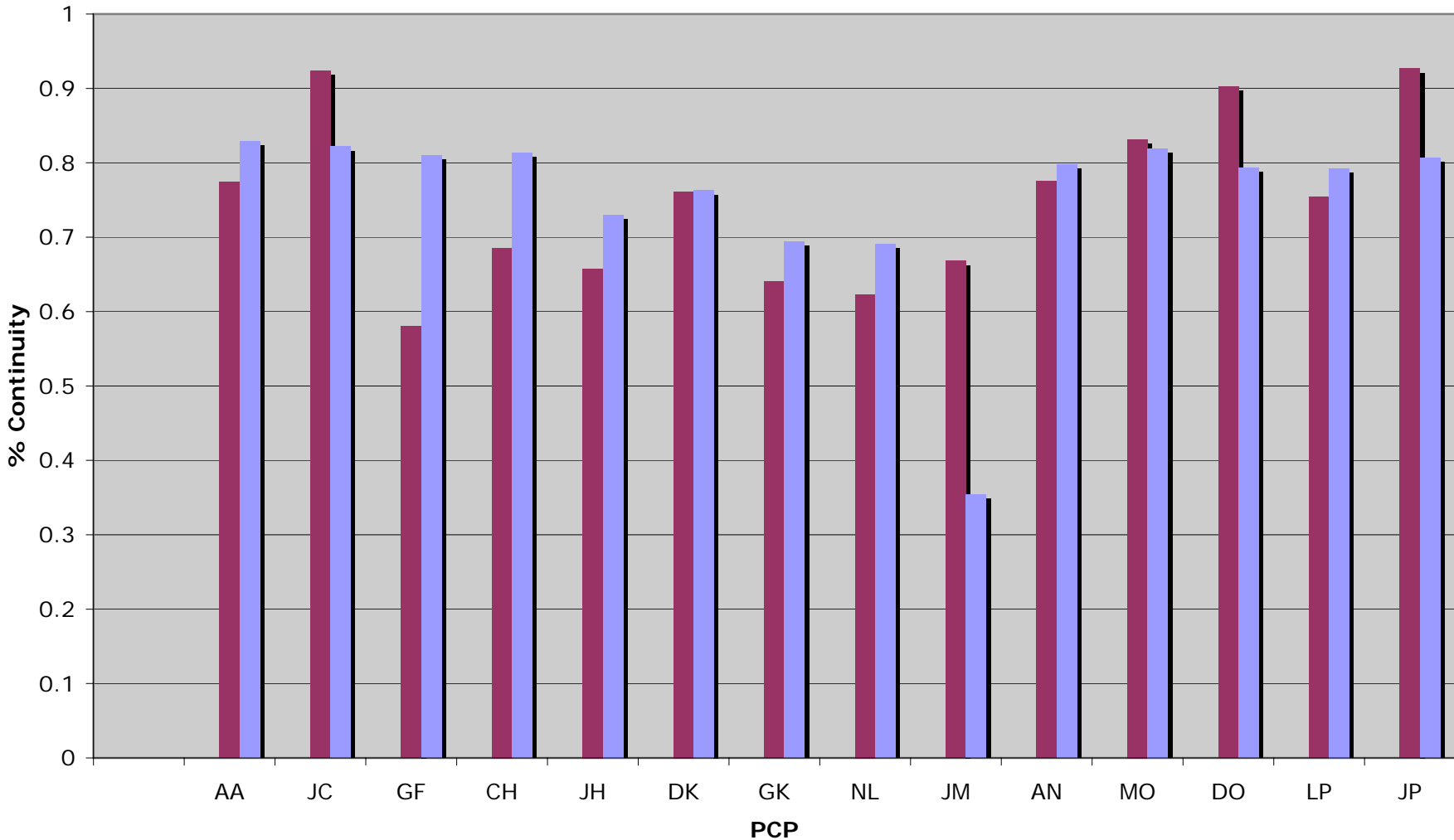
