Title:	Provider Encounter Turn Around Time – v. 12
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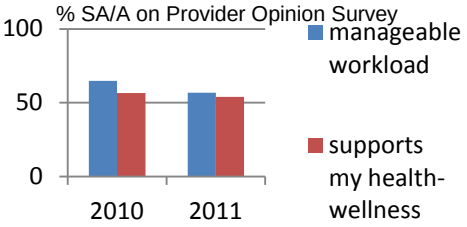
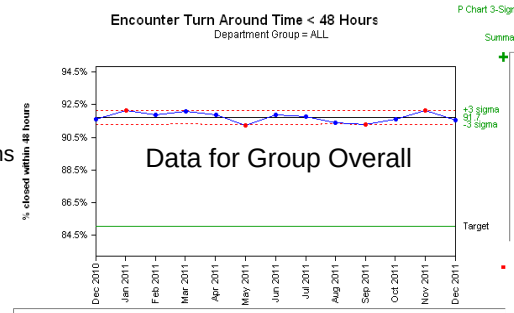
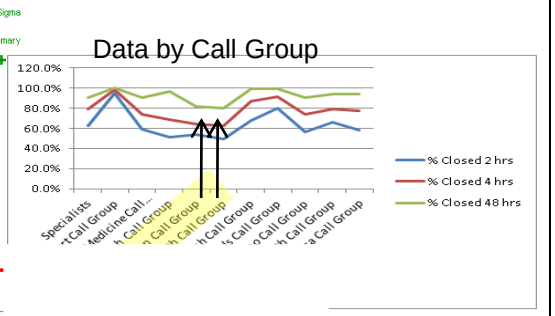
P L A N

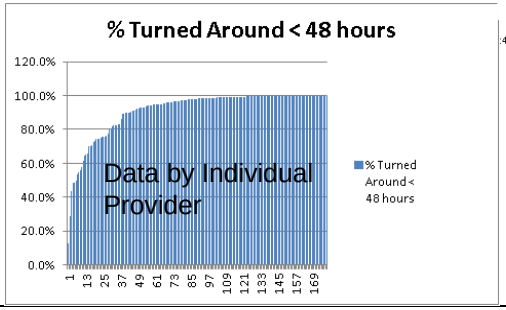
Background / Current Conditions

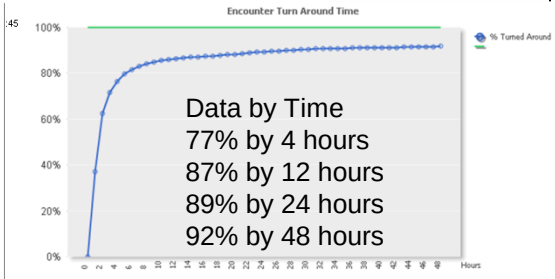
•Medical group office visit redesign is designed to support one-piece flow for providers, including patient visits, documentation in Epic record, and patient-responsive in basket work
•Physician employment contracts specify charting from patient encounters is to be completed within 2 days
•Internal and external changes have caused overloading of physicians electronic in baskets; improvement work implemented in 2012
•Provider visit lengths semi-customized to reflect provider as the pacemaker of work; based on face to face and documentation data
•Provider workflow improvement has occurred, but still variable and generally reactive
•Historically, full time providers have seen patients 4 days/week, but providers now often work during days off, nights, and weekends to complete non-visit work; total provider work hours uncertain











Problem Statement

In 2011, 8.6% of approximately 446,000 medical group patient visit encounters were not completed in Epic by providers within 2 days, resulting in incomplete records causing subsequent care for patients to be less safe, delayed or lost revenue, and invalidation of a portion of at least 135 or more physician employment contracts.

