Department of Medicine Expectations for Access to Outpatient Care

Prologue:

In October 2017, the Department of Medicine (DOM) Outpatient Leaders Group (OLG) formed to coordinate strategy and operations across all DOM clinics. The group, which is comprised of clinical leaders from each clinical division, DOM administrative staff, and HCS representatives, was charged with: (1) identifying key DOM clinic issues that affect multiple stakeholders and can be meaningfully improved; (2) for prioritized issues defining an operational framework that can be applied across clinics; and (3) empowering individual clinical medical directors to effect changes within the overall framework, yet tailored to their own clinics.

The group identified access to care – defined as both appointment wait times and "front door" service – as the initial focus area. A workgroup with representatives from a diverse group of specialties (endocrinology, gastroenterology, general internal medicine, pulmonology, and rheumatology) formed to define guiding principles and organizing tactics for improving access, narrowing the focus on appointment wait times. Through four 90-minute meetings, the workgroup drafted the earliest versions of this DOM Expectations for Access document. After multiple iterations, the workgroup presented the contents of the document in person to the entire DOM OLG in December 2017. Feedback was incorporated into an updated draft that was again shared with the DOM OLG, as well as the UNCMC outpatient care leadership team (both HCS and UNCFP leaders), and UNC HCS Care Access and Service Integration (CASI). Finally, the document was presented to DOM division chiefs at their March 2018 meeting. This final document incorporates the feedback of all key stakeholders in the process.

Introduction:

Appointment wait times affect quality of care, patient and physician experiences, and financial performance. This document outlines a Department of Medicine (DOM)-wide strategy for maximizing outpatient access to care. First, it establishes a standardized process for assigning faculty and APP clinical effort, and translating this effort into outpatient clinic sessions. Although most clinicians are already fully deployed, a clear and consistent standard will set proper expectations, ensure equity, and increase appointment supply. Second, because increasing appointment supply alone will not guarantee timely appointments, it sets an expectation that each division will identify and fast track high-priority patients. Finally, it outlines the resources and tools clinicians, medical directors, and clinic managers need to maximize productivity and minimize appointment wait times.

Framework:

Define clinical effort (cFTE) → Translate effort into clinical assignments (inpatient-FTE, procedure-FTE, and clinic-FTE) → Translate clinic-FTE into clinic sessions → Prioritize patient subgroups → Optimize and support productivity per session.

1. **Setting Clinical Effort:**

Twice annually, the division chief and ACA will calculate ***clinical FTE (cFTE)*** for each faculty member and Advanced Practice Provider (APP).Mid-semester changes in non-clinical salary sources (increases or decreases) will result in a new calculated clinical effort (cFTE) that will preferably be applied starting the following semester.

2. **Setting Clinical Assignments:**

Twice annually – preferably in March/April for the fall semester and September/October for the spring semester – the division chief will determine ***clinical assignments*** based on the division's needs, each clinician's cFTE and interests, and available space. Clinical assignments may be allocated to **inpatient-FTE, procedure-FTE,** and **clinic-FTE**. These three subgroups should add up to 100% of assigned cFTE. Assigned FTE cannot be overlapping. If a division assigns inpatient FTE that results in blocked clinic sessions, the allotted clinic-FTE must be reduced accordingly. Not all subgroups will be relevant for all clinicians or all divisions. The division chief will discuss any changes in *clinical effort* and *clinical assignments* with affected individuals.

3. <u>Converting clinic-FTE into Clinic Sessions:</u>

Based on division needs, clinician interest, and clinician cFTE, the division chief will assign each clinician an ***average weekly number of half-day clinic sessions***. A ***clinic session*** is defined as at least 4 hours of direct face-to-face patient care. Each clinician is expected to work at least 46 weeks per academic year. Combined, each clinician will be expected to complete a ***minimum number of clinic sessions*** each year as outlined in one of the two tables below. There are two tables because the DOM recognizes there is non-face to face work related to the care of clinic patients. The division chief may therefore allocate between 0.1–0.125 clinic-FTE per average weekly clinic session based on individual clinician productivity relative to targets, division clinical and financial needs, and relative load of after-hours clinical administrative work.

