Traverse Health Clinic

# EPIC

Coach Orientation

Introduction: Our organization made a commitment to undertake the Dramatic Performance Initiative. This is an improvement methodology intended to make our clinic processes work better for patients and for our team. EPIC strives to make massive changes in overhauling work habits and create new styles of communication and processes to make our clinic more efficient, satisfying and A GREAT place to work!

## Patient Care Team (PCT) Huddle:

**Purpose:** Creates synchrony and coordination with every member of the PCT.
PCT huddles is a placeholder for team members (primarily front desk, clinician, and MA) to make last minute changes to the schedule, develop a plan, tie up any loose ends and all start at once. The 10-15 min. investment pays off throughout the day.

**Successful PCT Huddles:** occur in an exam room for privacy and accountability. This also supports the Coleman tactical element in the Team Dance (Quick Start), provider remains in the exam room after the Huddle and begins to see the first patient, whose chart has just been reviewed during the Huddle.

**Goal:** Ensure PCT is prepared for each visit, as well as the schedule as a whole. All team members MUST be present, on time, and ready to take on the challenges of the upcoming shift.
PCT Huddles are held in (morning shift, afternoon shift, evening shift). Huddle on time means getting staff out and to lunch ON TIME.

**Leader:** Anyone can lead, someone comfortable speaking up and can easily find different pages in chart and/or needed information in the EHR. The huddle leader begins stating who the first patient is with a brief description of the visit e.g. "This is Jane Doe. She is the 0815 patient. She is a 72- year-old female coming in for a diabetes follow up. She was last seen in July and is returning to discuss her labs and talk about a medication change." The front desk person may chime in, "I called yesterday to verify her insurance and confirm her appointment. She has Medicare but no longer has her supplemental insurance. When I verified her reason for the visit she also had some questions about a bunion."

**Next step:** review any notes about this appointment, i.e. if labs are back. When conducting a PCT Huddle the team must ask themselves this question about all patients: "What are they coming in for and what else can we do for them?" It's crucial that no one looks ahead or lags behind: all team members must focus on the same patient at the same time.

**After reviewing immediate needs discuss other needs:** health maintenance needs, preventative care, social situation and other social determinants of health that need to be considered to maximize visit. **Everyone contributes, NO ONE dominates.** An important rule: "One Conversation at a Time."

**Expectation: team members will continue to <u>communicate after the Huddle and throughout the shift</u> in order to provide the necessary tools for optimal patient visits.**

## QuickStart & Soft Landing

Which patient visit causes the team to start running behind? **Tardiness** is a performance issue. When the morning session runs late, staff and providers are forced to go to lunch late or skip lunch altogether. A late morning guarantees a late afternoon.

Quick Start: **A deliberate focus on the first hour of the session in which less critical visit steps may be done out of order so that the team can ensure a smooth and timely start to the clinic session.** The principle is to start all visits on time. If the first two visits of the day start on time, meaning that the provider is in the exam room with the patient at the time of the scheduled visit, then the session tends to remain on time as it has consistent momentum to carry itself through the schedule.

Soft Landing: A deliberate focus during the last hour of the session to ensure that staff finish on time and that necessary activities get accomplished.

Goal: Get the first patient to the back as soon as possible after the Team Huddle ends.

**Juggling the first few patients of the day:**

- **Complete pre-registration over the phone for at least the first patient or two of the day** Ensuring that pre-registration is done with the first two patients of the day gives staff a better chance to make QuickStart a success without holding patients up at the front desk to fill out necessary forms or to discuss insurance changes or income verification.
- **Schedule patients who will have less demanding intake steps first.** QuickStart minutes and are better handled further into the session when the MA can begin this lengthier intake once the provider has started seeing another patient.
- **Avoid putting a patient for whom diagnostic tests will be required before the visit can begin.** if the first patient of the day needs a Urine Analysis (UA) or urine pregnancy test, rapid strep test, etc. before the diagnosis or visit focusing can really begin, it is better to get the provider started with another patient and then begin these diagnostics so that when the provider enters the room, the rapid strep or UA results can be a part of the initial provider-patient dialogue.

If a team ends up with a patient who requires more time, some providers will do **synchronous visits**.

As the provider and the care team develop stronger team communication, this synchronous planning can be done with the provider and the support team as part of the 30-Second Report.

Soft Landings should also include conversations about how much time will be needed to finish tasks to ensure that the necessary documentation gets completed on time. Great SoftLandings, like great QuickStarts, are evidenced in heightened communications, awareness and time planning, and a willingness to do side tasks in a different order or have different team members complete them.