Goals / Targets

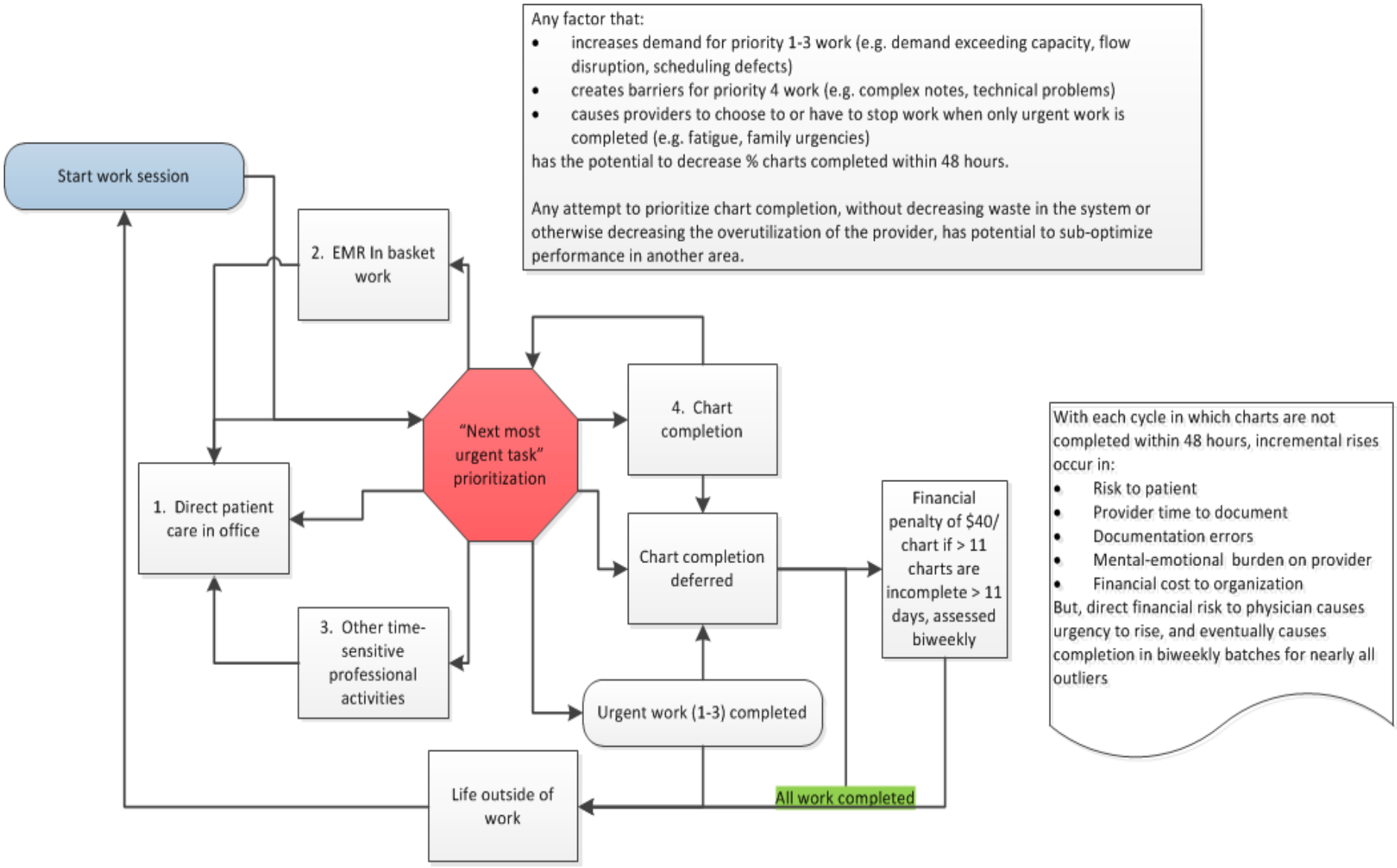
• Reduce encounters NOT documented and closed within 48 hours by 50% (increasing total to 96% or greater) by December 2012, and reduce remaining defects at end of December 2012 by 50% by end December 2013 (increasing total to 98% or greater)

• Improve providers' ability to meet TAKT for Encounter TAT and majority of provider work, by identifying, integrating, and balancing cycle time to TAKT time for all required provider work content

