

Strategies to Improve Provider Productivity Post Electronic Health Record (EHR)

September 2016

Important Content Note:

This technical assistance resource was developed prior to the August 2017 release of the Health Center Compliance Manual by the Health Resources and Services Administration's (HRSA) Bureau of Primary Health Care (BPHC). The BPHC Compliance Manual, issued August 2017, indicates where PINS, PALs and other program guidance are now superseded or subsumed by the BPHC Compliance Manual.

See:

<https://bphc.hrsa.gov/programrequirements/pdf/healthcentercompliancemanual.pdf>



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ACKNOWLEDGEMENT

The National Association of Community Health Centers (NACHC) promotes the provision of high quality, comprehensive health care that is accessible, coordinated, culturally and linguistically competent, and community-directed for all underserved populations.

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DISCLAIMER

This project was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant U30CS16089, "Technical Assistance to Community and Migrant Health Centers and Homeless." (Total grant award is \$6,375,000.00. Zero percent of this project was financed with non-governmental resources.) This information or content and conclusions are those of the author(s) and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.



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Introduction

Maintaining a reputation of providing high quality care, solid staff satisfaction, consistency of compliance and reporting, and a positive patient experience are all highly valued markers for organizations that receive grants under the Health Center Program as authorized under section 330 of the Public Health Service Act, as amended. Meanwhile, meeting provider productivity goals are a burden that continues to challenge both providers and many health center administrators. Hitting productivity goals in a fee-for-service environment provides the assurance that these goals can be met. However, the introduction of the Electronic Health Record (EHR) has added a new wrinkle in the productivity equation which can adversely impact provider productivity if the technology and practice workflows are not fully optimized.

There is conversation around whether the productivity dip that many practices experience post-EHR implementation is a forecast of the future, a self-fulfilling prophecy or a learning curve of temporary effect. According to one health center provider (Daren Wu, MD CMO of Open Door Family Medical Center), providers are *“being asked to be expert documentation automatons and coders to populate registries and databanks. Further, in being influenced to invest for a future of value-based reimbursement, too little is being done to help practices invest in the costly technology and team-based concepts that currently are not paid for.”*

Setting that factor aside, there are increasing pressures on the system, providers and health centers that will be examined and addressed in this issue brief. Distilled down, there are many factors that contribute to post-EHR provider productivity loss. This brief will specifically focus on the technology and operational enhancement and optimization strategies to regain those productivity losses.

What is Provider Productivity?

To responsibly address current provider productivity breakdowns, we must first challenge the notion of provider productivity. Currently even the language of “provider productivity” goes against a strict interpretation of the concept of team-based care. In a team-based care environment, the team takes collective ownership of the team productivity, thus moving productivity to a team and organizational concern as opposed to a provider specific one. In many organizations, providers may work in a less than ideal team environment because of limitations on exam room space, limited support staff and/or tools. These providers then struggle to attain needed billable visits. It is through these observations that we must acknowledge that the team-based care concept and medical home model is still in need of further evolution.

Defining provider productivity is a challenge because of the inability to consistently quantify both the numerators and denominators of the equation. Whether the calculation is based on patients per day, per session or per hour, both number of patients “seen” and unit of time required to “see” those patients is difficult to quantify. A typical provider productivity calculation follows one of the following two formulas:

$$\begin{array}{ccc} \text{\# of visits completed} & \text{or} & \text{\# of visits completed} \\ \text{hours worked} & & \text{session} \\ = 11 / 3.75 \text{ hours or } 2.9 \text{ patients/hour} & & = 11 \text{ patients/session} \end{array}$$

The Productivity Numerator

Each contact with the patient about his/her results, etc. is counted and therefore must be documented.¹ The conversion from paper to electronic charting and the remote ways in which patients reach their doctor have added unique complications to the definition of a “visit.” In a paper chart workflow, key bullets of phone conversations were jotted down on paper by the provider and then filed into the patient’s chart by a clerical team member. These conversations were not considered visits nor did they warrant the time investment of a visit. Likewise when normal labs were reviewed, a provider flipped through a stack of paper results, placing a signature or initial as adequate documentation of a review, then left the labs to be filed. For abnormal labs and consults, charts were pulled and patients called, and a quick phone note was jotted in the chart. With the advent of Electronic Medical Records (EMRs), necessary follow up and documentation on post-visit labs, consults, as well as patient generated phone/portal/email requests are documented through a series of clicks into the patient’s chart. This documentation begs for a redefinition of how much time and review constitutes a visit, and requires us to distinguish between a face-to-face consult and other non-face-to-face service time. As this non face-to-face service time is not currently “payable” by most payers, these types of contacts are “unbillable” and excluded from the clinic calculations and current definition of provider productivity.

In a future payment world that focuses outpatient reimbursement on pay-for-performance measures (as is already beginning in inpatient care) rather than fee-for-service, traditional face-to-face visits is no longer the unit of compensation.² If in-office visits will no longer be the unit of productivity in the outpatient world, then the definition of productivity must be redefined in a way that no longer penalizes providers for seeing patients in less traditional, non-face-to-face ways.

