Getting Practical on Teamlet Management of Workload, Continuity, and Access:

An Exercise in Three Dimensional Thinking

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VISN 22 VAIL Leadership

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Managing Clinical Work to Achieve PACT Goals

- Capacity & workload—How many patients can be cared for?
- Continuity—seeing the same provider over time
  - Strong evidence for improved cost & quality
  - Highly valued by patients with chronic disease
  - Less valued by healthy, younger patients compared to access
- Access—getting visits when needed
  - Strong relationship to patient satisfaction

Poll

- How many of you are based in sites that
  A. Have adequate staffing capacity for providing PACT care
  B. Meet access goals
  C. Meet continuity goals
  D. Have achieved all three

The PACT Compass Shows the Parts, But Not the Relationships

- The "sweet spot" is an intersection of capacity/workload, continuity and access

Capacity

- Site level
- Individual provider

Disclaimers

- A work in progress
  - Use with caution
  - The Site A example is hypothetical combines information from several sites
- Aim is to create tools to assist sites
  - Feedback is welcome

Capacity Step #1: Is My Site's Staffing Approximately Adequate for PACT?

- In PCMM, identify the number of primary care patients

- In DSS, identify the proportion of primary care face to face time for each provider

Provider Name	DSS Clinical Time
Provider #1	.5 FTEE
Provider #2	1.0 FTEE

- At 1200 patients per panel, calculate needed PCP, teamlet & team FTEE for PACT care

Example: Capacity for Site A

- Site A has
  - 16,000 patients in its population
  - Needs e.g.,
    - 13 PCP FTEE
    - 13 -15 each RN, LVN, clerk for teamlets
    - 4 - 8 teamlet pharmacists
    - 2 team social workers

Site A PACT Staffing & Deficits

This academic site has

- 18 individual MD/NP/PAs at 11 FTEE; needs 13 FTEE

  - 5 NPs work .1 to .7 clinical time

  - 6 MDs work .1 to .6 clinical time

- 10 RNs & 12 LVNs at 10 FTEE each; needs 15 FTEE (to assure coverage)

- 1 social worker at 1 FTEE; needs 2

Staffing deficits are a known major cause of teamlet dysfunction

Site A Approach: PCP Sufficiency

- Reevaluated and renegotiated PCP "non-clinical" paid time
  - Surveyed PCP's regarding time allocation for specific committees, research, teaching, QI
  - Identified e.g. low priority committees, unfunded research, QI without approvals
  - Renegotiated clinical time transparently & changed values in DSS
  - Hired one new PCP

Site A Approach: Team/Teamlet Sufficiency

- Reviewed ALL site functions and ALL staff vs work
  - Specialty clinic volume, activities
  - Procedure location and support
  - Patient information, greeting, MyHealtheVet
- Identified duplicated, untargeted, low use activities, e.g.
  - Low volume specialty clinics could be combined, releasing RNs, LVNs, pharmacist & social worker
  - RN procedure support, e.g., conscious sedation, duplicated & could be combined

Site A Approach: Support High Quality PCP's With .1 to .6 FTEE Clinical Time

- Evidence review shows equal or greater patient satisfaction for part-time PCPs
  - Teamlet structure can enable part time PCPs to achieve PACT goals
- Higher coordination demands on clinics generated by part-time PCPs & housestaff may be offset
  - These PCPs can bring leadership, research, education, or QI into the PC environment
- Efficient and effective use of time in clinic must be achieved to justify part-time practice, however

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Site A Capacity: Conclusions

- Overall site capacity was in the ball park for PACT with redistribution and limited hiring
  - Shifting/consolidation of jobs inside & outside of primary care based on careful analysis
  - PCP time was allocated fairly and transparently, including part time PCPs
- Enabling coverage for missing teamlet RNs & LVNs was a priority

ACCESS

Fine Tuning Supply and Demand

- Match expected to actual available PCP visit time (Jim Jackson/Justin Sivill formulas)
- Expected supply based on each teamlet/provider's
  - DSS clinical time, bookable PC hours per week (minus e.g. wound clinic)
  - Patients per hour when in PC clinic
- Actual supply based on evaluation of clinic schedules (grids)
  - Weeks per year in clinic
  - Cancellation rates, panel attrition rate, continuity, return visit rate, patient sicknesss/complexity

Supply: Simplified Calculation

- <u>Definition</u>: bookable appointment time is negotiated DSS clinical time using the formula→ (% clinical PC visit time x 40 hours) x .9.
  - Equates to 28.8 bookable hours per week for clinicians with 80% clinical time.