## 30-Second Report

Effective and efficient communication is vital and weak communication can lead to lost access and missed opportunities to help patients. It can also cause frustration on the part of patients who are forced to repeat their stories to multiple clinic staff, and frustration on the part of staff who complete unnecessary steps due to poor communication.

**The 30-Second Report and Midway Knock** are KEY ways to communicate and creates a space for team members to connect briefly and share patient information which can affect the flow of the day, the tests and procedures done, or even help to catch a potential missed diagnosis.

**The 30-Second Report**: brief sharing of information on between clinic support staff on the patient and the provider just prior to the provider entering exam room. **The purpose is to plan final tactics to help expedite the visit and that all of the patient's needs are met in an efficient and patient-centered. The MA starts e.g.** "You remember Ms. Smith that we talked about in the huddle, well she's ready for you in room 2 and here's what I found out…" **The provider should complete the pt. documentation for the current patient before the MA springs**

**Ideally BEFORE the 30-Second Report wraps up, the provider and MA may make a plan about when or whether to do a Midway Knock on this patient, and anything else that needs to happen to ensure a Soft Landing to the session.**

## The Midway Knock:

Saves the provider **"sneaker time"** running around the clinic looking for support staff to give orders, exchange information, or request help and support. These requests could be for the staff to give an injection, draw a specific lab, do a diagnostic (peak flow check, EKG, etc.), initiate a referral, or other clerical task (such as retrieving educational material or creating a note for work/school). The Midway Knock is a strong component of provider support and patients appreciate being the focus of attention.

**Midway Knock for a 15 min appt. is typically 6-10 minutes.** MAs typically put an ear to the door. This is not to betray privacy but to listen for things that would indicate they should NOT knock at this time. Listen for loud crying, specific exam commands, or even the stirrups moving on the exam table indicating that a gyn exam is about to start or has just finished, are indicators to come back in a couple of minutes. The MA asks "Can ***I get you anything?***" This simple question communicates value to the patient and allows the provider to request support without the provider having to leave the room or lose focus. At this time, the provider can request labs, diagnostics, or follow up visits, and this request serves as a confirmation to the care team (which includes the patient) that these are the already decided upon next steps.

If the provider has requested a second Midway Knock (sometimes this is done in anticipation of a particularly complicated or chatty patient), then sometimes the script is changed so that the support team asks, "*Ginny, can I get you anything else before I room your next patient?*" This subtle reminder is an indicator that the visit is coming to its end, but it continues to offer support to meet this patient's needs.

**Sometimes the Midway Knock happens late.** If the provider knows that there is a lot to discuss–lifestyle needs, blood sugar logs, or a tough diagnosis–sometimes the provider will ask the MA to come in just a couple of minutes before the visit concludes.

**Sometimes the midway knock does not happen.** If the clinician knows a tough diagnosis needs to be delivered, or there is a very sensitive topic to discuss (domestic abuse, drug seeking behavior, etc.

**A caveat about break time:** Oftentimes throughout the course of the clinic session, the team can anticipate when a patient will likely not have any needs that the MA will have to attend to. In these cases, this becomes the ideal time for the MA to deliver the 30-Second Report and then inform the provider of a break during this visit. Except in cases of urgent/emergent need, most teams find it is better to wait out that staff member's fifteen minutes rather than chasing down another team member for a ragged handoff with someone else who may have minimal familiarity with the patient being seen.

## Operational Metrics

Terms like No-Show Rate, Patients Per Hour, and Cycle Time should be a daily part of the team's vocabulary. Collecting data gives team members a powerful foundation of information to leverage and drive improvement; operational metrics can be used to assess the strengths and weaknesses of any PCT.

EACH metric represents a lever attached to a tactic. The more that lever moves in one direction or another, the more or less the tactics it's connected to should be utilized. If the No-Show rate for your PCT is higher than goal, perhaps the Robust Confirmation Call process may need to be ramped up. Whereas if the No-Show rate remains steadily at goal, then the Robust Confirmation Call process is producing the intended results and should continue as is.

Aside from accuracy, the data must also be timely to allows the team to identify inefficiencies clearly ***as they happen*** and correct them before they become habit. Teams should adjust their tactics from session to session to improve any metric and prevent a bad session from becoming a bad day.

**Missed Opportunity is the total number of slots on a PCT schedule where a patient should and could have been seen but wasn't for any reason.**

The reason for a Missed Opportunity Maybe the Missed Opportunity is due to a last minute cancellation or No-Show that couldn't be backfilled, because the care team was running behind and couldn't take on another patient, or the slot was never filled in the first place. Regardless the PCT was on the clock and the facility was stocked, the electricity was on, and the team was prepared to see a patient who needed care.