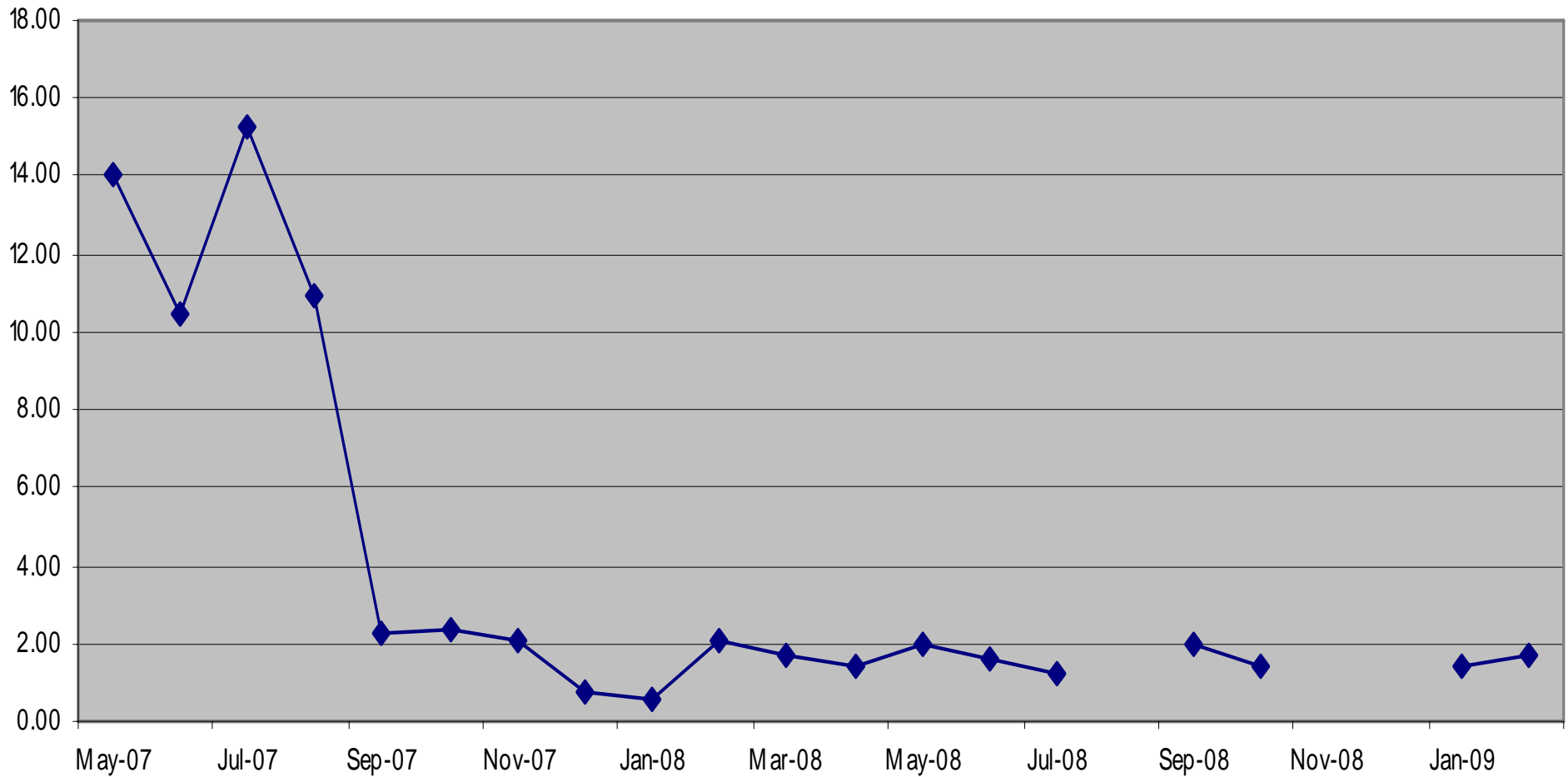


