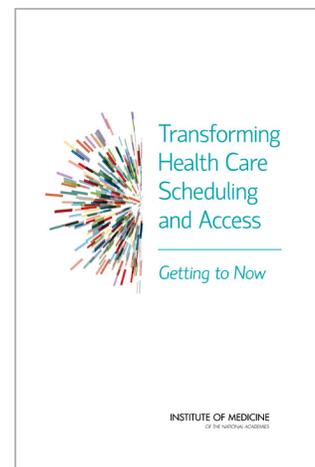


# Transforming Health Care Scheduling and Access

## Getting to Now

### *Key Findings and Recommendations*



#### Summary of Key Findings

- **Variability:** Timeliness in providing access to health care varies widely.
- **Consequences:** Delays in access to health care have multiple consequences, including negative effects on health outcomes, patient satisfaction with care, health care utilization, and organizational reputation.
- **Contributors:** Delays in access to health care have multiple causes, including mismatched supply and demand, a provider-focused approach to scheduling, outmoded workforce and care supply models, priority-based queues, care complexity, reimbursement complexity, financial barriers, and geographic barriers.
- **Systems strategies:** Although not common practice, immediate engagement for patients is achievable through queue streamlining and related systems strategies to access and scheduling.
- **Supply and demand:** Continuous assessment, monitoring, and realigning of supply and demand are basic requirements for improving health care access.
- **Reframing:** Alternatives to in-office physician visits, including the use of non-physician clinicians and technology-mediated consultations, can often meet patient needs.
- **Standards:** Standardized measures and benchmarks for timely access to health care are needed for reliable assessment and improvement of health care scheduling.
- **Evidence:** Available evidence is very limited on which to provide setting-specific guidance on care timeliness.
- **Best practices:** Emerging best practices have improved health care access and scheduling in various locations and serve as promising bases for research, validation, and implementation.
- **Leadership:** Leadership at every level of the health care delivery system is essential to steward and sustain cultural and operational changes needed to reduce wait times.

## Recommendations

### Recommendations for National Leadership

The committee recommends that:

1. National initiatives to address scheduling and access issues related to primary, specialty, hospital, and post-acute care appointments should be anchored in spreading and implementing basic access principles, including: supply matched to projected demand, immediate engagement, patient preference, care tailored to need, surge contingencies, and continuous assessment.
2. With active support and leadership led by the secretaries of the Department of Health and Human Services, Department of Veterans Affairs, and Department of Defense, coordinated federal initiatives should be initiated to draw upon the leadership and resources of the multiple federal agencies that are important to the practical and reliable realization of access principles throughout the nation. These efforts include
  - a. The Secretary of Health and Human Services, in close collaboration with the Secretaries of Defense and Veterans Affairs, should develop and test strategies to move from the office visit as the default site of care delivery to a broader care system, with expanded roles for telehealth, in-home visits, and group visits.
  - b. The Agency for Healthcare Research and Quality should strengthen its efforts to identify and disseminate the experiences of organizations with effective, innovative activities to expedite patient access.
  - c. The Office of the National Coordinator (ONC) for Health Information Technology should develop and test models of information technology to support the monitoring and analysis of operational data, including access metrics on scheduling and wait times. These data should integrate seamlessly into existing systems and be interoperable to enable communication and data exchange with other health care organizations and the assessment of comparative performance. ONC should also develop and test analytic tools that can continuously monitor current operational conditions, including the scheduling measures of supply and demand. ONC should provide technical assistance to health care organizations regarding the implementation of these operational data systems and analytic tools.
  - d. Major federally operated direct clinical service providers, including the Department of Defense and the Department of Veterans Affairs, should work individually and cooperatively to develop and test emerging best practices across different settings and geographic locations. The principles of the most successful models should be widely implemented.
  - e. The Health Resources and Services Administration should strengthen the capacity of its network of community health centers to share information about successes and failures in efforts to transform access to care, and it should assist with the implementation of the recommendations by partnering with professional organizations to offer education of the health care work force.
3. All coordinated efforts across federal agencies should include representation from leaders of health care delivery systems, patients and families, and industrial engineering who should work collaboratively with leadership of the federal departments to improve the broad application, assessment, and promotion of systems strategies for continuous learning and improvement in health and health care.
4. Measure developers and accreditors such as the National Quality Forum, the National Committee for Quality Assurance, the Joint Commission, and the Leapfrog Group should collaborate in research and development initiatives to build understanding and action for proposing, testing, and applying standards related to the access principles. These initiatives should include
  - a. Capacity assessments (supply)—Assessment should be conducted on staffing levels, exam room capacity, and hours and days of operation.
  - b. Patient factor assessments (demand)—Research should be conducted on the various implications of patient numbers, patient query volume, patient timing preferences, and impacts of no-shows.
  - c. Pilot demonstrations—Alternative approaches should be tested through pilot demonstrations.
  - d. Systems tools and expertise—Assessment instruments should be developed for use by organizations in identifying and applying systems-oriented practices and professionals.
  - e. Best practice assessment—Inventories should be developed and assessed on best practices under different circumstances.

