[Abhishek Sripad, Team Lead] ISP Application 3/13/2026

Project Lead/Key Contact

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Why are you interested in the Improvement Scholars Program?

I am interested in participating in the Improvement Scholars Program (ISP) because it provides a framework to address a substantial need in the division of UNC Urogynecology and Reconstructive Pelvic Surgery (URPS). Our division faces longstanding access issues despite prior efforts to solve them. The access problem impacts the care we provide. The ISP is a learning opportunity for quality improvement, leadership, data utilization for process improvement, and guidance for academic productivity in the quality improvement space. Versions of the virtual visit only clinic we propose exist in comparable academic urogynecology practices and within UNC. We seek to utilize all the feedback gained from multiple stakeholders in our division, and from leaders who run similar clinics within and outside UNC. Personally, this program also will provide vital education in quality, healthcare administration, and leadership that may prove foundational in future pursuits.

Problem Statement: What is the problem you are looking to solve?

What is the problem?

In 2025, over 5,580 new patients referred to UNC Urogynecology and Reconstructive Pelvic Surgery waited an average of 73 days between their scheduling date and first appointment date. This falls markedly short of the UNC Health goal of 10 days. Our office Press-Ganey (PG) scores reflect a critical consequence of this problem: diminished patient satisfaction and experience. In 2025, only 75% of patients rated their access to care 'very good', lagging 90% of patients who rated their care provider 'very good'. Our clinic ranked nationally at the 30th and 83rd percentiles in these categories, respectively. This discrepancy between access to care and the quality of care tangibly adds to generally known consequences of longer scheduling wait times including higher cancellation rates, no-shows, and patients seeking alternative care options. Another downstream inefficiency stemming from lengthy wait times is suboptimal clinical productivity. Our group treats surgical and non-surgical conditions. Delays in the care pathways for those who undergo surgery reduces the procedural revenue productivity compared to more efficient paths to surgery.

What happens?

Multiple factors impact scheduling to service time (SST), defined as the number of days between scheduling and appointment dates. The number of providers, clinical volume of each provider, provider office templates, and utilization of new appointment slots all drive availability of new patient appointments and SST. Increasing the number of providers has not impactfully reduced SST in our office. In August 2025, a newly hired physician created more available appointments, however SST did not dramatically decrease in the subsequent four months despite the increased number of available appointments. Simply, the scale of new referrals outpaces new appointment availability, even with an expanding provider team. ***The proposed solution in this project pulls the lever of creatively managing template structure and telemedicine. By introducing telemedicine-only clinic sessions with only new patients scheduled in shorter appointment slots than typical in-person new visits, we anticipate increased batches of new patient referrals moving to their first appointment in shorter durations.***

When does it happen? How often/how much?

The issue of lengthy access time has been a challenge for this clinic for several years and persists despite hiring additional surgeons and advanced practice providers.

To whom (which patients and or providers) does it happen?

Lengthy SST is ubiquitous amongst all faculty. The average SST by provider in 2025 ranged from 56 to 92 days. We will work to identify if there are any patient-related trends. From a clinical care standpoint, it may be advantageous to preferentially see patients who are referred for non-surgical conditions virtually, and those who may desire surgery in-person to maximize clinical efficiency and throughput of patients through appropriately care pathways.

Importance Statement: Why is this project important?

How will the improvement benefit patients?

Our division is a surgical subspeciality that cares for thousands of women with pelvic floor disorders yearly. Delays in patient care impacts patients' quality of life. Lengthy times to service also can be associated with reduced patient satisfaction, decreased utilization due to cancellations and no-shows, and seeking care at other practices. Establishing a safe, efficient, and effective care pathway that utilizes a telemedicine platform with shorter appointment slots for new patients represents a considerable adjustment to current clinic structure. The goal of this project is to improve quality of care, meet the institutional goal of scheduled to service time, and increase divisional productivity.

What is the potential downside of this effort for patients?

Patients who find navigating telemedicine difficult may be unable to participate in the virtual patient clinics. All patients with pre-defined indications would be eligible to be scheduled as new virtual appointments and can be triaged, evaluated, and initially managed without a physical exam. There will be some patients that require an exam and may have to come to our office for an expedited in-person return visit which may impact their treatment plan. Additionally, those who strongly prefer in-person appointments may be dissatisfied. These factors are considered in process outcomes.