Clinic Sessions Total (1 weekly clinic = 0.1 cFTE)			
Average Weekly Clinic Sessions	**Minimum No of Weeks***	**Minimum Annual No. of Sessions****	**Clinic-FTE credit**
10	46	460	1.0
9	46	414	0.9
8	46	368	0.8
7	46	322	0.7
6	46	276	0.6
5	46	230	0.5
4	46	184	0.4
3	46	138	0.3
2	46	92	0.2
1	46	46	0.1

Clinic Sessions Total (1 weekly clinic = 0.125 cFTE)			
Average Weekly Clinic Sessions	**Minimum No of Weeks***	**Minimum Annual No. of Sessions****	**Clinic-FTE credit**
10	46	N/A	-
9	46	N/A	-
8	46	368	1.0
7	46	322	.875
6	46	276	.75
5	46	230	.625
4	46	184	0.5
3	46	138	0.375
2	46	92	0.25
1	46	46	.125

*Clinicians are not required to complete or makeup clinic sessions on recognized UNCHS holidays or on official sick days up to maximum allotment. These will be deleted from the total minimum number of sessions.
**For divisions that do not allocate specific inpatient-FTE, the minimum number of clinic sessions may be reduced to reflect inpatient work that occurs *in place of* what would have been full clinic sessions.

Clinicians should follow division-specific processes to close a clinic session. This may involve notifying the medical director or directly contacting the scheduling team*, preferably at least 3 months before the clinic's scheduled date.* Closing a clinic too close to the date of service dissatisfies patients and causes rework for staff. Consistent with UNC HCS' Bump Policy, except for illness or personal emergencies, requests to close a clinic within 30 days of the clinic date must be approved by the clinic medical director and the clinician should accommodate bumped patients *within 2 weeks of their original appointment*.

Clinicians should also follow division-specific processes to open or reschedule missed clinic sessions. S/he should first contact the designated clinic administrator (e.g., clinic manager) with proposed dates and times for these new sessions. The clinic administrator will consider whether there is adequate space, staff, and other resources to accommodate the clinician and associated patients. If so, the request will be approved, the clinician will be assigned designated exam room(s) and her/his schedule will be opened. If not, the clinician will be asked to propose new dates. The clinic medical director may be asked to help when needed.

All clinicians regardless of overall clinical effort – including those with low clinic-FTEs and those on vacation – are expected to review their EPIC in basket and respond to patient-related messages daily, or delegate this responsibility to a qualified designee. Consistent with UNC Medical Staff Bylaws (item 16), all clinicians are expected to *sign clinic encounters within 72 hours*.

In order to utilize staff, space, and resources efficiently, clinic sessions should be relatively evenly distributed throughout the week, including on Fridays.

4. Optimizing Productivity Per Session:

Appointments must be utilized effectively. The specific patient volume expected per clinic session will be determined by the division chief/medical director in accordance with benchmark standards set by the DOM. Recognizing that different patient populations have different needs, expected productivity and scheduling templates must be tailored to individual practice areas. The division chief/medical director will monitor productivity per expected clinic session relative to peer clinicians in the same practice area and share this data with individual clinicians at least bi-annually.

- For those underperforming compared to peers, operational factors (space, clinic staff ratios, etc.) will be reviewed and, if necessary and possible, modified. Also, those underperforming will be asked to increase volume within each assigned session or increase the number of assigned sessions.
- Those with high patient no-show/late cancellation rates will be asked to increase the number of appointment slots on their templates.
- APPs are encouraged to have their own independent clinic templates. Faculty and APPs who share a template are expected to see at least 1.5 times as many patients as faculty in their practice area who work alone.
- Clinical faculty who work with scribes are expected to be more productive than peers who do not. Each practice may determine individualized standards for using scribes.

Various tools and strategies should be used to optimize appointment utilization. This includes using "switch rules" so when a certain type of appointment is unfilled several days prior to the date of service it can be converted into a different type of appointment, utilizing wait lists and Fast Pass to move patient appointments up when possible, and also adhering to UNC HCS No Shows/Late Cancellation Policy and Provider Bump Policy.

5. Prioritizing Patient Sub-Groups:

Demand for clinical appointments typically exceeds capacity. Each division should consider how to stratify patient populations into priority groups. Patients in high priority groups (e.g., those with conditions that require urgent clinical attention and/or that align with the DOM's mission) should receive scheduling priority. To operationalize this, each division should:

- Formalize a priority system.
- Sort each incoming referral into priority groups. This may be done either by physician/APP/nurse triage (appropriate training is necessary) or by clinic staff using well-defined protocols developed jointly by the medical director and clinic manager.
- Adjust templates when spare capacity exists to increase appointment supply for high priority patient groups.