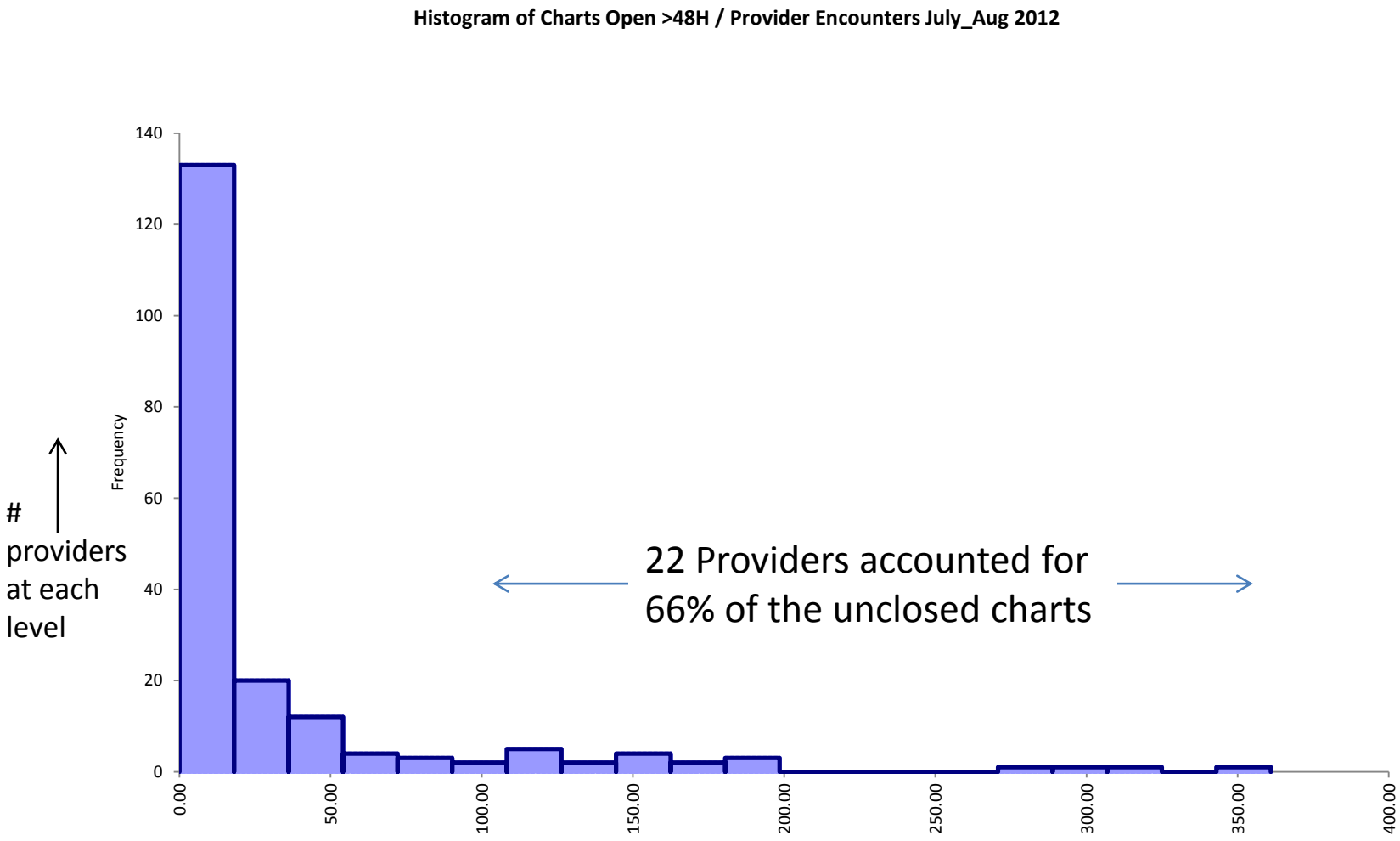
•Improve by 10% manageable workload and support for health/wellness scores on Provider Opinion Survey by 2013 POS