5. Professional societies should work with standards and certification organizations to advance professional awareness, understanding, and application of systems approaches, tools, and incentives for the implementation/uptake of systems strategies to assess and improve health care scheduling and access that are grounded in the six access principles. This includes

- a. Engineering partnership models—Models should be developed for partnering with systems engineering professionals for care improvement.
- b. Systems curricular components—Curriculum initiatives should develop modules for incorporating systems approaches into the education of health professionals.
- c. Care access research and demonstration—A research agenda should be developed for demonstration projects to improve insights on the necessary education, skill sets, and cultures that are most conducive to advancing systems approaches to care access.

6. Public and private payers—and employers who pay for care—should be active participants in system improvement through initiatives that encourage creativity and innovation in the implementation and achievement of the access principles. These initiatives include

- a. Payment that is consistent with or supportive of innovative approaches—Payment strategies should be developed to enable innovative access improvement approaches, such as the use of teams, virtual consults, and expanded hours.
- b. Access assurance networks—Support strategies should be developed to encourage access assurance networks, such as inter-organization backup and redundancy plans.
- c. Access learning networks—Approaches should be developed to ensure more rapid information sharing concerning successful strategies for access improvement.

### **Recommendations for Health Care Delivery Systems Leadership**

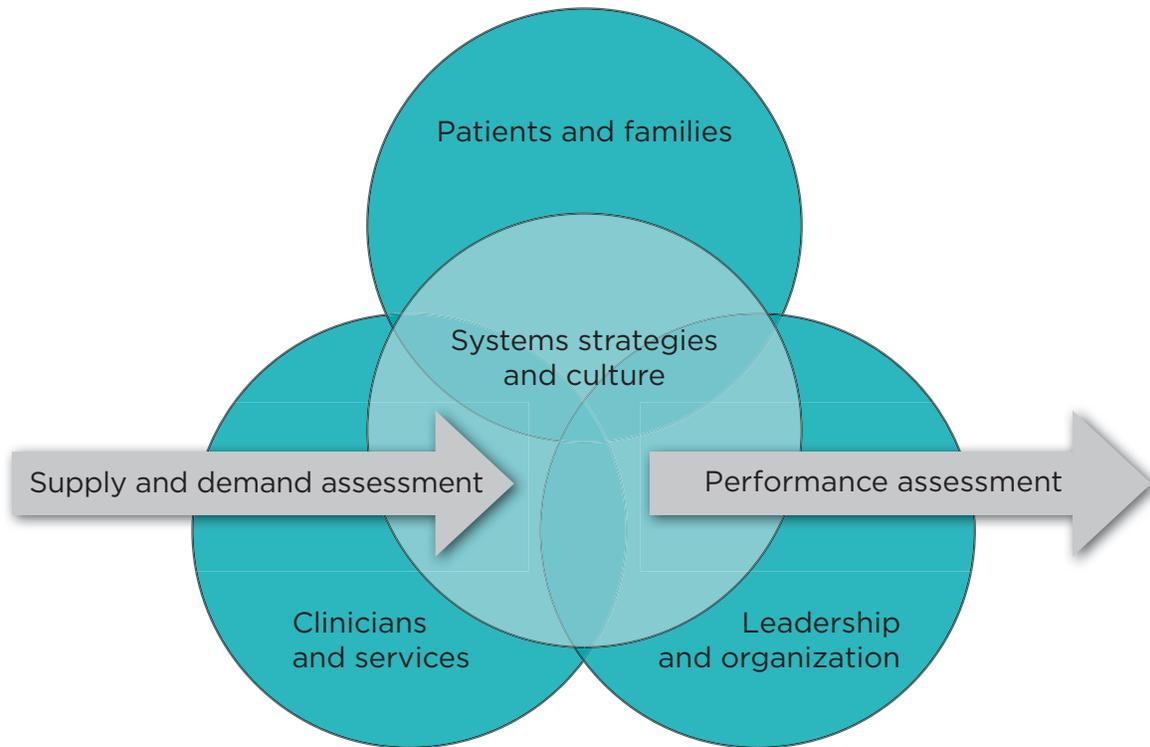
The committee recommends that:

7. The front-line scheduling practices of primary, specialty, hospital, and post-acute care appointments should be anchored in basic access principles, including: supply matched to projected demand, immediate engagement, patient preference, care tailored to need, surge contingencies, and continuous assessment.

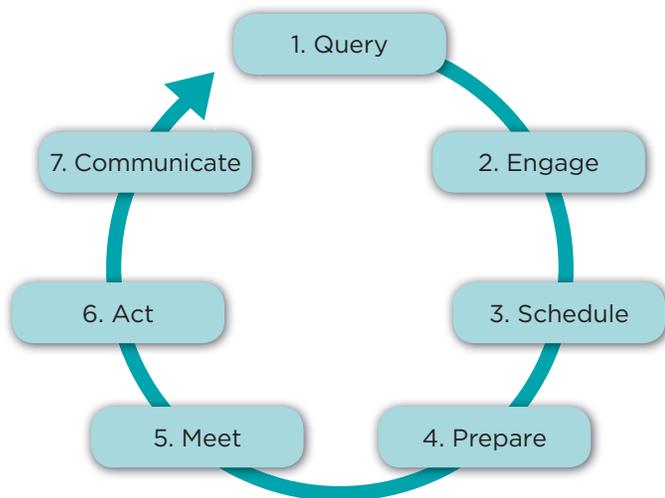
8. The leadership and governing bodies at each level of the health care delivery sites should demonstrate commitment to implementing the basic access principles through visible and sustained direction, workflow and workforce adjustment, the continuous monitoring and reframing of supply and demand, the effective use of technology throughout care delivery, and the conduct of pilot improvement efforts.

9. Decisions involving designing and leading access assessment and reform should be informed by the participation of patients and their families. The potential ways that patients could provide their expertise through informal or formal channels (e.g., patient and family advisory councils, surveys, and focus groups) include contributing input on their expectations, experiences, and preferences for scheduling practices and wait times; helping representatives of health systems explore alternative access strategies; contributing to the design of pilot improvement efforts; helping to shape communication strategies; and interfacing with governance and leadership.

10. Care delivery sites should continuously assess and adjust the match between the demand for services and the organizational tools, personnel, and overall capacity available to meet the demand, including the use of alternate supply options such as alternate clinicians, telemedicine consults, patient portals, and web-based information services and protocols.



**FIGURE 1** Framework for access and wait times transformation.



- 1. Query:** Patient presents health question
  - Patient can access system 24/7; system responds immediately
  - Patient's concerns are respected
- 2. Engage:** There is a collaborative process to answer question
  - Communication is provided in an understandable and convenient way
- 3. Schedule:** Patient can easily/quickly schedule consultation
  - Patient can schedule care 24/7 and can do so online
  - Rescheduling is easy and readily available
  - New appointments can be synchronized with existing ones
- 4. Prepare:** Patient can make preparations in the interim
  - Needed prior approvals and forms are obtained automatically
  - Needed lab tests are arranged and scheduled automatically
  - New appointments can be synchronized with existing ones
- 5. Meet:** Patient has encounter with health care provider
  - Encounter takes place in person, online or by telemedicine
  - Encounter takes place on time; patient is given alternatives to waiting (when delays occur)
  - Staff is respectful and courteous; exam space private and comfortable
  - Team goes to patient
- 6. Act:** The patient and provider take follow-up action
  - Understandable visit summary is provided on patient portal and hard copy
  - Team uses teach-back to insure patient understands critical information
  - Rest of care team fully informed about visit
  - Prescriptions are e-prescribed
- 7. Communicate:** Patient has ongoing care from care team
  - Any follow-up appointments are scheduled
  - Care team checks in to answer questions or ensure follow-up care

**FIGURE 2** Framework for patient and family engagement: Care, scheduling, delivery, and follow-up.