The Productivity Denominator

The Denominator of time spent seeing patients is also evolving post-EMR. Whether a provider sees 22 patients a day and spends 3.5 hours at home charting or a provider sees 22 patients a day and spends 30 minutes after work charting, the productivity denominator is often considered by administrators to be the same unit: a day. However, to those providers, the day looks and feels very different to them. The top work-related factor in physician burnout

1 APC’s Insider. (2011). Tip: Knowing the Documentation Essentials for E/M Coding. *HCPPro*. Retrieved from <http://www.hcpro.com/HIM-269669-859/Tip-Know-the-documentation-essentials-for-EM-coding.html>

2 The U.S. Government Site for Medicare. (n.d.). Linking Quality to Payment. *Medicare.gov*. Retrieved from <https://www.medicare.gov/hospitalcompare/linking-quality-to-payment.html>; The U.S. Government Site for Medicaid. (n.d.). Fee-for-Service. *Medicaid.gov*. Retrieved from <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/fee-for-service.html>.

is the documentation burden.³ This burden has changed dramatically in the paper chart to EMR conversion. In a paper chart workflow, most providers did not take home a stack or bin of charts due to confidentiality, so work had to be done in the office. As a partial solution, many practices provide remote EMR access to providers to support physicians charting off-site.⁴ While this allows physicians some flexibility of lifestyle, it leads to a feeling that they are never done with their work.

The unit of day is not rigorously defined in part because it would require us to monitor hours outside of work hours—hours for which it is controversial to say that providers are already compensated since the compensation is often indirect. While the 22 visits mentioned in the above scenario still get completed, provider burnout data suggests that this higher number of hours required to complete visit tasks for patients does cost the organization in less quantifiable ways: provider dissatisfaction and potential turnover.⁵ Moreover, in cases where the days to close/lock notes in the EHR carry out beyond the end of the clinic session, this backlog in charting creates frustration and opens a practice up to potential risk. Frustration and financial vulnerability occur when billers have open claims. Frustration and risk rise when nursing support has insufficient visit notes to adequately and timely answer a post-visit question posed by a patient, family member, pharmacy, or other outside entity.

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3. Rosenstein, A.H., MD, MBA. (n.d.). Physician Stress and Burnout: What Can We Do? *Amazon.com*. Retrieved from <http://crawl.prod.proquest.com.s3.amazonaws.com/fpcache/311c53381fe20625bfa4f3210c1d3238.pdf?AWSAccessKeyId=AKIAJF7V7KNV2KKY2NUQ&Expires=1466014542&Signature=z51vCbiYbrjjUJv5VWzaPCWxb5Q%3D>
 4. Prasad, A. (n.d.). Strategies for Reducing Stress. *Psych Central Professional*. Retrieved from <http://pro.psychcentral.com/physician-burnout-5-ehr-based-strategies-for-reducing-stress/007896.html#>.
 5. Swift, D. (2015) Physician Burnout Climbs 10% in 3 Years, Hits 55%. *Medscape Medical News*. Retrieved from <http://www.medscape.com/viewarticle/855233>.

Rethinking Productivity, Payment, and Visit Alternatives

Redefining productivity requires a reframing of current visit definitions to include phone consults, group visits, etc., as well as a subtle but powerful way in which we talk about productivity. This trend and evolving transition has broad and powerful implications for not only productivity measures but also for overall health outcomes.⁶ Productivity may be a misnomer as it has historically been defined by practices only as it is defined by payers and what they deem as a billable service unit.

Once a visit unit is redefined, it can open up new options for how to operationalize those visits. In closed payer systems (like Kaiser Permanente, for example), several Kaiser physicians interviewed for this article report that a certain number of phone visits are built into the schedule and treated as billable visits from the provider perspective. At a minimum, this redefinition assigns a perceived value to a phone consult and incentivizes provider care teams to conduct at least a few of these non-face-to-face visits. In a recent study, about 50% of patients said they did not have online access to their provider, but rate it as important. In a similar question, 44% of patients surveyed feel that the ease of reaching their provider by phone or email outside of the visit leads to their satisfaction.⁷ For providers in systems where payers do not reimburse for phone visits, this work is described as “work we are not paid for.”

The role of ACOs in redefining visits: While ACOs (Accountable Care Organizations) and MCOs (Managed Care Organizations) provide the promise of redefining visits and replacing traditional face-to-face visit billing with a variety of patient communication modalities, most providers are not yet experiencing a dramatic relief from their productivity stresses. While studies show providers are receiving incentives in the new ACO models, these incentives have not yet become part of a new algorithm for re-figuring productivity expectations.⁸ This is expected to change in the coming years as Sylvia Burwell, the U.S. Secretary of Health and Human Services, has established targets of 30% of Medicare payments tied to quality by 2016 and 50% by 2018.⁹

6 Porter, M. E & Thomas, H.L., MD. (2013). The Strategy That Will Fix Health Care. *Harvard Business Review*. Retrieved from <https://hbr.org/2013/10/the-strategy-that-will-fix-health-care>.

7 Preidt, R. (2016). More Patients Satisfied With Doctor Visits: Survey. *HealthDay*. Retrieved from <https://consumer.healthday.com/general-health-information-16/doctor-news-206/more-patients-walking-away-satisfied-after-doctor-visits-survey-707273.html>.

8 Athenahealth, Inc. (2013). Succeeding as an ACO: A 6-Step Guide for Health Care Organizations. *Athenahealth, Inc.* Retrieved from http://www.athenahealth.com/~media/athenaweb/files/whitepapers/aco_whitepaper.pdf.

9 Burwell, S.M. (2015). Setting Value-Based Payment Goals—HHS Efforts to Improve US Health Care. *The New England Journal of Medicine*. Retrieved from <http://www.nejm.org/doi/full/10.1056/NEJMp1500445>.