PHC - Continuity 9/08 - 3/09

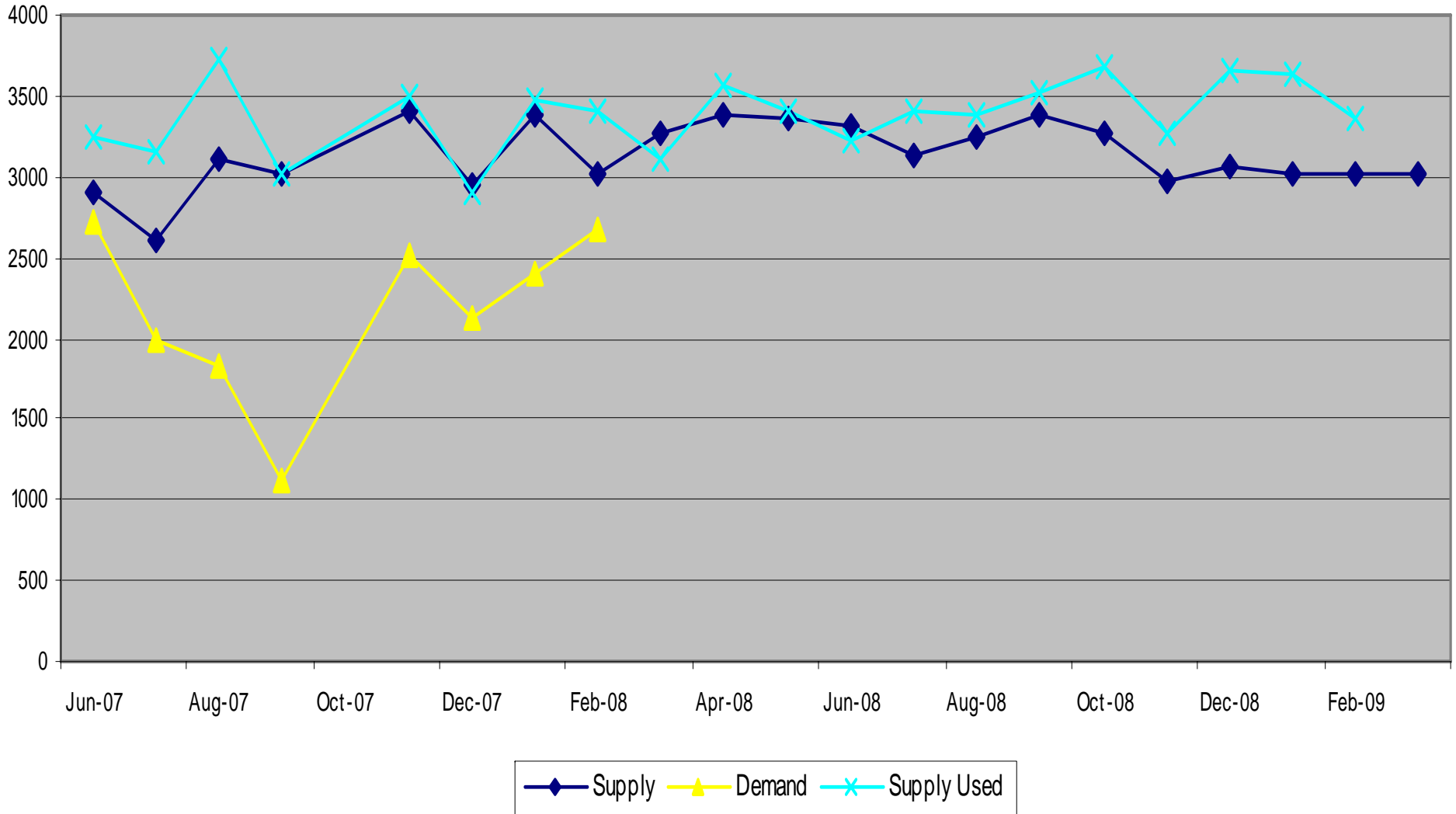


■ Percent of provider's encounters with panel ■ Percent of encounters by panel with their PCP

Results (Measures) – Delay



Results (Measures) – Supply & Demand





John Pendleton, MD
Family Medicine
Associate Medical Director
5/8/2009

Increasing Capacity Supply and Demand in Primary Care

Petaluma Health Center

- 15 Family Medicine providers serving 14, 000 patients at FQHC site.
- 4 OB providers
- 0.5 FTE Psychiatrist, 1 psychologist, 3 LCSW
- 1 nutritionist

Best Ideas:

Optimizing Primary Care Initiative 2007 - 2009

1. Develop accurate panel sizes based on true provider supply
2. Enforce continuity and care of own panels. Increase phone followup by trained MA's rather than appts.
3. Study demand trends in previous years and increase or decrease supply accordingly
4. Cross train MA's to help in front office when needed
5. Those MA's doing non-appointment work made more available to flex to help busy providers on busy days
6. Increase on-floor MA presence to 4 MA's to 3 Providers. Allows extra MA to help the busiest providers.
7. Increase Group visits for high utilizing patients
8. Make all appointment lengths the same to avoid delays in access and minimize the impact of no-shows.
9. Evaluate high utilizing patients and identified common issues that create high use. Use of IBH, diabetic educators, group visits to better meet the needs rather than using "doctor time"
10. Prevent the "complicated hour-long visits" by use of IBH, diabetic educators at the time of visit.

How:

1. OPC team with members from each department, weekly hour long meetings, and whole team attendance at Quarterly 2 day meetings for one year. Team members could more easily spread the change.
2. Used data to understand supply and demand
3. Senior leaders given 4-12 hours admin time weekly now for 2 years to continue process.
4. Engaged providers and staff primarily through data and "unwavering confidence" in solid, thought out plan that had respected members of other departments involved.
5. Convinced senior leaders that these processes eliminate waste and re-work, and identify problems ahead of time in order to save money. Improves staff and patient satisfaction and improves outcomes.

Outcomes:

1. Continuity data improved
 2. Visits per patient per year slowly decreasing
 3. No show rates decreasing
 4. Cycle time decreased to 40 minutes
 5. Staff and patient satisfaction scores have improved.
-
6. As visits per patient per year decrease, panel size increases and access to new patients increases. But only through the changes performed above did we get the provider and staff buy-in and create a system that allows the visits per patient per year to decrease.



