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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

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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
3. MARIANNE HAMILTON LOPEZ (Study Director), Senior Program Officer, National Academy of Medicine

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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

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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.

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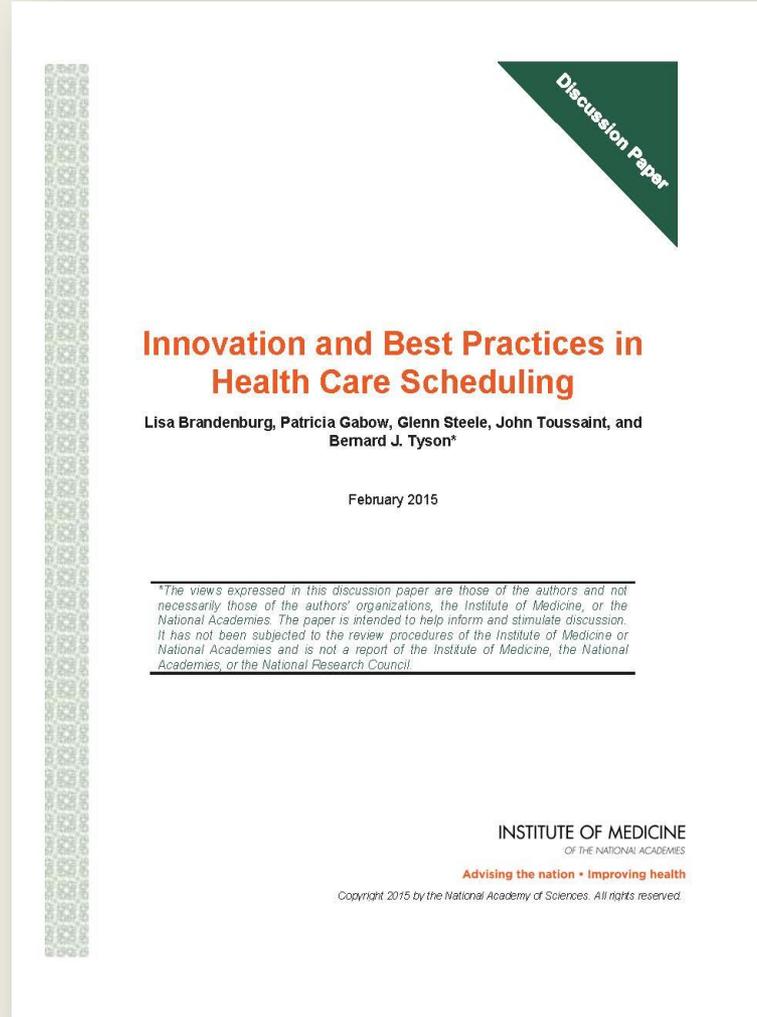
Committee Approach

- 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

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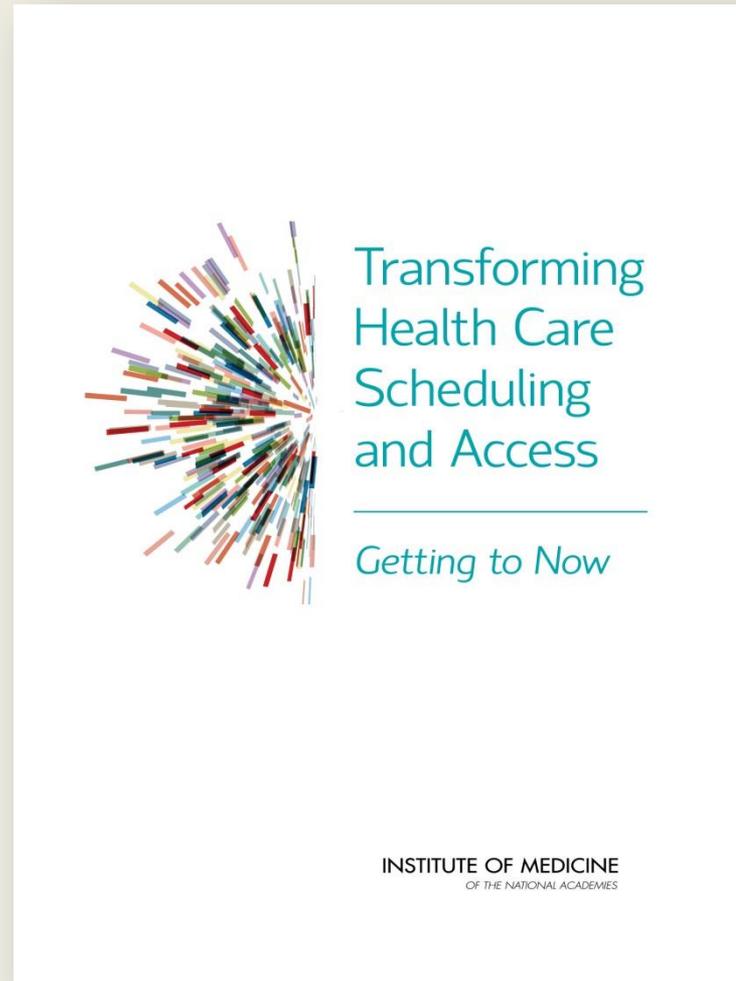
Discussion Paper by Field Leaders