Optimizing the Technology in Your Practice

The adoption of EMRs have provided an amazing capacity to collect and analyze data. Many established clinicians express frustration at now being both a physician and a data entry staffer—entering notes to feed the EMR data needs, with one provider reporting, “I’ve come to hate reporting on Meaningful Use metrics on every chart. Physicians were taught to diagnose and treat disease and take care of patients – not hunt and peck at a keyboard,” reiterates Dike Drummond, MD on MedJobNetwork.com. This frustration is understandable and yet is the epitome of the EMR usability issue—treating the EHR as a data **input** machine rather than the data **output** machine that it was designed to be. EHR implementation has moved most health centers from being data poor to data rich in a few short years. However, without the ability to harvest and put to use the new data outputs, it feels like a cumbersome data entry system—one that drains productivity.

With the majority of healthcare providers using EMRs, providers will start to see bigger payoffs for the data entry they have been doing for years by leveraging that data to inform practice at the point of care and predict certain health conditions before they become more chronic problems. In addition, through EMR data and more intensive coding, the national database created through coding and payer claims ICD-10 data will allow more national review and decision-making based upon outcomes data.¹⁰

Historically, providers and payers have not shared outcomes and cost data freely. One reason for this may have been that the data was not readily available or that open data creates an unprecedented transparency and performance based workplace for both health care organizations and payers. The next glass ceiling for coordination is for payers and providers to become strategic care coordination partners and therefore more transparent about care plans, associated costs (and consequently profits), and patient management. Making the connections for healthcare providers between data input and the expected data output and optimization can help. Demonstrating the utility of output data will make it possible for clinicians and other staff to see the fruits of their (data input) labor.

Diversity of EHR Systems

More than a dozen well-known EMRs are currently in the marketplace. While general functionality is the same, the clicks required, habits formed, templates established and system alert variations require a significant learning curve, resulting in lost productivity. While a provider may be trained and savvy with one EHR, switching jobs often means switching EHRs. These variations make the workload more complicated for locum tenets who go from organization to organization and have to learn new clicks and EMRs daily, weekly or monthly.

For clinicians who are computer savvy and who may have had positive experiences with the data output and usability, there are many technological challenges within clinics that remain a barrier to increased productivity. These challenges include inappropriate/inadequate templates for charting, policies and procedures around pending or

10 Coustasse, A., DrPH, MD, MBA, MPH & Paul III, D., DDS, PhD. (2013) Adoption of the ICD-10 Standard in the United States: The Time is Now. *The Health Care Manager*. 32 (3), 260-267. Doi:10.1097/HCM.0b013e31829d77bc.

ders for providers, workstation set up, availability of peripherals (printers, scan card logins, etc.), server responsiveness and connection speeds to name a few.

Standardizing Templates, Order Sets and Smart Phrases

Completion of visit notes has been improved in many organizations by the development of smart phrases, creation of order sets, and development of visit templates. These three solutions can be tailored in the EMR by the specific provider and decrease the number of keystrokes needed to record key information. Upon identification of a frequent visit type (often a chronic condition, chief complaint, or routine treatment), a tailored template can be created. Templates have been criticized by some as driving the conversation to complete check boxes, while others see the templates as a huge time savings when tailored to the type of questions that are typically asked.¹¹ While tailored templates do not eliminate provider clicks, they do reduce the time it takes to type free text details into the EMR. While many providers have been observed using templates, it is not uncommon that peers within the same organization have not used or been made aware of the particular type of template. Teaching these key phrases, order sets and templates for certain types of visits, and coaching providers on their use, creates a more uniform and eventually a quicker charting experience. These standardizations in templates also allow for a more standard and typically faster review of past notes by colleagues.

Pended Orders

Like the lack of standardized adoption of templates, there is also wide variety in use of the EMR to pend orders before the visits. Adoption of this process can increase provider efficiency and speed up charting during the visit. Most EMRs have a location where providers can make notes or put in pended orders or pended order sets during the huddle in order to minimize charting later. Furthermore, during a visit, taking a moment to pend orders or annotate orders for future visit(s) saves future charting time and is a minimal workflow adjustment that providers can make immediately to their practice.

WorkStation Set Up

When EHR implementation began, many offices installed desktop computers/monitors, replacing traditional countertops with ergonomic desks, etc. However, some providers have opted for a more productive option of choosing laptop computers, as they allow them to stay logged in to one station for a much longer period of time. Providing, maintaining and securing laptops can be an expensive and rigorous undertaking. However, saving provider time can pay for itself. Other facilities have evolved from their initial ergo-desk and desktop computer set up to a smaller screen and computer set up that is positioned such that providers can see both the patient and the computer screen simultaneously. This eliminates the need to swivel back and forth or find their place in the EMR after looking up and engaging the patient in conversation. There is some evidence that while patients do not object to providers typing in the exam room, they find tablets and laptops “less bothersome” than desktop computers.¹²

11 Hartzband, P., MD & Groopman, J., MD. (2008). Off the Record—Avoiding the Pitfalls of Going Electronic. *The New England Journal of Medicine*. Retrieved from http://www.praxisemr.com/why_templates_dont_work_articles.html.

12 McCormack, M. (2014). Survey: Do Patients Really Care if You Use Your EHR in the Exam Room? *The Profitable Practice*. Retrieved from <http://profitable-practice.softwareadvice.com/do-patients-care-about-ehrs-0414/>.