John Pendleton, MD
Family Medicine
Associate Medical Director
Petaluma Health Center
5/8/2009

The Benefits of Provider Panels

Petaluma Health Center

- 15 Family Medicine providers serving 14, 000 patients at FOHC site.
- 4 OB providers
- 0.5 FTE Psychiatrist, 1 psychologist, 3 LCSW
- 1 nutritionist

Best Ideas:

Joined the Optimizing Primary Care Initiative 2007 – 2009

1. Establish and maintain accurate panel sizes.
2. Developed accurate panel sizes based on provider supply and goal of 12 visits per 4 hour clinic
3. Analyzed data and developed plan of 2.8 visits per year for FNP/PA's and 4.4 visits per year for MD's.
4. Goal of decreasing MD visits per patient per year through panel management:
 - Increase phone follow-up by trained MA's rather than appts.
 - Increased Group visits for high utilizing patients
 - Made all appointment lengths the same to avoid delays in access.
 - Evaluated high utilizing patients and identified common issues that create high use. Use of IBH, diabetic educators, group visits to better meet the needs rather than using "doctor time"

How:

1. OPC team with members from each department, weekly hour long meetings, and whole team attendance at Quarterly 2 day meetings for one year. Team members could more easily spread the change.
2. Used data to analyze visits per patient per year for each provider.

3. Senior leaders given 4-12 hours admin time weekly now for 2 years to continue process.
4. Engaged providers and staff primarily through unwavering confidence in solid, thought out plan that had input from respected members of other departments.
5. Providers WANT continuity. That's why they went into Family Medicine. But continuity requires providers to own their panel and work harder when the panel dictates. Give providers extra support when their panel is extra active.
6. Convinced senior leaders that these processes eliminated waste, re-work, and identifies problems ahead of time in order to save money. Improves staff and patient satisfaction and improves outcomes.

Outcomes:

1. Nearly 2 years with stable panels and continuity averaging 80%.
2. No show rates decreasing now to 15% from 25%
3. Visits per patient per year slowly decreasing as providers get a handle on their high utilizing patients
4. Cycle time decreasing. Less time spent "getting to know" the patient.
5. Staff and patient satisfaction scores have improved.
6. Accurate panel sizes form the basis for fair distribution of work and more accountability from providers.
7. Study of visits per patient per year by provider provides great insight into providers work habits, patient behaviors, and areas for improvement.
8. A transparent panel size improves provider faith in their workload and decreases the stress of busy days or weeks and decreases the "it is just getting busier and busier here" anxiety.
9. With panels sizes, providers feel empowered to manage their panel and to work to improve health of their patients by looking for systems to improve care
10. Opportunity to use other resources to decrease activity of some patients and indicates who is not coming in to be see enough.
11. As visits per patient per year decrease, panel size increases and access to new patients increases. But only through the changes performed above did we get the provider and staff buy-in and create a system that allows the visits per patient per year to decrease.

Demand moderation ideas

Comb schedule to eliminate unnecessary visits

Duplicate visits

Follow up visits that are sooner than needed

Follow up visit that require lab, x-ray, or specialty consultation results that are scheduled before the results are back

Other ideas?

Delegate clinician visits to other team members

Follow-up visits for HBP or diabetes or cholesterol to RN or health coach

Follow-up visits for asthma to MA trained in educating patients on how to use inhalers and spacers

Visits for forms, referrals, lab results to RN

Clinicians can be available to consult for 1-2 minutes at these visits

Increase intervals between visits if medically appropriate

Many follow-up visits are scheduled sooner than needed; try to increase the interval. That one tactic can hugely open up capacity

Schedule phone or e-visits for follow-up if appropriate

A lot of what we do face-to-face can be done by phone or email with appropriate patients

Policies toward patients who come late

This isn't strictly demand moderation, but patients who come late are a major source of frustration and chaos in primary care. Decide on a policy (we will not see them at all or we will see them only at the end of the session) that tries to change patient behavior

For patients who are chronically late, make a policy and stick to it

Policies toward patients who no show

Patients with more than 2-3 no shows should not be given appointments except same day appointments.

Consider group visits or mini-group visits

Group visits don't moderate demand; they increase capacity. Larger group visits are quite challenging to implement, and if there are a fair number of no-shows, the

admin work needed to plan then is excessive. Mini-group visits means seeing 2 or 3 patients at the same time; for example, 3 Spanish-speaking patients with diabetes. If you have 20 minutes slots, see 3 patients for 40 minutes; one slot is saved. If the patients are chosen well, they love the mini-group visits and often want to continue to get their care with the other patients on a regular basis.

Confirmation calls

Well-executed confirmation calls that find out that a patient is planning to no-show is not strictly demand moderation, but increases capacity if another patient can be placed in that slot. Calls can also reduce demand by finding out, for example, if the patient has done the lab or x-ray or specialty referrals that are needed for the visit, and to reschedule the visit if these have not been done.

Make continuity a priority

If patients see a clinician who is not their PCP, they often are given another appointment soon to see their PCP. Continuity of care reduces demand.

Panel management

Many preventive and chronic services can be performed by a panel manager, who could be a RN, MEA, health worker, or reliable volunteer. The panel manager can comb the registry, contact patients who need preventive or chronic care routine services, and arrange for those services to be done. A follow-up method for looking at the results is needed. This can eliminate work from the clinician visit, allowing the visit to focus on the patient's agenda which could shorten the visit, or it can eliminate clinician visits altogether. If the panel manager is a RN, she could intensify meds by phone or with an RN visit using physician-approved protocols. This both saves a clinician visit and improves care by intensifying meds more rapidly.