• Use "Just Culture" methodology for provider performance management

Current Provider Work System

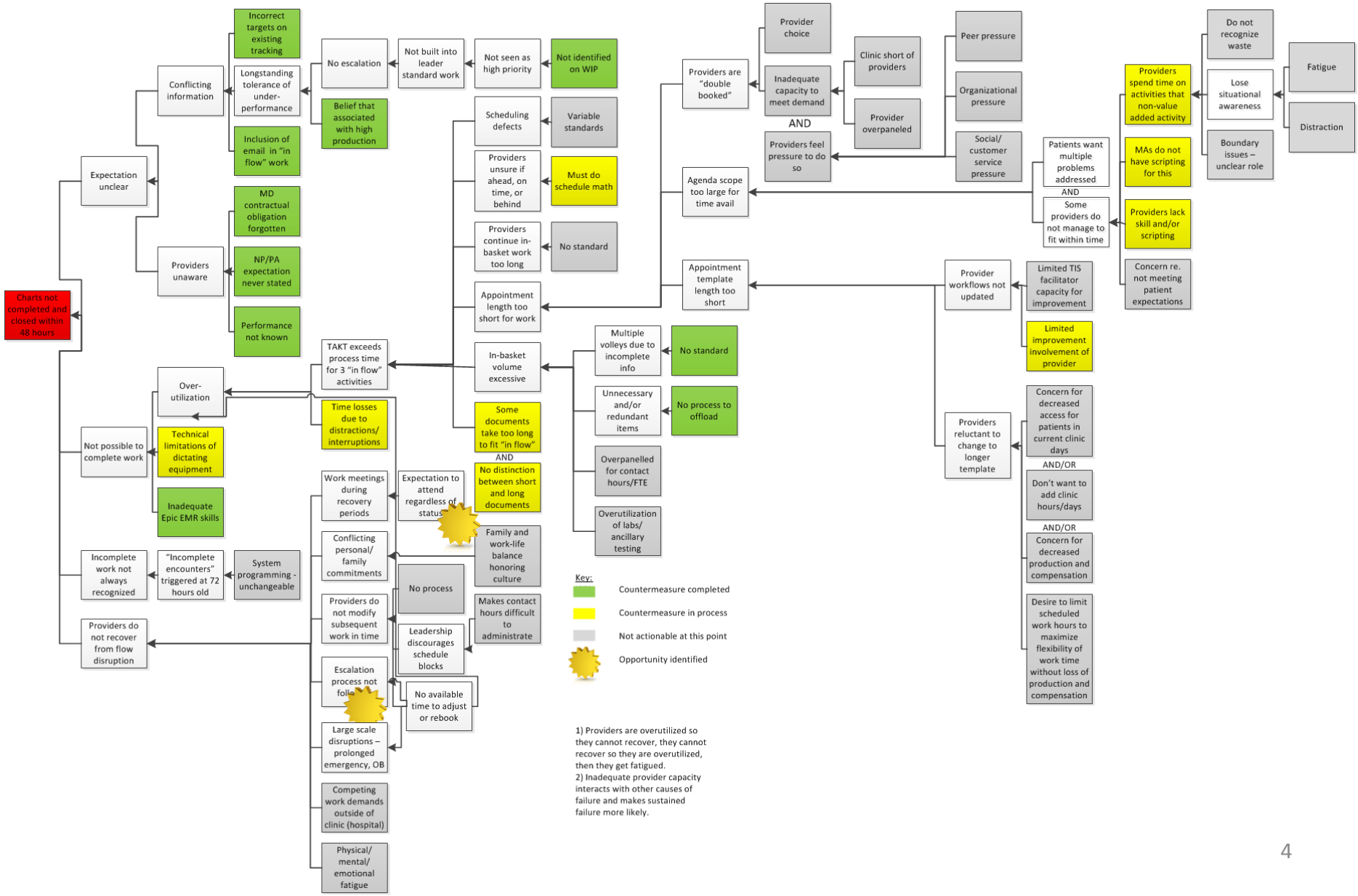


Understanding Top Contributors



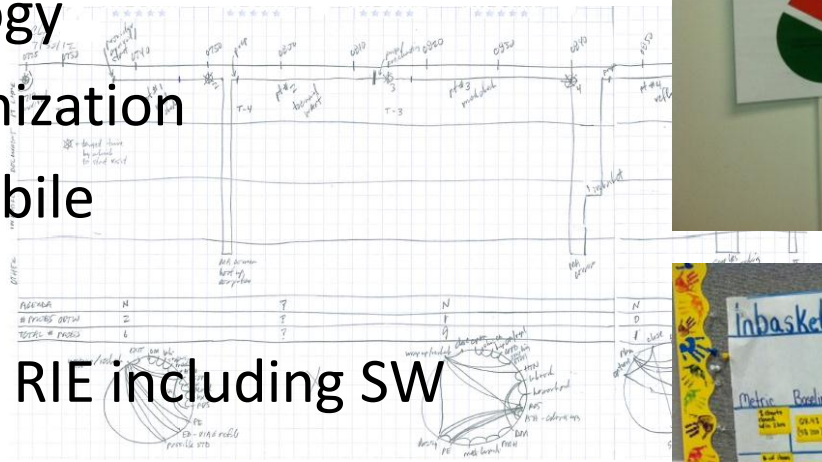
Number of charts per provider open > 48 hours in July-August 2012