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IOM Report Developed by Committee



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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

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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

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Multiple Contributors

- Supply and demand inattention
- Provider-focused approach
- Outmoded workforce models
- Priority-based queues
- Care complexity
- Reimbursement complexity
- Financial access
- Geographic access

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Basic Access Principles for All Settings

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

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10 Recommendations

- 6 National Leadership
- 4 Health Care Facility Leadership

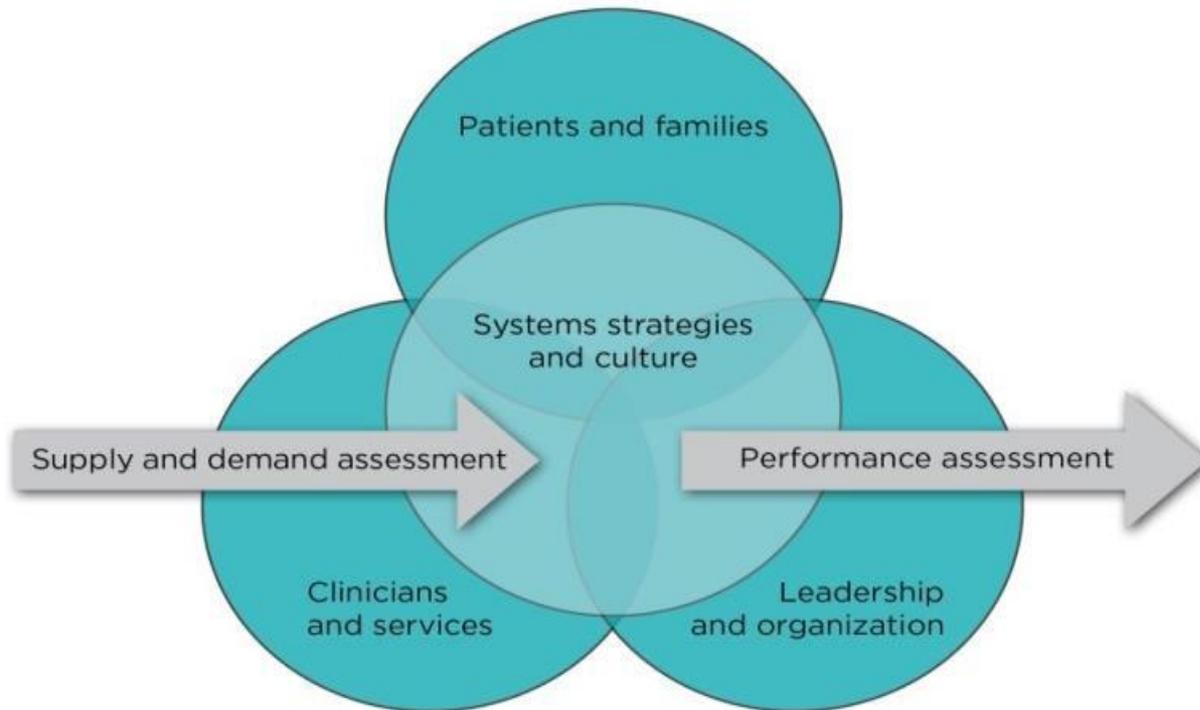
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SUSAN DENTZER

Conceptual Reference Points

Systems Strategies



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Conceptual Reference Points

Patient and Family-Centered Focus

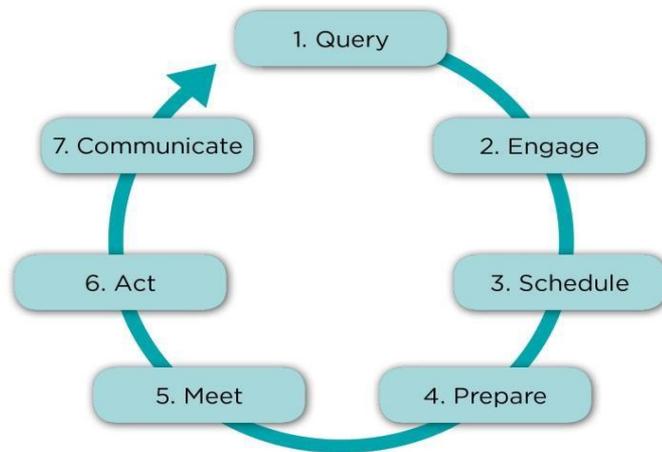
Patient and family-centered care is designed, with patient involvement, to ensure timely, convenient, well-coordinated engagement of a person's health and health care needs, preferences, and values; it includes explicit and partnered determination of patient goals and care options; and it requires ongoing assessment of the care match with patient goals.

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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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MARIANNE HAMILTON LOPEZ

Learning from other sectors

- Integrated perspective
- Analysis and measurement capacity
- Emerging technologies anticipation
- Culture of service excellence

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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

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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.

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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

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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

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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.

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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.

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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.

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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

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