**SAN FRANCISCO
HEALTH PLAN**

201 Third Street, 7th Floor
San Francisco, CA 94103
www.sfhp.org



David Lown
San Francisco Community Clinic Consortium

SFCCC Idea Summary – Network Wide Discussion of Productivity/Access

WHO

- SFCCC represents and advocates for 10 independent Community Clinics and Health Centers in San Francisco with 16 individual sites including one mobile medical van.
- The SFCCC partnership (SFCCC with its partner clinics) provides full scope primary care services to over 72,000 San Franciscans each year (a little more than half of the estimated 130,00 patients served by the Safety Net) during over 315,000 encounters. (includes 236,000 encounters with roughly 50 MDs & 25 Mid-Levels). Together we work toward a future in which all people have access to quality, community-based health care provided in a culturally, linguistically and population-sensitive manner.
- SFCCC partner clinics are Medical Home to almost half of all Healthy San Francisco enrollees.
- We are the primary grantee for the San Francisco Health Care for the Homeless Program (encompassing a partnership between SFCCC partner clinics and the SFDPH Primary Care Clinics), one of the largest federal HCH programs in the country.
 - The Street Outreach Services (SOS) Van provides homeless clients with linkage to primary care as well as needed preventive and urgent health care services.
 - Our VET SOS program offers care to homeless animals, as a way to reach out to homeless San Franciscans.
- SFCCC is also the Ryan White Part C (Early Intervention Services) grantee for San Francisco. Patients receive comprehensive HIV medical, counseling, and referral services within their culturally appropriate community at 5 of SFCCC clinics and 2 DPH clinics.
- Since 1995, San Francisco Community Clinic Consortium has been the host site for the San Francisco Community HealthCorps (health-focused Americorps program) availing the clinics of 24 AmeriCorps and 5 VISA Volunteers each year.
- Funding: 8 of our clinics are Federally Qualified Health Centers & two are Free Clinics that do not take government funding. The 8 FOHCs also receive funding from a mix of the above mentioned federal funds, various state funding sources, some city funds (for HSF enrollment) as well as other grants and private sources.

WHAT

- SFCCC partner clinics represent a wide range of populations of focus and cultural environments as well as a staffing ratios and funding sources. Our clinics must answer to a variety of funding sources, each with its own particular requirements for services provided, patients seen and reimbursement patterns. This creates a very complex system in which clinics must balance their own economic survival, the various funder requirements and the ever growing demand for client services that is independent of payor source.

HOW

- In an effort to bring clarity & understanding of these issues to our network, as well as add to the discussion of city wide Safety Net capacity, we have initiated a comprehensive discussion, beginning with the SFCCC Medical Directors, on the following topics:
 - Productivity
 - Panel Size
 - Efficiency
 - Access
- Our plan is to consolidate national, state & local data on these topics with the data reported in our discussions, actions taken by individual clinics to address these topics, and general points of agreement among the Med Directors. From this we will develop recommendations for network wide targets and approaches to the above topics which we will take to the SFCCC Board of Directors for review and approval.

RESOURCES AND TOOLS

- 2007 UDS Roll up data (Uniformed Data Set – annual required reporting for FQHCs on clinical and operational data):
 - National - <ftp://ftp.hrsa.gov/bphc/pdf/uds/2007nationaluds.pdf> - see page 34
 - California - ftp://ftp.hrsa.gov/bphc/pdf/uds/2007/07Rollup_StateCA_08Jul2008.pdf - see page 26
- Productivity, Panel Size, Efficiency & Access question grid – see attached

Contact info:

David Lown, MD
Medical Director
San Francisco Community Clinic Consortium
1550 Bryant Street, Suite 450
San Francisco, CA 94103
dlownd@sfccc.org
(415) 355-2238 ph.
(415) 865-9960 fx.

This grid is designed to help facilitate a discussion among SFCCC Medical Directors about access, productivity, panel size, and efficiency. The topic will be discussed in the March Medical Directors meeting. The questions require no written response.