What background information (data/analysis/literature) supports the choice of this effort?

Telehealth visits are favorably viewed by patients seen by primary care or specialty physicians compared to in-person visits with regards to doctor communication, care coordination, overall rating of doctor, and willingness to recommend to family and friends.[1] Urogynecology and Reconstructive Pelvic Surgery has utilized telemedicine increasingly since the COVID-19 pandemic. Patients seeking care for stress incontinence have demonstrated a positive perception, high acceptability and satisfaction of telemedicine visits as new patients in settings where they were taught pelvic floor muscle exercises.[2] In another study of 205 patients, 24.4% believed logistics of in-person visits were the primary cause of stress for these appointments.[3] Virtual appointment clinics for new patients with rapid access has reduced wait times and increased patient throughput in Neurology clinic in a large academic setting.[4] To our knowledge, while virtual clinics exist, no study evaluating this outcome in academic urogynecology practices has been published.

What area or organizational goals does this project align with/support?

The UNC Health holds a goal of 10 days or less from scheduling to service time, and for reducing time to service if this goal is not achieved. Our project aligns with this directly. Additionally, urogynecology division leadership has emphasized improving access as a high priority goal. Our division director (also a member of this team) endorses this project with strong support.

How has this problem been addressed successfully at UNC or elsewhere?

The use of virtual clinics exists in comparable academic urogynecology practices. Specifically, we have sought insights from the division director of Urogynecology and Reconstructive Pelvic Surgery at Northwestern University, where all new urogynecology patients are seen virtually. Additionally, we have spoken other divisions within OBGYN, who have piloted smaller virtual-only clinic templates for insights. The takeaways from these conversations are reflected in our virtual clinic structure, and process measures.

Which Local Quality & Operations Council would this project report up to, and what feedback have you received from them and your leadership about your project concept?

After review of our proposal in concept with Quality leadership, I was advised to gain approval with divisional and department leadership. Both the Division Directory of Urogynecology and Reconstructive Pelvic Surgery, and the vice chair of Quality of Obstetrics and Gynecology are in support of this proposal.

Project Scope

In Scope:

- *What is the specific patient population your project will impact?*

This project will impact all patients with pelvic floor disorders (PFDs), which include but are not limited to: pelvic organ prolapse, urinary incontinence, and fecal incontinence who are referred to UNC URPS.

- *How many patients are in the population?*

The population of effected patients is significant and is likely to grow in the coming years. PFDs are common conditions, with 20% of women estimated to have a surgical procedure by age 80.[5] This aligns with the high volume of patients seen by our division, which received over 5580 new patient referrals in 2025.

The number of referrals is likely to grow due to a rapidly growing regional population, and increasingly elderly population. The Research Triangle Region is one of the fastest growing areas in the US, with the population increasing 10.5% from 2020 to 2025, compared to the entire US population growth of 2.6%.[5] Age is an important risk factor for PFDs. In the US, from 2022 to 2050, the 65 year and older population will increase by 42% (from 58 million to 82 million), which will account for 23% of the population (from 17%).[7]

- *In what setting(s) would this problem be addressed? (e.g., hospital unit, outpatient practice setting, non-clinical setting, etc.)?*

This will be addressed in an outpatient setting – with providers conducting virtual clinics from either the office clinic or from another private location.

Out of Scope: patients of referring providers who could be seen sooner if our access times improve and we can accommodate shorter duration form referral to provider visits

Measures: (Process, Balancing, Structure)

Please describe the anticipated outcome measure(s), 2-3 process measures, and one balancing measure. Please do not include more than 5 measures total.