Example Site A Supply Findings

- Variations in
  - teamlet/provider return visit rates
    - Sometimes accounted for by variations in panel sickness, especially mental health
    - Also affected by discontinuity, rates of non face to face encounters
  - available grid time per year for same clinical FTEE (e.g., due to travel, teaching)

Site A Approach: Working With PCPs and Teamlets

- Review teamlet scheduling grids, panel size, attrition, no-shows, patient complexity, return visit rate and identify outlying values

- Review available teamlet PCP clinic visit slots per week and per year and adjust expectations

- Set a realistic panel size goal for each provider
  - Adjust expected panel size based on return visit rate if justified by complexity level

Site A Approach: Open Access

- For Open Access
  - Aim for 30% to 50% of slots unbooked at the start of a workday
  - This reflects a judgment that 50% to 70% of slots should be pre-booked follow-ups (internal demand)
  - Scheduling method may require adjustment for part-time clinical PCPs
  - Emphasize non face to face and teamlet supported interactions to reduce return visit frequency

Open Access and Continuity

- Open access generally means open access to the continuity teamlet and PCP
    - Having some slots available for walk-ins to non-continuity providers is necessary
- Use of non-continuity walk-in slots must be minimized to hit the continuity/access "sweet spot"
    - Ensure access to someone to reduce ED visits, improve satisfaction
    - Maximize decision-making by the continuity PCP through teamlet continuity management

Continuity:

It's easy to achieve continuity if you don't care about access, and easy to achieve access if you don't care about continuity

Continuity, Access and Walk-ins

- Increasing one can worsen the others
- Improvement requires intensive focus on
  - Telephone answering, pharmacy refills
  - Post discharge & post-ED follow-up
  - Scheduling, including resident/attending
  - Use of non-face to face visits
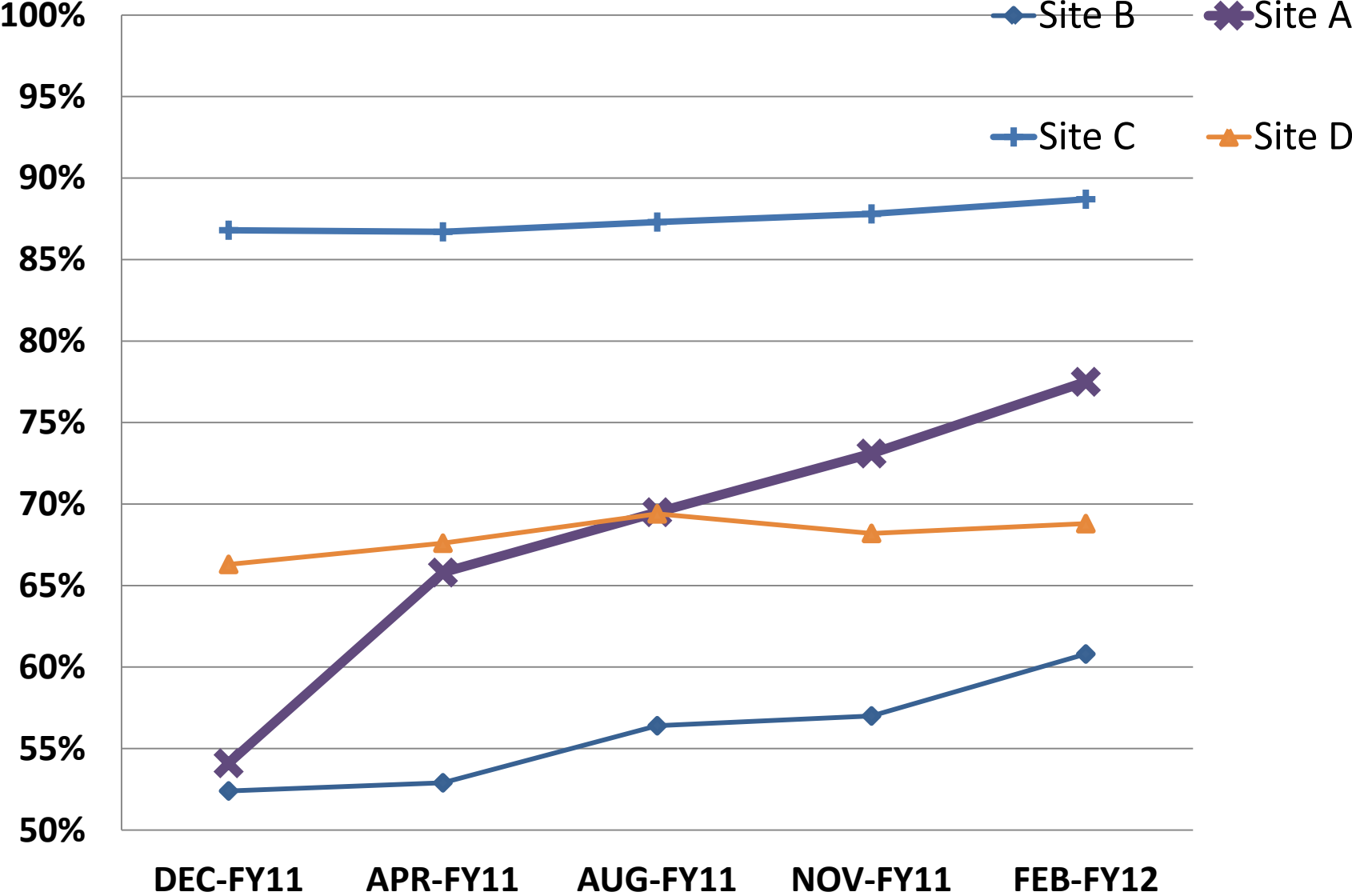
Site A Continuity Interventions