Missed Opportunities can be translated into money walking out the door. Considering a typical average reimbursement rate for an appointment of $120. Four Missed Opportunities occur for just one PCT and those 4 unused slots equal $480 in lost revenue–revenue that could be used to keep the doors open and further improve services.

Every Missed Opportunity is an opportunity when the clinic could have said yes to a patient and met that patient's needs, versus turning that person away because there were no appointments available. Team members should make a note as to why the Missed Opportunity occurred **A general guideline is that any more than one Missed Opportunity is at least one Missed Opportunity too many.**

**Capacity Utilization is expressed as a percentage: The difference between the patients actually seen by the PCT and the productivity goal for that PCT.** "Capacity" refers to the potential number of patients who can be seen based on the PCT's resources i.e. the staff, facility, tools, and specifically to the slot available on their schedule.

The Capacity Utilization rate of a PCT allows members to assess how well they can manage their schedule to best meet their patient panel's need. This metric should also help teams asses how well their No-Show rate reduction, **Missed Opportunity reduction, and Scrubbing and Raking tactics are working.**

## Operational Metrics: Productivity

Productivity assessed in Patients Per Hour (PPH) the numerator is linked to the duration of the session (in hours) on time and the denominator is linked to the total patients seen (kept appointments) within that session. Productivity is one of the most commonly assessed metrics in healthcare.

To calculate a care team's productivity in PPH, the team needs to tally up the total number of patients seen/completed visits during the session to attain the numerator. Identify the total hours of clinical time spent during the specified PCT session; this is the denominator (division: numerator over denominator) is the PPH for the PCT.

## Operational Metrics: Cycle Time

**Cycle Time refers to the amount of time patients spends in the office; from the time they walk in the door to the time they leave the building.**

**Not checking patients in "until it gets closer to their appointment time" is not patient-centered and a violation of DPI methodology.** When the visit status is "checked-out" is likely an accurate Cycle Time. **Calculate Cycle Time**: identify the time interval in minutes between the time each patient arrived and left the health center. Once each individual Cycle Time has been established, add them together and divide by the total visits completed during that session. The result is the average Cycle Time for the PCT.

## Operational Metrics: No-Show Rate

No-Show rate: **percentage of patients on schedule who did not attend their appointment without cancellation or rescheduling prior to the exact time of that appointment.**

**To calculate:** identify how many total appointments were booked on the schedule to begin with; this is the denominator. Best accomplished at the beginning of each session. At the end of that session, teams need to account for all the No-Shows on the schedule; this is the numerator. Once the denominator and numerator are clearly determined, follow the basic mathematical procedures to attain a result, and then convert that number into a percentage to establish the No-Show rate for that PCT.

**Metric Analysis**

Knowing a PCT's Capacity Utilization and Third Next Appt. (TNAA) can potentially tell us if that PCT is over demanded or under demanded. If a team's capacity utilization is in the mid 70s and their TNAA is less than a week, then it's likely their patient load is too low. If the alternate is true, then perhaps patient load is too high. The the team now has clear insight into how to craft a response strategy to improve access for that PCT. This may include various Moderating Demand tactics like Scrubbing and Raking, reassessing appointment intervals, or revamping how the team Jockeys the Schedule.

What insight can Productivity and Cycle Time give teams? Together, these two metrics can tell team members how efficient a PCT really is. If their productivity is high and their Cycle Times are within goal, then they are working well as a team. If their productivity is low and their Cycle Time is high, then they need to dig in a little more to figure out why. The Patient Visit Tracking Toolkit is a great resource to use in this case, as it illustrates where the bottlenecks are in a team's workflow.

**The sooner the care team reviews the data, the more likely they recall the intricacies of each visit.**

**Questions to ask:**

- Did team members double-check the Cycle Time calculations?
- Did patients show up too early or later than expected?
- Did any patients receive additional services like EKGs, vaccines, or a warm hand-off?
- Were siblings seen together in one room?
- Did the provider need to wait for the vitals to be completed? Could the order of events be changed (i.e. vitals mid-way through visit or at the end)? Furthermore, were vitals necessary for this visit? Could the team members have conducted the visit differently?

**To calculate the Cycle Time of two or more siblings/partners seen at the same time:** take the total Cycle Time and divide it by how many patients were seen within that time. Since multiple billable visits were generated within that time frame, splitting the time ensures the team assesses Cycle Time the same way across the board.

**If team members take these lessons into consideration as they collect data and work diligently to analyze it, they will be on their way to improved patient care.**