Dictation and Scribes

Some physicians have experimented with dictation systems and scribes. Dictation systems, once set up and tested for voice recognition patterns, relieve providers of the burden of free-texting; however, they do little to reduce the number of clicks and small data entry components of charting. Some providers feel the dictation solution is inadequate. Other providers who feel the technology is outpacing their typing and computer skills may be helped by the use of scribes. While some practices are using scribes, often scribes present another hiring and managing dilemma for middle managers, as scribe positions are often not filled by long-term employees, but students looking to gain healthcare exposure or others looking to advance their own education and careers. According to the American Healthcare Documentation Group, “traditionally scribes are pre-med students looking for clinical hours in their gap year.”¹³ Some health centers have experimented with volunteers in these roles, but the long-term forecast for scribes as permanent members of the care team has not been filled with hope. Emerging technologies using virtual scribes can reduce the cost and burden of hiring internal scribes; however, the video/communication technologies have not been fully embraced by all patients and providers.¹⁴

Some very productive providers have proven the viability of using a nurse in the role of the scribe. In these cases a clinically trained scribe can not only free text and annotate the visit; he/she can find relevant results and testing dates, consult notes, discern details out of past visits and then follow up on care, teaching and serve as a very strong support to the provider. Given the expense of nursing staff in this role, the providers observed in this technique were highly productive seeing five, six or more patients in an hour consistently in a way that provided comprehensive yet efficient care. This solution is explored more in the operations and staffing section of this brief.

Server Speeds

Beyond improved workflows and EMR shortcuts, system slowness can leave clinicians, site managers, and support teams feeling helpless. With a number of different hardware and software vendors, it is difficult to determine where a system-wide slow down originates and how to fix it. Slow screen change/response time is a frustration and also acts as a barrier to recording answers to questions or to doing additional documentation in a timely way. End users know intuitively whether the screens move slowly as compared to other Internet usage to which they are accustomed. Measuring timings between clicks can help determine whether a problem is localized to a machine, site, or if it is a more systemic problem.

While minimizing purchases of peripherals will save expense, it adds time and frustration to providers when they struggle with slow logins and access to few printers and scanners. These cost savings on technology expenditures may push staff and providers to make up that budget savings with their own time, resulting in lost productivity. It is preferred to reduce log in occurrences that waste time (in the office, exam room, etc.). Proximity sensors (Radio-Frequency Identification or RFIDs) and smart cards or fobs that utilize bio metric technologies decreases key-strokes and login time. When establishing these login systems, consider the capacity of your EMR to have unique

13 American Healthcare Documentation Professionals Group. (2015). Debunking the Scribe Myth. *Ahdpg.com*. Retrieved from <http://www.ahdpg.com/debunking-scribe-myth>.

14 American Medical Association. (2011). Scribes Can Ease Documentation Burden—for a Price. *amednews.com*. Retrieved from <http://www.amednews.com/article/20111128/business/311289959/5/>; McCormack, M. (2014). Survey: Do Patients Really Care if You Use Your EHR in the Exam Room? *The Profitable Practice*. Retrieved from <http://profitable-practice.softwareadvice.com/do-patients-care-about-ehrs-0414/>.

sessions running at the same time. For example, a Medical Assistant using a computer in the exam room, can enter information and providers can log back into their session right at the place in the chart where they left off, saving them time and clicks.

Of course, considering the lack of EHR standardization, these technologies interface with various EHRs differently. A further discussion with your EHR vendor, and/or demos with these companies, can provide ideas and possible solutions.

Exploring Technology as Paired with Resource Solutions

In some organizations providers have a strong belief that the lackluster productivity numbers stem from a lack of support resources, which is exacerbated by the technology.

In these cases, in order to create more bottom-up change, it is wise to determine if the system has set expectations too high for the resources provided. To run a Plan-Do-Study-Act (PDSA) Cycle or a pilot test, one can identify a few clinic sessions to give a pilot provider double the exam room space and/or double the support staff. If the productivity goes up, then the test should be extended to ensure sustainability of results.¹⁵

Based upon this PDSA, administration will have to determine if there is sufficient return on investment (ROI) from the increased productivity to cover the cost of the additional resources. With visit numbers calculated per Patient Care Team, clinic administrators can often find a happy medium in the resource levels. Some organizations, like San Juan People's Clinic in Colorado, discovered (through a pilot project) that they could see almost the same number of patients with two providers than they had seen with three, when those two providers were given increased space and support staff. This effectively retains the same budget for support staffing but decreases the cost of one increasingly difficult to recruit provider while still preserving overall visit numbers.¹⁶ Similarly, at United Health Centers in Parlier, California, Ron Yee, MD and Team Catalyst did a pilot as early as 1999, in which they were able to demonstrate that with productivity gains they could pay for a change in the MA provider ratio from 1:1 to 2:1 so that they had a higher level of support staff: this increased productivity and revenue also provided an increased wage to support staff—allowing them to attract and retain a higher caliber of support staff members.

If a pilot project provides additional support staff and space to clinicians, and yet a definitive, predictable boost in visits per session is not attained, then one should look to these technological and operational fixes to begin to solve the problem.