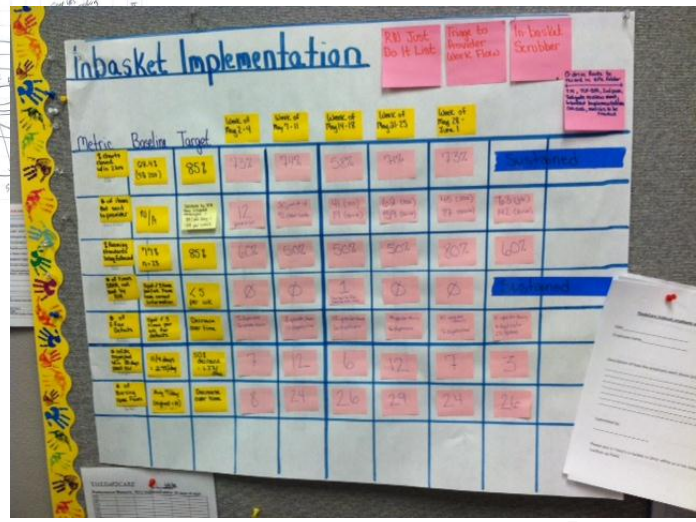
Cause Map


Charts not completed and closed within 48 hours
Expectation unclear
Conflicting information
Incorrect targets on existing tracking
Longstanding tolerance of under-performance
Inclusion of email in "in flow" work
Providers unaware
MD contractual obligation forgotten
NP/PA expectation never stated
Performance not known
No escalation
Belief that associated with high production
Not built into leader standard work
Not seen as high priority
Not identified on WIP
Scheduling defects
Variable standards
Providers unsure if ahead, on time, or behind
Must do schedule math
Providers continue in-basket work too long
No standard
Appointment length too short for work
Providers are "double booked"
Provider choice
Inadequate capacity to meet demand
AND
Providers feel pressure to do so
Clinic short of providers
Provider overpaneled
Peer pressure
Organizational pressure
Social/ customer service pressure
Agenda scope too large for time avail
Patients want multiple problems addressed
AND
Some providers do not manage to fit within time
Providers spend time on activities that non-value added activity
MAs do not have scripting for this
Providers lack skill and/or scripting
Concern re. not meeting patient expectations
Do not recognize waste
Lose situational awareness
Boundary issues – unclear role
Fatigue
Distraction
Appointment template length too short
Provider workflows not updated
Limited TIS facilitator capacity for improvement
Limited improvement involvement of provider
Providers reluctant to change to longer template
Concern for decreased access for patients in current clinic days
AND/OR
Don't want to add clinic hours/days
AND/OR
Concern for decreased production and compensation
Desire to limit scheduled work hours to maximize flexibility of work time without loss of production and compensation
TAKT exceeds process time for 3 "in flow" activities
Time losses due to distractions/ interruptions
In-basket volume excessive
Some documents take too long to fit "in flow"
AND
No distinction between short and long documents
Multiple volleys due to incomplete info
No standard
Unnecessary and/or redundant items
No process to offload
Overpanelled for contact hours/FTE
Overutilization of labs/ ancillary testing
Over-utilization
Technical limitations of dictating equipment
Inadequate Epic EMR skills
Not possible to complete work
Incomplete work not always recognized
"Incomplete encounters" triggered at 72 hours old
System programming - unchangeable
Providers do not recover from flow disruption
Work meetings during recovery periods
Expectation to attend regardless of status
Conflicting personal/ family commitments
Family and work-life balance honoring culture
No process
Makes contact hours difficult to administrate
Providers do not modify subsequent work in time
Leadership discourages schedule blocks
Escalation process not follo
No available time to adjust or rebook
Large scale disruptions – prolonged emergency, OB
Competing work demands outside of clinic (hospital)
Physical/ mental/ emotional fatigue
Key:
Countermeasure completed
Countermeasure in process
Not actionable at this point
Opportunity identified
1) Providers are overutilized so they cannot recover, they cannot recover so they are overutilized, then they get fatigued.
2) Inadequate provider capacity interacts with other causes of failure and makes sustained failure more likely.