Access			
<i>Does your clinic track access indicators (i.e., wait times for new appts., waiting lists, open/closed status for HSF)?</i>	<i>Does your clinic have a plan to increase access?</i>	<i>Where do discussions about access occur (i.e., staff meetings, leadership meetings, etc)?</i>	<i>Are discussions about access ad-hoc or ongoing?</i>

Productivity						
<i>Does your clinic measure provider productivity (i.e. visits per hour, per week, per year, etc.)?</i>	<i>What measurement does your clinic use?</i>	<i>If productivity is measured, are the measured #s generally agreed to be accurate and meaningful?</i>	<i>How are productivity numbers used?</i>	<i>Where do discussions about productivity occur?</i>	<i>What is the nature of those discussions (i.e., goals, expected outcomes, etc.)?</i>	<i>Does your clinic have a goal or standard or benchmark for productivity?</i>

Panel Size							
<i>Does your clinic measure panel size for the clinic and per provider?</i>	<i>What measurement does your clinic use? How are panels and provider FTEs calculated?</i>	<i>If panel size is measured, are the measured #s agreed to be accurate and meaningful?</i>	<i>How are the panel size numbers used?</i>	<i>Where do discussions about panel size occur? What is the nature of those discussions?</i>	<i>Does your clinic have a goal or standard or benchmark for panel size?</i>	<i>Does your clinic measure average visits per patient per year?</i>	<i>Are panel size measurements weighted by any kind of acuity/complexity factors? If so, how?</i>

Efficiency				
<i>Does your clinic track efficiency indicators (i.e., transit time, no-show rate, support staff/provider ratios, etc.)?</i>	<i>What efficiency indicators does your clinic use?</i>	<i>Does your clinic have some sort of plan to increase efficiency or to "restructure"?</i>	<i>Where do discussions about efficiency occur?</i>	<i>Does your clinic have a form of "open access" scheduling?</i>

SLIM Network: Sharing Better Ideas

Albert Yu, MD, MPH, MBA
Director, SFDPH Chinatown Public Health Center
Clinical Professor, UCSF Department of Family & Community Medicine
(415) 364-7909 or Albert.Yu@ucsf.edu

EXPANDING CAPACITY: MANAGING SUPPLY AND DEMAND

Chinatown Public Health Center

- Part of the SF Community Health Network, has been serving Chinese immigrants, “vulnerable” residents and those with limited English proficiency since 1929.
- Our TEAM – MD (2.45 clinical FTE), NP (2.55), RN (4.0), MEA (3.0), HW (2.8), EW (4.5), clerk (1.0), med record (1.0), nutritionist (1.0), health ed (0.9), MSW (1.0), psychiatrist (0.2), DDS (1.1), dental aide (1.8), podiatrist (0.1), PharmD (0.2)
- Services – in addition to primary care: public health nutrition, medical nutrition therapy, community health education and outreach, pediatric dentistry and audiology, podiatry, dementia screening and assessment by UCSF Memory Center, Eye Van, Disability & Autism clinic for children, WIC, refugee-asylee-newcomer’s program and mental/behavioral health
- Clients – 84% speak Chinese, 65% female, all age groups, insurance (HSF 27%, Medi-Cal FFS & Cap 32%, CHN Capitated 29%, Medicare 5%, uninsured 6%)
- Productivity and utilization – active patient panel (about 5K), average panel per clinical FTE (MD: 1,380, NP: 1,120), annual PC medical visits (13K) & all visits (22K), average visits per hour (MD: 2.5, NP: 1.9), average no show rate: 10% and daily capacity 89%

Demand Moderation and Supply Enhancement Change Strategies

- 1) Pilot SMART Clinic (Same-day Medical Attention Response Team) – daily afternoon clinics staffed by designated teamlet (PCP/RN/MEA) and designed to: a) address the needs of patients who need “timely” medical attention with or without an appt, b) facilitate panel management and communication within teamlet, and c) promote MEA identification of “overdue” clinical preventive services for next-day patients.
- 2) Initiate brief RN visits for BP check and/or panel management related actions as part of the SMART pilot.
- 3) Pilot brief focused-intervention telephone visits between PCP and pre-scheduled pts.
- 4) Implement Orientation Clinic – a 2-hour introductory visit with a RN and a MSW in a group setting, designed for new Cantonese-speaking pts as a way to: a) introduce them to services available at CPHC and SFGH, b) review medication labels and refill procedures, c) highlight insurance coverage, d) explore the benefits of a “proactive” visit, and e) complete standing orders for recommended clinical preventive services and laboratory studies before the initial visit with PCP.
- 5) Offer group medical visits for patients with diabetes and/or coronary heart disease
 - a) POGMA (Planned One-stop Group Medical Access) – a planned monthly multidisciplinary clinic staffed by a MD, PharmD, RN, MEA and MSW, designed to provide ALL evidence-based services in one 3-hour visit to pts at high-risk for developing complications or for not adhering to recommended treatments
 - b) ABCD (A1C, BP, Cholesterol, Do Not Smoke) is a planned monthly clinic staffed by MD and health educator, designed to: a) educate pts about the harm from tobacco use, b) help pts set action plans to stop smoking, c) review ABC treatment goals and actual test values and d) reconcile and adjust medications to ensure attendees are taking Aspirin, Statin and ACEI/ARB .
- 6) Expand nursing roles through training and mentoring to:
 - a) Motivate pts through coaching and setting action plans (RN, MEA, HW, PCP)
 - b) Identify “due” recommended clinical preventive services using standing orders (MEA)
 - c) Complete diabetes-related medication reconciliation and limited adjustment based on decision-support algorithms (RN)
- 7) Ensure diabetic pts get necessary blood tests before medical appointment with PCP.
- 8) Make continuity a priority
 - a) Clean up the PCP designation field in EHR (LCR) by matching pt visit pattern to PCP assignment
 - b) Schedule pts with their own PCP whenever possible
 - c) Combine several part-time clinician positions into one full-time family physician hire