15 The W. Edwards Demming Institute (n.d.) The PDSA Cycle. *The W. Edwards Demming Institute*. Retrieved from <https://www.deming.org/theman/theories/pdsacycle>

16 Association of American Medical Colleges. (2015). Physician Supply and Demand Through 2025: Key Findings. *aamc.org*. Retrieved from <https://www.aamc.org/download/426260/data/physiciansupplyanddemandthrough2025keyfindings.pdf>

Optimizing Your Center's Workflows

Probably the greatest area for improvement in productivity has to do with the processes and operations that have evolved to surround the new technology: the actions and workflows of the practice, not just the providers. Providers who have worked in practices with well-supported and well-defined operations prefer them significantly over offices in which operations are inconsistent in training, coaching or outcomes. Anecdotal and empirical data support an emphasis on operational improvements.¹⁷ Providers who work in health centers that have undergone major operational improvements after implementing an EMR often comment that they can now see more patients each session and in a less stressful environment.¹⁸

Many centers have produced great leaps in productivity using these techniques. One such example will be highlighted later in this brief as a case study with data. In a people-based industry such as healthcare delivery, the most influential factor in determining the success of operational changes is the people or staff involved and their rate of adoption of change. Getting staff to follow optimized workflows requires more than just a conversation or compelling evidence. Sustainable improvements shake staff loose from their current habits and help them to re-establish new ways of working that revolve around more efficient techniques.

In this brief we review key operational changes that yield the greatest level of productivity return.

Reduce the No-show Rate

No-shows have the potential to cause a deep drop in productivity with almost no warning. They are very costly to the organization and must be managed. The most elementary and common fix for a high no-show rate is to double book the provider's schedule based upon the percentage of average No-shows. This solution, while logical, is fraught with problems as patients inevitably show up in unreliable increments and create longer wait times. These unreliable wait times frustrate patients and decrease patient satisfaction.¹⁹ Moreover, providers feel out of control and frustrated that support staff aren't able to provide them with a steady stream of patients.

For facilities that have a rampant no-show rate, the first step is to take strong measures to decrease that rate and increase the predictability of the day.²⁰ One of the most reliable tactics to reduce the no-show rate is by making a personal, direct confirmation call to the patient. Robust confirmation calls are similar to a traditional appointment reminder call, yet are done in such a way that stresses the patient-practice relationship.²¹

17 Stratman, M. (2016). Testimonial. *Coleman Associates*. Retrieved from <http://colemanassociates.com/testimonial/1598-2/>.

18 Stratman, M. (2016). Testimonial. *Coleman Associates*. Retrieved from <http://colemanassociates.com/testimonial/1609-2/>.

19 Rodriguez, J.S. (2016). How We Reduced Our No-Show Rate to 7%. *Advanced Sleep Medicine Services, Inc.* Retrieved from <http://www.sleepdr.com/blog/how-we-reduced-our-appointment-no-show-rate>.

20 Reese, S. (2012). How to Stop those Money-Draining No-Shows. *Medscape*. Retrieved from <http://www.medscape.com/viewarticle/773992>

21 Stratman, M. (2016). Those Darn No-Shows. *Coleman Associates*. Retrieved from http://colemanassociates.com/what_we_do/those-darn-no-shows/.

New software is becoming available that will allow practices to predict, with a reasonable level of certainty, which patients are most likely to no-show. Those who always show up may no longer require confirmation calls. Those who often no-show might be given a series of calls in order to reach them, and if they are unreachable, that slot might be strategically overbooked—counting on the proven likelihood of a no-show. This sorting has been done manually by many health centers in the past with good success and upcoming automated technology provides the potential for an even quick sort.

Pre-registration

In order to speed up registration at the time of arrival, some practices couple a full pre-registration process with these confirmation calls. Reducing the amount of time that patients spend registering for the visit means that from the time patients arrive, they can get back to the room quickly.²² To reach the same means, some practices request that all patients arrive early. However, early arrival practices create confusion, unmet expectations, increased volume and chaos in the waiting area, and frustrated patients who have waited a long time. Before providers can address patients' clinical needs, most providers will need to take the time to assuage patients' front office experience frustrations, thereby adding more unnecessary time to the visit and decreasing provider efficiency.

Dynamic Schedule Management

With patients confirmed to come in, the schedule can be used powerfully as a tool to optimize provider time. Dynamic schedule management, done by informed, empowered support staff, can reduce missed opportunities for care and lost productivity.²³ This technique relies upon support staff to move patients up, down, or sideways in the schedule (from one provider to another provider, typically to their Primary Care Provider to encourage continuity of care), in order to maximize the schedule and ensure better slot utilization for each provider.

The Patient Care Team Huddle and Visit Preparation

Each Patient Care Team should conduct a Patient Care Team huddle at the start of each clinic session. A care team huddle is a marker of a Patient Centered Medical Home; however, not all facilities leverage the huddle, which can also be used to capitalize on lost capacity.

Many practices, having heard the phrase “care team huddle,” have adopted the phrase and believe they are following the practice.²⁴ One physician interviewed for this paper explained that she “huddles” alone each day in order to start her notes in the EMR. While starting her notes with a history that is already available helps her to get thoughts organized, her technique to ‘huddle by herself’ has not demonstrated any productivity increase or increase in sat-

22 Backer, L.A. (2002). Strategies for Better Patient Flow and Cycle Time. *Family Practice Management*. Retrieved from <http://www.aafp.org/fpm/2002/0600/p45.html>.