Do - Experiments/Improvement Work Through November 2012

- Leadership
  - Expectation setting
  - Visual Management
- EMR/Technology
  - Skills Optimization
  - Dragon Mobile
- Interruptions
- EMR In-basket RIE including SW
- Agenda Setting
- Provider Workflow
  - Making visual
  - Repeat “Middle flow” work





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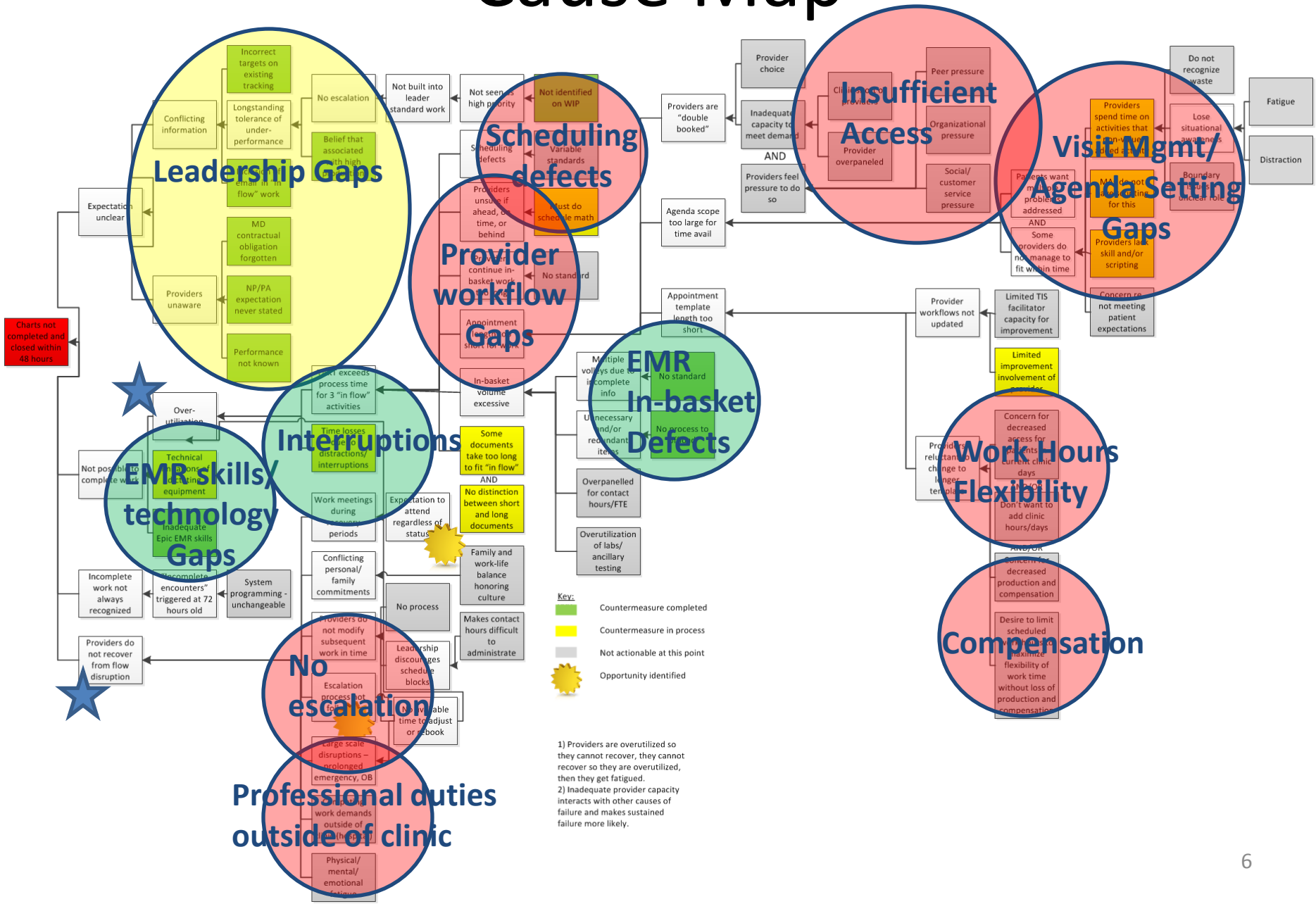
Leadership Gaps
Scheduling defects
Provider workflow Gaps