- 9) Enhance office flow through deliberate design
 - a) Bring all services to pts (in-room intake, PCP visit and discharge)
 - b) Conduct pre-clinic huddles to ensure clinic starts on time
 - c) Introduce teamlet patient care teams to include 2 PCPS , 1 RN and 1 MEA/HW
 - d) Standardize supplies and referral forms in each exam room
 - e) Redesign a central space for team huddles, chart preparation, pt orders and easy surveying of clinic flow
- 10) Engage clinicians to rethink appt intervals
- 11) Enforce late arrival and frequent no-show policies

Change Process

- 1) Participated in the Kaiser-CHN PHASE (Preventing Heart Attack & Stroke Everyone) initiative
 - a) Received training on health coaching, panel and medication management
 - b) Created a disease registry and performance dashboard that staff review regularly
 - c) Created many point-of-care enabling tools (progress notes, standing orders, pt education materials, etc.)
 - d) Shared ideas with and learned from change leaders within CHN
 - e) Held monthly CPHC Phase team meetings to include: MD, RN, MEA, PSA and nurse manager
 - f) Assigned panel management teamlets (PCP/RN/MEA)
 - g) Delineated and expanded non-PCP staff roles and responsibilities
- 2) Participated in the PCDC-Changing The Way We Care Redesign initiative
 - a) Convened a change team that meets 2-hrs weekly (MD, NP, RN, HW, principal clerk & nurse manager)
 - b) Shared ideas and learned from other change team leaders from other CHN clinics
 - c) Participated in Webinar and periodic learning sessions
 - d) Engaged entire staff in the change process
 - e) Applied PDSA rapid improvement cycle principles and tools to test change ideas
 - f) Received feedback and coaching from PCDC and UCSF consultants
- 3) Critical factors that promote buy-in, spread test strategies and sustain momentum
 - a) Articulate clear and coherent clinic goals and staff expectations
 - b) Eliminate inefficiency in a transparent and meaningful way (remove something before adding new tasks)
 - c) Communicate succinctly and regularly about planned actions, highlighting especially the potential benefits from change strategies to staff and patients
 - d) Create enabling tools to facilitate work – IT, forms, physical space and etc.
 - e) Empower staff to speak willingly and problem-solve actively
 - f) Develop internal change champions to serve as liaison to other unit staff
 - g) Listen and appreciate staff's insights and perspectives
 - h) Understand existing data capability and leverage them fully to design and evaluate change tactics
 - i) Appreciate variable computer/technology fluency among staff; and that adoption is slow and requires experiential learning and often coaching
 - j) Be prepared to deal with resistance and don't take "no" for an answer

OUTCOMES

- Myriad new models to care for pts (new or PHASE) are sustained with positive feedback from staff and pts
- New patient appointments are consistently within 2 weeks – moderate Orientation Clinic to meet demand
 - Average panel size growth since July 2008 (MD: 1,260 to 1,380 and NP: 1,090 to 1,120)
- Clinic flow enhancement tactics are now fully spread and part of standard clinic operation
 - 75% of visits are now under Cycle Time (CT) goal of 60 minutes
 - Average visit CT are now near goal of 60 minutes (baseline: 84 minutes)
 - Patient visit stops dropped from an average of 9.4 per visit to about 3-4 stops per visit
- Patients without PCP assignment – over 25% in August 2007 to less than 5% in April 2009

SLIM Network: Sharing Better Ideas

Albert Yu, MD, MPH, MBA
Director, SFDPH Chinatown Public Health Center
Clinical Professor, UCSF Department of Family & Community Medicine
(415) 364-7909 or Albert.Yu@ucsf.edu

Establishing “Right Size” Provider Panels to Optimize Continuity of Care

Chinatown Public Health Center

- Part of the SF Community Health Network, has been serving Chinese immigrants, “vulnerable” residents and those with limited English proficiency since 1929.
- Our TEAM – MD (2.45 clinical FTE), NP (2.55), RN (4.0), MEA (3.0), HW (2.8), EW (4.5), clerk (1.0), med record (1.0), nutritionist (1.0), health ed (0.9), MSW (1.0), psychiatrist (0.2), DDS (1.1), dental aide (1.8), podiatrist (0.1), PharmD (0.2)
- Services – in addition to primary care: public health nutrition, medical nutrition therapy, community health education and outreach, pediatric dentistry and audiology, podiatry, dementia screening and assessment by UCSF Memory Center, Eye Van, Disability & Autism clinic for children, WIC, refugee-asylee-newcomer’s program and mental/behavioral health
- Clients – 84% speak Chinese, 65% female, all age groups, insurance (HSF 27%, Medi-Cal FFS & Cap 32%, CHN Capitated 29%, Medicare 5%, uninsured 6%)
- Productivity and utilization – active patient panel (about 5K), average panel per clinical FTE (MD: 1,380, NP: 1,120), annual PC medical visits (13K) & all visits (22K), average visits per hour (MD: 2.5, NP: 1.9), average no show rate: 10% and daily capacity 89%