23 Spindola, L., RN. (n.d.). The Team Dance. *Coleman Associates*. Retrieved from <http://colemanassociates.com/tool/the-team-dance/>; Stratman, M. (n.d) Jockeying The Schedule. *Coleman Associates*. Retrieved from <http://colemanassociates.com/tool/tetris-ing-the-schedule/>.

24 Stratman, M. (2012) The Patient Care Team Huddle 1,2,3, Hut, Hut! *Coleman Associates*. Retrieved from http://colemanassociates.com/what_we_do/the-patient-care-team-huddle-1-2-3-hut-hut/

isfaction with the role. Without tangible outcomes, the huddle may not be happening as optimally as it could (see appendix for examining questions).

Providers who huddle and experience productivity boosts report that while they “have always done huddles,” this new patient care team huddle approach leaves them feeling more connected to their team and ready for their patients. Approaching the concept of a strong care team huddle with an eye toward uncovering opportunities, both for visit numbers and to improve the outcomes for each patient, can make the difference for many providers and care teams.

Pre-Visit Preparation

The huddle is made more optimal when the care team does a review of the patient chart briefly prior to the huddle.²⁵ Instead of waiting until patients arrive to review the past notes, the notes are reviewed in advance, so that records can be requested, and unnecessary visits can be rescheduled. Preparing in advance allows the team to maximize the huddle and often gives the provider needed confidence to enter pending orders that will save time during the day.²⁶ All of these steps have been credited with boosting productivity.

Starting Together Ending Together

With patients confirmed and the care team well-prepared the first hour of the clinic day, it is not guaranteed to have a productive start. Often valuable provider time and visit capacity is lost due to a ragged start to the day. A QuickStart methodology encourages a quick audit of clinic session start up, to assess lost productivity and capacity at the beginning of the session.²⁷ Lost capacity at the beginning of the day is often caused by inconsistent arrival times of providers and support staff, inconsistent expectations among staff, or confusion around priorities in the first hour of the day. In a highly functioning center, staff and providers arrive at the same time (or nearly the same time) and are ready to begin patient care right at the time of the first appointment. Often this on-time start is concretized with the Patient Care Team huddle as discussed above.

30-second report & Midway Knock

There are many tested techniques to make the session run smoothly and on time. Two less common but tested in-the-visit techniques utilized by practices which follow a Dramatic Performance Improvement™ are the 30-second report and the mid-way knock.²⁸ Once the vitals have been completed (which can also be sped up through use of integrated EKG machines or integrated vitals monitors that can automatically update the chart with the vitals through a USB connection), an effective but brief update (aptly referred to as a 30-second report) is given to the

25 Sinsky, C., MD. (n.d.). Pre-Visit Planning. *Steps Forward*. Retrieved from <https://www.stepsforward.org/modules/pre-visit-planning>.

26 Backer, L.A. (2002). Strategies for Better Patient Flow and Cycle Time. *Family Practice Management*. Retrieved from <http://www.aafp.org/fpm/2002/0600/p45.html>.

27 Stratman, M. (n.d.) QuickStart Toolkit. *Coleman Associates*. Retrieved from : <http://colemanassociates.com/tool/5-quickstart-toolkit/>

28 Stratman, M., (n.d.) DPI Collaborative. *Coleman Associates*. Retrieved from <http://colemanassociates.com/product/rapid-dpi/>; Spindola, L., RN. (n.d.). The Team Dance. *Coleman Associates*. Retrieved from <http://colemanassociates.com/tool/the-team-dance/>.

provider by the nursing staff. This update allows the provider to make last minute decisions about orders, timing, etc., and plan a more efficient start to the visit.

An effective way to keep a less organized or more talkative provider on track is by providing noticeable, timely support to him/her with a midway knock. Productivity is often lost when the provider exits an exam room in search of people or supplies. Similar to an efficient dental practice where the dentist stays in place on the rheostat as often as possible, the intent is to keep the provider focused, uninterrupted, and face-to-face with the patient. With the midway knock, a support team member comes as a planned disruption to the provider midway through the visit. With a simple knock on the exam room door, support staff can be invited in where discussions, orders and next steps can be taken. The midway knock requires a willing provider. Clinicians who effectively use this technique must start their visits differently. Pamela Weisse, a Nurse Practitioner who trains staff on the midway knock, describes it as a need for clinicians to organize the visit differently in their minds and “think less linearly” about how they accomplish the tasks of the visit with the welcomed “interruption” of support.

Medical Assistant Roles

The majority of Patient Care Teams in most health centers are comprised of Medical Assistants (MA). Many practices are finding that Medical Assistants are willing to learn more and take on more activities within their scope.²⁹ Allowances for these activities vary by state and include tasks that contribute to positive patient outcomes which can be carried out through a series of protocols or standing orders. Writing these protocols, as well as training and coaching to them, can be time consuming up front but can pay off down the road when MAs are fully trained and function optimally within the team. Such forward thinking pays dividends to future practitioners. When working to raise up the level of MA activities, most organizations begin by creating standing orders and protocols for certain types of common visits.³⁰ Many sample protocols are now available online and in the public domain and practices can, depending on the laws of their state, establish activities that will provide further training of MAs. This training and possible compensation boost to some of our lowest paid support staff can also help take some of the burden of work off of the providers and meet broader industry and workforce development goals.³¹

The Tactical Nurse™ or a Strong Team Nurse

Nurses, with their trained clinical judgment, are a strong addition to the team and have been able to provide great leaps in team productivity when trained and coached to work in a tactical role.³² In order to really leverage provider support, communication within the team may take precedence over other nursing tasks. Nurses can often begin a visit, take a more complicated history, provide medication reconciliation, perform diagnostic tests per standing or-

29 Alidina, Shehnaz, MPH, SD, et al. (2014). Practice Environments and Job Satisfaction in Patient-Centered Medical Homes. *Annals of Family Medicine*, 12 (4). Retrieved from <http://www.annfammed.org/content/12/4/331.full.pdf>.