Insufficient Access
Visit Mgmt/ Agenda Setting Gaps
EMR In-basket Defects
Interruptions
EMR skills/ technology Gaps
Work Hours Flexibility
Compensation
No escalation
Professional duties outside of clinic
Incorrect targets on existing tracking
Conflicting information
Longstanding tolerance of under-performance
No escalation
Belief that associated with high
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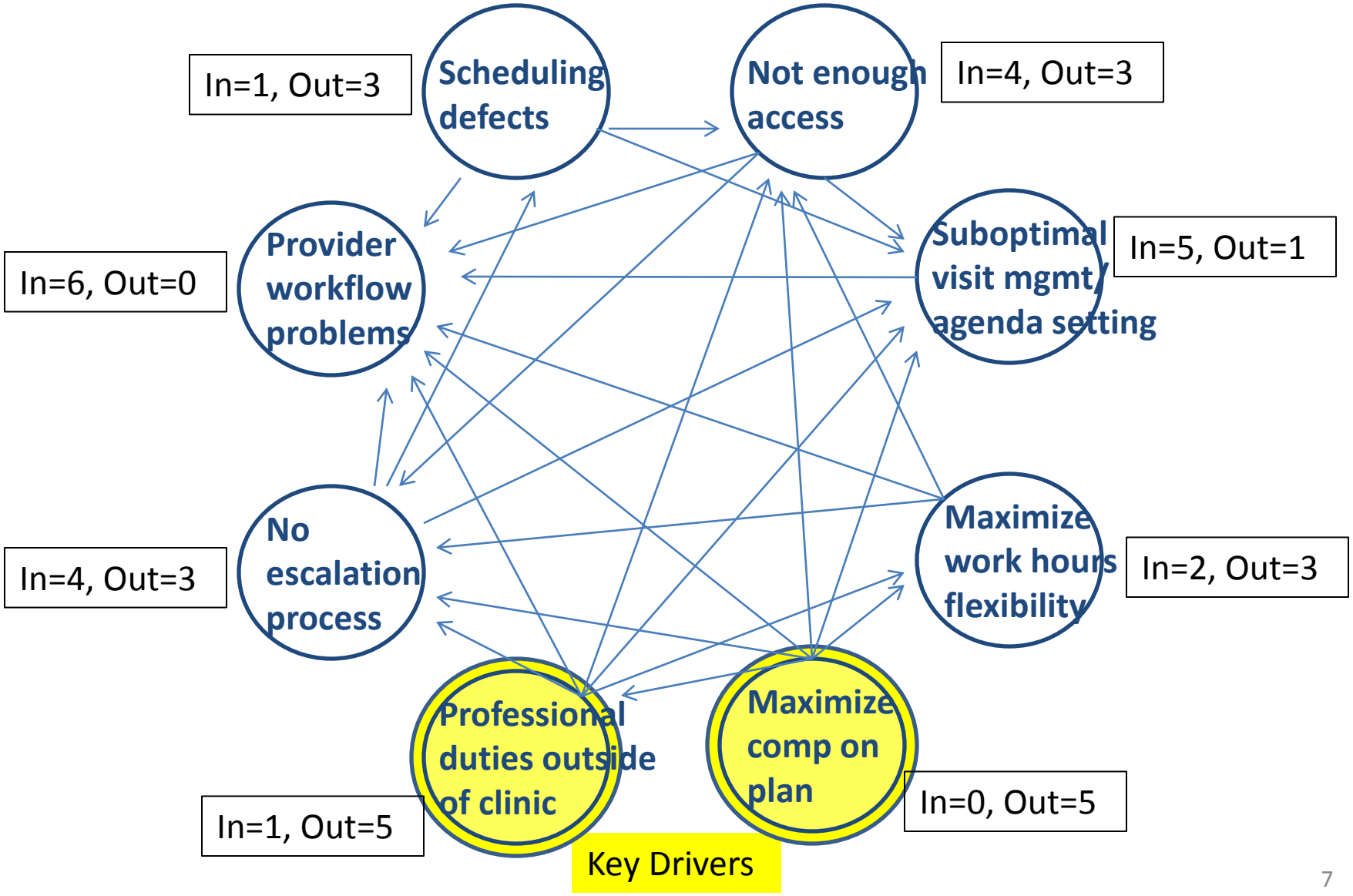
Interrelationship Digraph