Measure Name	Measure Type	Measure Calculation	Measure Exclusion	Data Source	Baseline	Goal	Collection Frequency
Average schedule to service time (SST) (schedule to service time)	Outcome	Number of days between new patient appointment scheduling, and appointment date with provider	None	EPIC	73 days	10 days	Monthly
Patient experience	Secondary outcome	"very good" Press Ganey scores (access and provider categories)	None	PG Scores	Care provider: 90%, access: 75%	Access scores: 90%	Monthly
Provider satisfaction	Process	Satisfaction questionnaires with virtual visits	None	Administered-likert-scale questionnaires that include assessment of process issues, overall satisfaction	N/A	N/A – need baseline assessment	Quarterly
Opt-out patients	Process	Percentage of patients who opt out of virtual appointments	None	Intake personnel documentation	N/A	N/A – need baseline assessment	Monthly
Return patient throughput	Balancing	First to third visit appointment (TTA) time	None	EPIC	96 days	No increase in TTA	Quarterly

Root Cause Analysis

Our current clinical model to evaluate new patients includes exclusively in-person appointments. Our group consists of six physicians and three advanced practice providers (APPs). Both physicians and APPs see new patients. Physicians are slotted 40 minutes, and APPs 60 minutes for new patient appointments. There is no maximum number of new patients possibly seen during each clinical session.

With our current paradigm, the number of referrals we receive outpaces our ability to see new patients. Conceptually, this underpins our persistent access issue. More specifically, there are three root causes. Firstly, the appointment lengths in our clinical template for APPs allows 60 minutes for new patient consultations. In comparison with other academic institutions that we have consulted, this exceeds time given for new patient appointments (which typically range form 20-40 minutes). This length of appointment set by institutional policy for in-person appointments, limits the number of new patients seen per day. Secondly, the number of new patients scheduled each day is dependent on available slots and is limited by return patients who are already scheduled. Additionally, our access issue has persisted despite hiring two new physicians within the last two years. Although new hires increase our overall volume, our office space and clinical staff to support in-person appointments has inherent limitations to higher volume. Virtual appointments at high volumes is not limited by the logistical bottleneck of in-person appointments. Combined, these factors limit our ability to shift the imbalance of the pace of number of referrals and patients seen.

Ideas for Improvement

The strategy in this project for improving our issue of access is to rebalance the pace of referrals and new patients evaluated. To do this, we propose having full clinic days that are only include 30-minute virtual new patient appointments, for both physicians and APPs.

<u>Schedule process</u>

- All patients referred to UNC URPS should be scheduled for a virtual new patient appointment. This can be done with physicians or APPs. Those who desire surgical intervention based on referral review should be scheduled with surgeons, and those who desire non-surgical care should be scheduled with APPs.
- Virtual new appointments will be offered to patients in an 'opt-out' manner. If a patient desires an in-person appointment, then will be scheduled with the appropriate provider type based on desire for surgical intervention.
- They will be scheduled a rooming/nursing appointment, and separately a provider appointment.
- Diagnoses and associated ICD 10 codes that will be scheduled in-person appointments only (i.e. not offered virtual visits):
- vesicovaginal fistula (N82.0), urethrovaginal fistula (N82.1), urethral diverticulum (N36.1), mesh complications (vaginal mesh exposure - T83.721, mesh exposure into viscera - T83.711, other complications such as pain, inflammation of implanted mesh – T83.79)

<u>Rooming appointments</u>

- 3-4 days prior to their appointment date with the provider, patients will be scheduled with an appointment a clinical staff member (RN or MA)
- These appointments will be scheduled as types will be: NEW VIDEO HCP DIRECT LINK [11704441] or NEW VIDEO HCP MYCHART [11703543], depending on if the patient is enrolled in MyChart**.** Examples of rooming appointment schedule dates based on day of provider appointment:
    - Monday provider appt -> prior Thursday or Friday rooming
    - Tuesday provider appt -> prior Thursday or Friday rooming
    - Wednesday -> prior Monday or previous week Friday rooming
    - Thursday -> prior Monday or Tuesday rooming
    - Friday -> prior Tuesday or Wednesday rooming
- Rooming the patient – updating medications, allergies, medical history, surgical history, social history
- Confirm patient has access to new patient paperwork and **strongly encouraged** to fill this out
- Ensure properly functioning camera/audio capabilities. If any issues identified that cannot be solved in this appointment, the rooming RN/MA will submit an ISD ticket.