30 Good Companies at Work. (2015). The Pioneers of Healthcare. *The Hitachi Foundation*. Retrieved from <http://www.hitachifoundation.org/our-work/good-companies-at-work/pioneer-employers/the-pioneers-of-healthcare>.

31 Bureau of labor Statistics. (2015). Occupational Employment and Wages, May 2015. *United States Dept. of Labor*. Retrieved from <http://www.bls.gov/oes/current/oes319092.htm>.

32 Spindola, L., RN, Stratman, M. & DeBella, D. (2013). Are You a Tactical Nurse? *Coleman Associates*. Retrieved from http://colemanassociates.com/what_we_do/1393-2/ (http://colemanassociates.com/what_we_do/are-you-a-tactical-nurse/).

ders, and prepare the patient for an efficient and effective visit with the provider. These support activities can save a provider significant time, therefore providing an opportunity for increased productivity.

Often nurses can begin a patient visit and that visit can then be turned over to the physician for an assessment and plan. This is sometimes referred to as a co-visit (by Kaiser Permanente) or Flip Visit (by Dr. Carolyn Shepherd from Clínica Family Health Services, Lafayette, Colorado). In some cases the nurse can take back the responsibility for the visit, taking much of the burden of teaching and following up off the provider. A nurse with strong clinical skills can work alongside a provider, handling many acute issues, or he/she can have an area of focus such as wound care, diabetic teaching, contraceptive education, etc., that can help support the clinician, and most importantly, leave the patient feeling like he/she got the focused attention of two health care professionals in just one visit.

Again, while these operational steps are very honed and well tested, they come with a word of caution. Getting these steps ingrained as new habits for staff requires an intensity of coaching and training, typically through a process of disruptive innovation and outside forces.

Case Study

A suburban Health Center in Northern California with a 18,000 visit annual volume experienced a significant dip in productivity post-EMR implementation and began the process of improving their productivity to get back up to profitable numbers. This case study keeps the health center anonymous, but was put together through interviews and conversations with several individuals employed by and involved in their productivity turn around.

The health center was building technology changes upon a strong provider and staffing cadre, a tested executive leadership team, a previously established strong quality emphasis, and an efficient process of entering incoming paper labs, Rx refills, etc. They converted to eClinicalWorks (eCW) EMR in July 2009. Their planned rollout included an EMR configuration designed to meet their needs, and a thorough training for providers and staff at all three sites. They planned for and anticipated productivity drops and established time for providers to get back up to speed on the productivity numbers.

Twelve months post EMR implementation, the organization had still not realized its original productivity. To mitigate financial strains, the health center reached outside for external guidance (Coleman Associates). They contracted with outside consultants and began an intense visit process redesign initiative. Over the course of three months, through intense re-training and coaching of staff and providers, their data results showed that they were able to increase and sustain a gain from 8.9 patients per session per provider (their one year post EMR productivity average) up to 11 patients per provider per session (which was back up to pre-EMR expectations).

There were a few key factors that contributed to the improvements:

1. An emphasis on a team-based approach and culture of productivity including creation and sharing of weekly team based data dashboards and data reviews.³³
2. Improved operations, including consistent reliable care teams, preparing/previewing the chart prior to the visit, patient care team huddles, QuickStart and dynamic schedule management. In addition, a change to a short term revolving partially pre-booked, partially open template, the 30-second report and midway knock the implementation of a Tactical Nurse role.³⁴
3. Improved technology including the addition of printers in the rooms, computer screens on a swivel ports on the wall, use of laptops by some providers and support staff, and an increase in the number of simultaneously active sessions available on one device.
4. Dismantling of a temporary but growing walk-in service staffed by primary care providers and housed internally. (This once had value when through EMR implementation the same-day visit capacity was lower than the needed demand, but eventually disrupted continuity of care and siphoned visits off the primary care role in a way that dampened overall productivity.)³⁵

33 Stratman, M. (2016). Performance Dashboard. Coleman Associates. Retrieved from http://colemanassociates.com/what_we_do/performance-dashboard/.

34 Spindola, L., RN. (n.d.). The Team Dance. Coleman Associates. Retrieved from <http://colemanassociates.com/tool/the-team-dance/>.

35 Spindola, L., RN, Stratman, M. & DeBella, D. (2013). Are You a Tactical Nurse? Coleman Associates. Retrieved from http://colemanassociates.com/what_we_do/1393-2/ (http://colemanassociates.com/what_we_do/are-you-a-tactical-nurse/).



Summary

Increasing provider productivity is the desire of almost every health center administrator across the country. When planning ahead to the future of care, more than just visit numbers must be considered in order to be well positioned for new reimbursement structures and payment reform. These operational and technological fixes can help maintain a healthy bottom line, as well as preserve engaged, satisfied patients and content, invigorated staff.

“We always hope for the easy fix: the one simple change that will erase a problem in a stroke. But few things in life work this way. Instead, success requires making a hundred small steps go right - one after the other, no slipups, no goofs, everyone pitching in.”