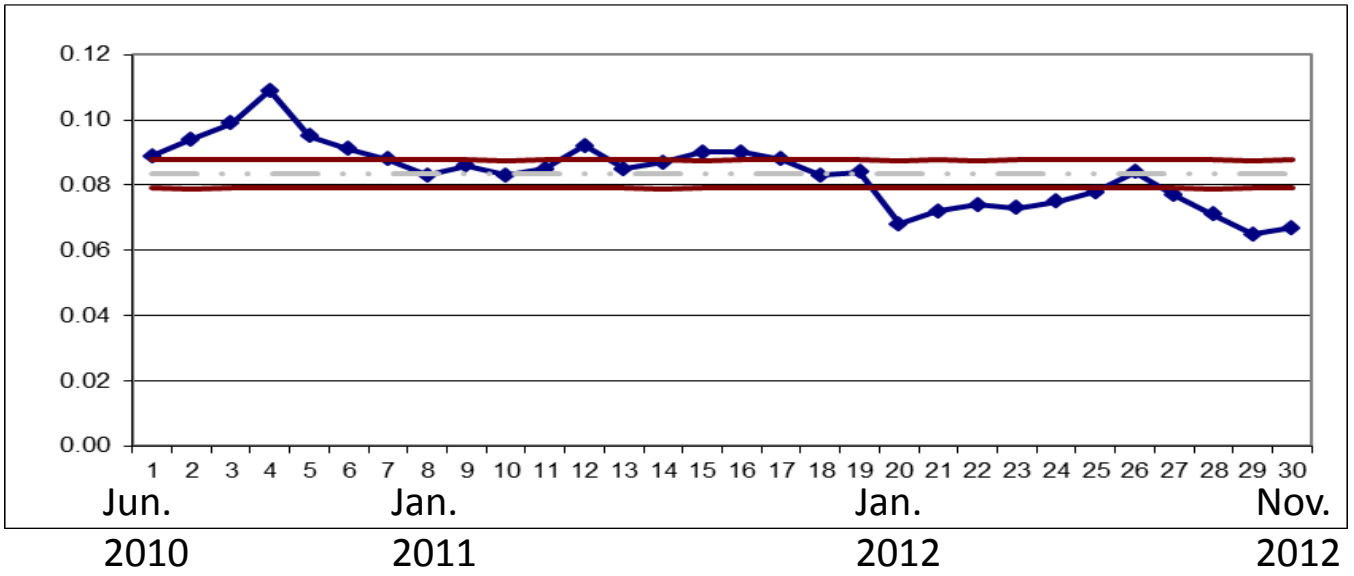
Study - Results

Goals/Targets:

- Improve providers ability to meet TAKT for encounter turnaround time

Metric	Baseline	Target	Current
% Encounters Closed in 48 hours	91.4%	96%	93.5% (+24%)
Improve % Strongly Agree/Agree scores for manageable workload and support health-wellness on provider opinion survey	56.7%, 53.9%	61%, 58.5% (10% by 2013 POS)	60.8%, 66.0%

Encounters Not Closed within 48 Hours (proportion of defects)



Study - Reflections

What worked well:

- Provider engagement
- Data easily available
- Able to cause technical changes quickly
- "Middle flow" process already existed and EMR in-basket improvement RIE was already in queue
- Adaptation of tools to make provider work and visit flows visual
- Learning approach with providers – Just Culture
- In room observations
- Leadership support for performance management
- Coaching to help "see the forest for the trees"

What did not work well:

- Provider total available time currently unavailable
- No definition for quality documentation or balanced performance at provider level
- "Middle flow" improvements solved problem, but work-style and production pressures drove reversal, and leadership (temporarily) allowed it
- Improvements significantly influenced by performance management of 4 of 8 lowest performing providers; 3 no longer with organization
- Inadequate delegation
- Scope too large given complexity of system and human factors

Key learnings:

- 100% of providers want to close their charts within 48 h
- Chart closure is a "vital sign" of each providers work system, and multiple clinic processes and human factors drive it
- Overutilization due to "overscheduling the resource" is common
- Urgency-based prioritization is constant, and closing charts always seen as less urgent than customer-facing work
- Each provider is their own value stream in current system
- Non-value added work present in the provider-patient visit
- Compensation plan is a key driver
- Division leadership has enabled this problem historically

Would do differently:

- Avoid calling this "my project"
- Seek out barriers outside clinic more directly
- Focus on 1 call group to better understand and influence culture
- Build better guiding coalition and more leadership commitment to prioritize and help drive this
- Apply systems thinking sooner; identify and study systems that contribute to the defects
- Study providers who are performing at 100% to see what factors enable that performance

Adjust

- Remapping (3rd pass) of medical group primary care VS Q1 2013
  - True demand and CTQCs
  - Staffing to demand
  - Provider overutilization and workflow
  - Escalation process
  - Information flow
  - Population management
- Compensation Plan Redesign 2013
- Leadership Standard Work
- Lean for Physicians A3