6. Operational Needs to Maximize Access:

The health care system and the Department of Medicine must provide adequate ancillary and nursing support (defined using MGMA benchmarks) to support clinical care at the actual appointment (e.g., check in, tests, and other in office tasks) and between appointments (including telephone call triage and messages, basic medical advice, refill requests via standing orders, prior authorizations, and other forms of support). Salary and other benefits must be competitive to keep a stable support staff. Clinics should not have to consistently rely on the float pool. A stable full-time staff is more appropriate.

Each clinic should develop an accountability system for their defined triage and prioritization process to help ensure it is working correctly.

Clinic scheduling staff should be adequately trained and held accountable for referral processing. Incoming referrals from non-UNC clinicians should be transcribed as an EPIC order with records uploaded to EPIC.

Referral conversion rates and turnaround time targets as set by UNC Outpatient Leadership should be regularly reported.

Clinic scheduling staff should be adequately trained on template management strategies, and supported to and held accountable for maximally filling appointments (e.g., “look ahead” reports to identify unfilled appointment slots; referral conversion rates and turnaround time reports; and “look back” reports to identify the percentage of appointments never filled, and no-show and late cancellation rates).

Clinic medical directors and clinic managers should be provided access and productivity dashboards that include key metrics at the multiple levels, including (a) overall clinical practice across locations; (b) individual clinical locations; (c) individual appointment types; and (d) individual clinicians. Key metrics include: Bump Rate, Time to 3rd Appointment, No show & Late Cancellations Rates, New and Return visits, Referral Conversion Rate, Referral Turnaround and overall Appointment Utilization.

Best practices will be shared across the DOM and process improvement coaches embedded in individual clinics as needed.

APPENDIX A: Standard Definitions

- **Clinical Effort (cFTE):** is calculated as employment FTE x % time deployed for clinical effort. (For instance, a full-time (1.0 FTE) faculty with 50% clinical effort = 1.0 FTE x 50% time deployed for clinical effort =0.5 cFTE).
- **cFTE subgroups:** each clinician's cFTE may be allocated to one of the three following subgroups. Combined, these subgroups should equal overall cFTE.
  - **Inpatient-FTE:** the portion of the cFTE allocated to work supporting an inpatient ward service and/or consult service.
    - *Inpatient teaching service*: Each division will assign the weight of the inpatient-FTE for supporting inpatient teaching services. This should be consistent across the division. Inpatient teaching service coverage should follow the attending expectations developed by the DOM Inpatient Leaders Group.
    - *Inpatient consultation service*: Each division will assign the weight of the inpatient-cFTE for supporting inpatient consultation service. This might include designated inpatient-FTE credit. For example, when clinicians support a consult service while *simultaneously* seeing clinic patients they may receive clinic-FTE but not inpatient-FTE credit. For another example, when clinicians support a consult service *in place of* seeing clinic patients the division chief may opt to either (a) allocate inpatient-FTE (by extension, reducing the clinic-FTE required to meet assigned cFTE) *or* (b) not allocate inpatient-FTE but instead reduce the minimum number of required clinic sessions (explained above) by the number that coincides with inpatient consult work.
  - **Procedure-FTE:** portion of the cFTE that is allocated to performing or supervising procedures and/or interpreting billable diagnostic studies, such as echocardiograms and motility tests.
    - Each division will assign the weight of the procedure-FTE. This should be consistent across the division.
  - **Clinic-FTE**: portion of the FTE allocated to work in a clinic or outpatient contract based setting, including precepting trainee clinics.
    - Each division will assign the weight of the clinic-FTE. The DOM standard is that each weekly clinic session equals between 0.1-0.125 clinic-FTEs.
    - Each division chief may adjust this standard for unique circumstances where necessary. (For example, when a clinician is contracted to outlying communities to support multiple clinical activities in one day, including rounding, clinic, and dialysis, s/he may receive either inpatient-FTE or outpatient-FTE credit).
    - **Clinic Session:** is defined as at least 4 hours of direct face-to-face patient care.