— Atul Gawande, *Better: A Surgeon’s Notes on Performance*

Productivity Opportunities Assessment

Logins and EMR Workflows:

- Survey your providers and support staff. How long does it take to log on to the computer? (A login should be secure, but quick to log in each time.)
- When staff and providers move from a hallway workstation to an exam room computer, do they have to log in from the start or can they have a session open in each location?
- Do providers and care team members make operational work choices because of the log in process? (This must be observed for accurate answers. For example, do they move patients from one exam room to another where they are already logged in? Do they avoid immediate documentation because of complaints that it takes too long to log in? Do they ask someone else who is already logged in to enter a small piece of data or access a document?)
- Have you explored use of a scanner style or badge style login device for your providers?

Workstation Setup and Space Utilization:

- Watch a provider patient visit:
 - Does the provider seem uncomfortable jumping back and forth between the patient and the computer?
 - Is the provider able to share the screen with the patient and allow the patient to be a part of the visit and the notes?
 - Can the provider see the patient and the EMR screen at the same time?
- Are care team members easily identifiable and co-located in order to optimize communication and enhance productivity?
- Does each provider have 2 – 3 exam rooms to use when seeing patients?
- Do staff or providers send patients back to the waiting room in between visit steps in order to free up valuable exam room space and optimize time?

Templates, Pended Orders, Smart Sets:

- Do you have templates that are tailored by your providers to chart on their most common visit types?
- How many primary care providers use templates daily for their charting?
- How often is charting done in the templates you already have established? (This can reveal a lack of comfort with the template and/or its design, or inability to access it easily.)

- In a provider meeting, present on common word phrases, shortcuts and templates used. Assess providers' comfort level and understanding around how to use these tools and how to best optimize their time.
- Ask a provider who is proficient at charting at the time of the visit to review charts of his/her colleagues and/or coach them on techniques and shortcuts in the EHR and other habits that may make their charting more concise and time effective.
- Examine your EHR and talk to your EHR vendor or support team about the ability to enter future orders and begin notes for future visits (e.g. pending an immunization now for the fourth patient of the morning that is expected to arrive and need her second Hepatitis B immunization)

EMR Configuration/Outside Communication/Server Speeds:

- Ask providers if there are facilities from which they struggle to get up to date reports and documentation.
- Are there outside systems (hospital/hospital records systems, outside non-integrated lab systems, etc.) that present significant delays in getting needed data? What options and Application Program Interfaces (APIs) are available to help connect them to the EMR?
- Ask about connection speeds. Do staff or providers complain about connectivity speeds?

Visit Preparation and Anticipation:

- Are patients given a robust reminder call? (This can be evidenced by a decreased no-show rate and also by a decreased number of last minute changes or requests from the patient for forms, tests, new complaints or changes in reason for visit, etc.)
- Do all members of a care team arrive before the time of the first scheduled patient appointment?
- Are staff and provider schedules aligned such that members of a care team start the day together?
- Does the care team conduct a Patient Care Team huddle together?
 - Does the huddle start and end on time?
 - Are all team members present?
 - Does the huddle take place around the computer so that everyone can see the EHR?
 - Does the huddle take place in a location that is free of distractions?
 - Do all team members contribute?
 - Does the huddle “bring each patient to life?”
 - Does the team notice a lack of coordination when the huddle doesn’t happen, or in lack of ability to plan well for patients that were not discussed in the huddle?
 - Does the provider feel that the team provides new information that he/she does not already have when reviewing the chart?

Optimizing Team Roles and In-Visit Communication:

- In the huddle, does the nursing support emanate strictly from provider decisions or is the nurse pro-active in identifying patients that she/he can support?
- At the time of the first appointment of the day, are team members still arriving at the clinic? Are patients checking in or is each care team (including the provider) already in with the first patient? Using pre-registration and other stated techniques, the delay should be no more than five minutes in order to maximize capacity and not lose productivity at the start of the day.
- In many/most visits, does the provider do tasks that could be done by the MA or nurse? (This may be evidenced by the provider leaving the exam room during the visit to retrieve print outs, documents, forms, etc. either during or while wrapping up the visit.)
- Does the provider often look for support staff or often need to ask other support staff from other care teams to assist when their nursing team member is unavailable?
- Are there protocols and standing orders for diagnostics or visits in which the provider does not need to be involved?
- Does the nurse have the availability to start visits and then turn them over to the provider with less provider involvement? Is there a process for updating billing information for these types of visits?
- Is there established communication around these types of provider-nurse co-visits? (This will reveal gaps in training or role redefinition needs.)
- Does the team do a midway knock on each patient?
- How often does the provider take advantage of the support offered during the midway knock?
- Do providers fight for a favorite “most competent” support team member? Do some providers complain that they are faster just carrying out orders themselves?
- Is there a formal mechanism for team members’ performance to be considered by leadership during performance reviews?

Culture of Data and Productivity:

- How often is productivity discussed and with what tone? (This is an ideal question to use in polling providers.)
- Is productivity labeled and discussed by provider or care team?
- Is data posted publicly for staff to see and react to their own results?
- Can staff explain how the work they do each day affects the operational data metrics that are reviewed?
- How do staff and providers react with notification of no-shows? Is there a sense of relief (indicating a less optimal system), or a sense of disappointment (indicating a need to chase down this patient to get them back in for needed care)?
- What is the organizational culture around productivity data? Is it positive or negative?