<u>New patient appointment process:</u>

- Patients told to log on 10 minutes prior to their appointments

- If patients are 10 minutes late for either rooming or provider appointments, they will be cancelled. If a patient no-shows or cancels their rooming appointment, they need to reschedule their provider appointment
- Morning panels: first patient scheduled 8:00 AM, last 11:30 AM
- Afternoon panels: first patient scheduled 12:30 PM, last 3:30 PM

Risks and Opportunities

- Continued improvement of our clinic will come from regular involvement of all stakeholders to assess data and offer ongoing solutions. A strength of our division is respectful, positive collaboration. Given this significant change in how we offer patient care, our ability to engage nursing staff, providers, and scheduling personnel will be critically important to foster iterative growth. Our project is well positioned to do this, as our division director, office medical director, and nurse manager are all leads/co-leads as listed below.
- Our project faces several challenges. First, is human resistance to change. The proposed virtual clinic is a deviation from the paradigm in our office, and there have been numerous questions surrounding its introduction. We believe with continued collaboration with iterative improvements and demonstration of progress towards our goal of increasing access and volume, the provider team will be motivated to invest enthusiasm into this clinic. Another foreseeable challenge is the potential bottleneck of return visits in our office after we increase the volume of new patients via the virtual clinic. While not part of this project, we are reflecting on ways to effectively triage established patients to either follow-up with their referring gynecologist/PCP or space their return appointments. Third, we anticipate use of technology to pose challenges for both the care team and patients. We plan to address this by trouble shooting any patient technical difficulties with the nursing staff at the 'rooming appointment. Reassuringly, we conduct virtual appointments currently, so our providers are well-versed on this platform.

Stakeholders and Project Team Members

- *Who are the key stakeholders in your system and processes?*
- *Who are the key project team leaders to design and implement change?*

Name	Role
Marcella Willis-Gray, MD (Division Director)	*Sponsor(s)*
Abhishek Sripad	*Team Lead*
Jennifer Antonios, RN (RN Clinic Manager)	*Subject Matter Expert – Nursing Level*
Latisha Poole (Clinic Manager)	*Subject Matter Expert – Scheduling Level*
Whitney Franks, PA (APP representation)	*Subject Matter Expert - APP Level*

Impact on the Quintuple Aim

Our believe is that this project promotes all components of the quintuple aim.

As described above, PFDs are very common and will certainly increase in prevalence in the future. With PFDs' impactful consequences, increasing access to a care for PFD **improves the quality of life and health** for thousands of women in North Carolina. As we expand our access to the care, we additionally improve the principles of **health equity** by providing our services to patients in need at the same cost and without compromised quality. The project also offers opportunity for assessment of virtual visit utilization and demographic characteristics such including age, race, socioeconomic status, home distance from our office. General literature indicates that lengthy access time is a reliable patient dissatisfier with implications for cancellations, no-shows, and delays in care. Press Ganey scores in our office reflect this phenomenon. Improving our access time helps in addressing this longstanding issue and contributes to **enhanced patient experience.**

Further, for patients, a virtual visit in replacement of an in-person visit can **reduce the cost** associated with travel and the logistical hurdles that in-person appointments can present.

Clinicians and staff often find flexibility in workdays as a welcome feature. Offering scheduled virtual clinic days that can be done from any private location may offer them flexibility that is not always present with in-person visit sessions. We hope to study this idea, and we anticipate that providers having all virtual appointments as a portion of their practice will enhance flexibility and wellness, and will improve their experience.

Sustainment Plan

What ideas do you have for sustaining the improvement?
We are committed to a successful new paradigm for our clinic. The ISP would be a resource to help build our new-patient virtual clinics, and our plan is to permanently feature this model with integrative improvement independent of ISP participation. Several strategies anchor our sustainability plan, all including the principle of long term, iterative assessment and improvement:

Multilevel stakeholder involvement: from this project's inception, representatives from all roles in our outpatient service line have been included: providers, front desk/scheduling staff, and nursing staff. Their input throughout this project will continue and is included in process measures. In the long term, they will continue to be co-owners of the initiative and will be the foundation for iterative improvement. Additionally, we plan to monitor billing after implementation of the virtual clinics. We have met with our billing compliance team, and we anticipate we will be able to bill our virtual visits with the same level coding as our current in-person new visits. We anticipate this will increase billing and will assess this through the lens of sustainability in implementing the new clinics.

