review and the scheduling status to In Process. Send an in-basket alerting the following the individuals responsible to perform medical review of the patient chart notes for the respective programs. For any questions, please contact the Scheduling Supervisor.

f. Provider will reply to EHR in-basket with scheduling instructions.

   i. Once you receive the scheduling instructions, please go into the referral shell and click on “Notes” on the left hand of the screen
   ii. Click “New” at the top of the referral screen
   iii. For type of note, choose “Scheduling Notes” Copy and paste the scheduling instructions to scheduler on what appointments the patient needs. Click “Accept Note”
   iv. Update the referral status to Referred and then “Accept” at bottom of referral page.

Scheduler then watches for status of Referred and the scheduling status of In progress.