Strategies to Optimize Continuity of Care

- 1) Clean up the “PCP” field in electronic health record by matching patient (pt) visits pattern to PCP assignment
- 2) Produce monthly panel size reports for PCPs and use the data to inform decisions about panel closure
- 3) Engage system-wide discussions around panel size standards and calculation methodology
- 4) Schedule pts with their own PCP whenever possible
- 5) Combine several part-time clinician positions into one full-time family physician hire
- 6) Cut appointment (appt) types from over 15 to 5 (new, return, urgent, gyn and procedure) and combine “return” option with all other appts to optimize daily capacity and to promote scheduling with assigned PCP
- 7) Educate new Cantonese-speaking pts, during Orientation Clinics, about the meaning of “primary care provider” and the benefits of “care continuity”
- 8) Create teamlets (PCP/RN/MEA) to facilitate panel management and planned visits
- 9) Pilot brief focused-intervention telephone visits between PCP and assigned pts who do not need face-to-face encounters but who do need correspondence before typical 3-6 months follow-up intervals
- 10) Pilot SMART Clinic (Same-day Medical Attention Response Team) – daily afternoon clinics staffed by designated teamlet (PCP/RN/MEA) and designed to: a) address the needs of patients who need “timely” medical attention with or without an appt, b) facilitate panel management and communication within teamlet, and c) promote MEA identification of “overdue” clinical preventive services for next-day patients
- 11) Introduce group medical visits to patient with DM and/or CHD at high risk for complications
- 12) Match knowledge and skills to task requirements in order to increase PCP productivity
 - a) Pilot brief RN visits for BP check and/or planned activities to reduce the need to see PCP
 - b) Train MEA/HW/RN to motivate pts through coaching and setting action plans
 - c) Train MEA to identify “due” recommended clinical preventive services using standing orders
 - d) Train RN to complete diabetes-related medication reconciliation and limited adjustment based on decision-support algorithms
- 13) Engage clinicians to rethink appt intervals to create capacity for manage assigned panel of pts

Change Process

- 1) Participated in the Kaiser-CHN PHASE (Preventing Heart Attack & Stoke Everyone) initiative
 - a) Received training on health coaching, panel and medication management
 - b) Created a disease registry to support planning for group medical visits

- c) Shared ideas with and learned from change leaders within CHN
- d) Assigned panel management teamlets (PCP/RN/MEA)
- e) Delineated and expanded non-PCP staff roles and responsibilities
- 2) Participated in the PCDC-Changing The Way We Care Redesign initiative
 - a) Engaged entire staff in the change process
 - b) Applied PDSA rapid improvement cycle principles and tools to test change ideas
 - c) Tested capacity enhancement and demand moderation strategies
- 3) Persisted in pushing system-wide discussions around “right sizing” panels
- 4) Critical factors that promote buy-in, spread test strategies and sustain momentum
 - a) Hire a full-time family physician eliminated “provider” hopping among pts who had no identified PCP
 - b) Recognize that everyone, especially front desk and PCPs, wants continuity
 - c) Coach front desk staff to verify PCP assignment in EHR before scheduling appts
 - d) Create a culture and supportive environment where staff can speak freely, share their insights, problem-solve, think team and feel appreciated
 - e) Engage staff in regular PDSA rapid cycle improvement activities during weekly clinic meetings
 - f) Articulate clear and coherent clinic goals and staff expectations
 - g) Eliminate inefficiency in a transparent and meaningful way (remove something before adding new tasks)
 - h) Communicate succinctly and regularly about planned actions, highlighting especially the potential benefits from change strategies to staff and patients
 - i) Develop internal change champions to serve as liaison to other unit staff
 - j) Be prepared to deal with resistance and don’t take “no” for an answer

OUTCOMES

- New patient appointments are consistently within 2 weeks – moderate Orientation Clinic to meet demand
 - Average panel size growth since July 2008 (MD: 1,260 to 1,380 and NP: 1,090 to 1,120)
- Clinic flow enhancement tactics are now fully spread and part of standard clinic operation
 - 75% of visits are now under Cycle Time (CT) goal of 60 minutes
 - Average visit CT are now near goal of 60 minutes (baseline: 84 minutes)
 - No show rate is sustained at 10%
 - Daily capacity is sustained at about 90%
- Patients without PCP assignment – dropped from over 25% (August 2007) to less than 5% (April 2009)
- Myriad new models to care for pts (new or PHASE) are sustained with positive feedback from staff and pts