EHR integration of new patient paperwork: our plan includes incorporating new patient paperwork and questionnaires into MyChart such that patients can fill this out before their appointment. This feature will help providers more efficiently document and review patients' symptoms and history.

Academic productivity: While other clinics exist like our proposal, we are not aware of any prior or planned studies to assess the impact of such a clinic on quality metrics. Our division productively publishes in several areas of clinical research. Publishing in in the quality improvement space would be an addition to our research portfolio and has garnered divisional interest. Ongoing assessment of impact of this project will promote continued attention and assessment for improvement.

How do you see the work you start with IHQI's support continuing?
The current project of seeing new consultations virtually in shorter appointment length that are batched for each provider in a single day is endorsed by division leadership. This model has several elements that make it an attractive long-term model for our division to invest time and energy. Beyond the grant period, we seek to use knowledge gained in the evaluation/action processes, data gathering and analysis in our long-term goal of being a modern URPS division that maximizes the high-volume, accessible, and equitable care we already provide.

Carolina Quality Tools

How will Carolina Quality tools (Just Culture, SAFE reporting, TeamSTEPPS, huddles, and visual management boards) be used to support the work? Although use of these tools is not required, applications including them will be strengthened.

Our project plans to utilize Carolina Quality tools while building a program to see new patients virtually, and that allows patient and team member safety. **Just Culture** principles will help promote an environment of open dialogue to help identify issues in our system and project, while not assigning blame or punitive action on members of the team. Regular assessments and PDSA cycles will embed these principles and foster a healthy working environment. While the nature of this project and our office makes it challenging to have daily huddles, we anticipate doing **monthly huddles** with representatives from all teams involved (providers, clinical staff, front desk). Additionally, roll out of our new clinic may yield events characterized by miscommunication and

inappropriate scheduling that may impact patient care. We will use **SAFE reporting** to capture any safety concerns.

Currently we utilize a large visual management board in our office to indicate important progress and celebrate achievements. We will utilize this **visual management board** to indicate progress and ongoing efforts to improve this project, such that team members can quickly and easily visualize our progress and current iterations.

References

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7. U.S. Census Bureau, 2023 National Population Projections Tables: Main Series, accessed 2/21/2026

- **Sponsor letter** – Marcella Willis-Gray MD (Division Director, Urogynecology and Reconstructive Pelvic Surgery)

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March 8th, 2026

Re: IHQI Scholars Program Dear Review Committee,

I write today to enthusiastically support Dr. Abhishek Sripad's application for the UNC Institute for Healthcare Quality and Improvement (IHQI) Scholars Program. As outlined in his application, Dr. Sripad is a thoughtful and dedicated urogynecologist with a clear commitment to advancing quality improvement in the care of patients with pelvic floor disorders. Participation in the IHQI Scholars Program would provide him with the mentorship, tools, and structure to build on his clinical expertise and lead sustainable, system-wide improvements.

In the role of office medical director, Dr. Sripad identified our longstanding access issue as one of critical importance. This led to the development of this project. Lengthy schedule to service times in our office likely contribute to patient dissatisfaction as our Press-Ganey access scores lag considerably behind our provider scores, which are high. There are inherent limitations to our current clinical structure. These include template restrictions for providers, clinic space, and clinical staffing to accommodate more patients. The project proposed by Dr. Sripad address several root causes to our access issue by shortening appointments and conducting batched new patient visits virtually.

Importantly, the project has incorporated all stakeholders in our clinic setting: scheduling staff, nursing, advanced practice providers, and surgeons. Representation from all areas were included in formulation of the project and will be involved in iterative feedback throughout the project's implementation. The project also builds on the virtual platform in which we conduct visits currently, thus not introducing a new technology for providers or nursing staff.

Dr. Sripad's work aligns strongly with institutional priorities, particularly to reduce access time and improve patient experience and volume. More broadly, this may promote health equity by seeing more patients, and especially those with barriers to travel for in-person visits. I am committed to his success and will ensure that he has protected time to pursue this important work, including full participation in IHQI meetings. I hope you will give this application your highest consideration, as I feel the project holds real potential to improve

patient care in our office, and serve as a model for other clinics who are interested in implementation of a similar model.

Sincerely,

Marcella Willis-Gray, MD
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