- Teamlet report card
  - Can drill down to individual discontinuity visits
- Walk-in reduction
  - Pharmacy refill and expiration generated 50% of walk-in visits
  - Engaging teamlets & pharmacists reduced walk-ins for refills to 20%
- Changed schedules for residents

Teamlet Report Card*

BLUE	PCMM Panel Continuity with Provider			PCMM ED Encounters		PCMM Phone Encounters	
	Numerator	Deno-minator	% Continuity	Numerator	% ED	Numerator	% Phone
May Team Summary →	654	782	**83.6%**	55	**7.0%**	131	**20.0%**
June 1-15 Summary →	347	399	**87.0%**	29	**7.0%**	66	**19.0%**
June 1-15 Detail ↓							
Blue 1A	46	56	82.1%	8	14.3%	3	6.5%
Blue 1B	71	78	91.0%	3	3.8%	11	15.5%

*Programmed in SQL to generate up to date results

PACT Measure: PCP Continuity

Legend:
- Site B
- Site A
- Site C
- Site D

X-axis: DEC-FY11, APR-FY11, AUG-FY11, NOV-FY11, FEB-FY12

Y-axis: 50% to 100%

Lesson Learned: It Takes a Village

- The whole process falls apart if
  - Teamlet is dysfunctional
  - Scheduling system is too rigid or too loose
  - Schedulers are free to put non-continuity patients into open slots
  - There is no good system for walk-ins
  - Teamlets function inequitably
- Bottom line: If teamlets do not function, AND/OR do not back each other up, patients are at risk

Open Access, Continuity, and Capacity—A 3-Dimmensional Puzzle

Characterizing Primary Care Provider Activity in Routine Practice

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Overview

Understand primary care provider roles and activities during patient encounters and explore opportunities for productivity improvement in care teams.

1. What types of care occurs during patient provider interactions?

2. Who could be providing this care?

3. Could the care occur off-site?

Methodology

Video taping "day in the life" of primary care provider at PVAMC.

1. Characterize the full range of activities that occur during the encounter and quantify the amount of time used in each one.

2. Characterize the encounter by having physicians quantify the amount of time in each visit that could be done remotely or by an extender.

3. Describe physician judgment of appropriate time to next follow-up appointment.

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A Typical PCP Patient

Male, 59, here for a primary care follow-up visit. Last PC visit was 5 months ago. Patient had been hospitalized due to numbness in the legs and inability to walk or talk. His blood sugar was 500 and he was started on insulin. His blood sugar had spiked due to poor diabetic dietary adherence (eating candy and soda), but was 225 at the time of the last visit.

Progress note for current PC visit indicates that his diabetes may be "too tightly controlled, given that he is taking his long acting insulin as if it were short acting insulin," putting him at risk of overdosing on insulin. Provider gave patient's wife, who administers the medication to him based on his glucometer reading, instructions on how to properly administer the medication. Provider also set patient up with pharmacy diabetes management clinic for insulin management and education.

Example of a Timed Video Encounter

Time [min]	Activity
0	Patient enters
1	Pt asks about glucose levels and insulin shot levels
2	Dr. looks up prescription information on pc
3	Dr calls pt's caregiver to consult about pt's insulin medication
11	Dr discusses possibility of signing pt up for diabetes management
12	Dr discusses getting the pt glucagon
14	Dr/off phone, on computer
15	Dr asks pt about any low blood sugar history
16	Dr explains to pt how to store new meds
17	Dr/on computer, prints something
19	Dr gives patient printout of medication information
20	Pt asks Dr to make consult for liver ultrasound
20	Dr puts in liver ultrasound and pharmacy consultation
21	Dr/on computer
25	Dr briefly examines pt
26	They discuss pt's weight and exercise
27	Dr goes through meds
27	Dr/on comp
28	Dr orders blood work to watch sugar & reschedules ultrasound
29	Dr/on computer
30	Dr examines pt briefly again
31	Pt leaves

Analysis 1: What Type of Activities are Performed?

We examined 21 encounters from 5 PVAMC PCPs for specific activities which we grouped into 12 categories.

1. Small Talk
2. Discussing Existing Condition
3. Discuss New Conditions
4. Medication Review
5. Treatment Plan-Med
6. Treatment Plan-Other
7. Examine Patients
8. Health Promotion and Disease Prevention
9. Coordination of Care
10. Write Visit Notes
11. Interruption
12. Other

Analysis 1: Time Spent on Various Activities

Time spent During A PCP Visit
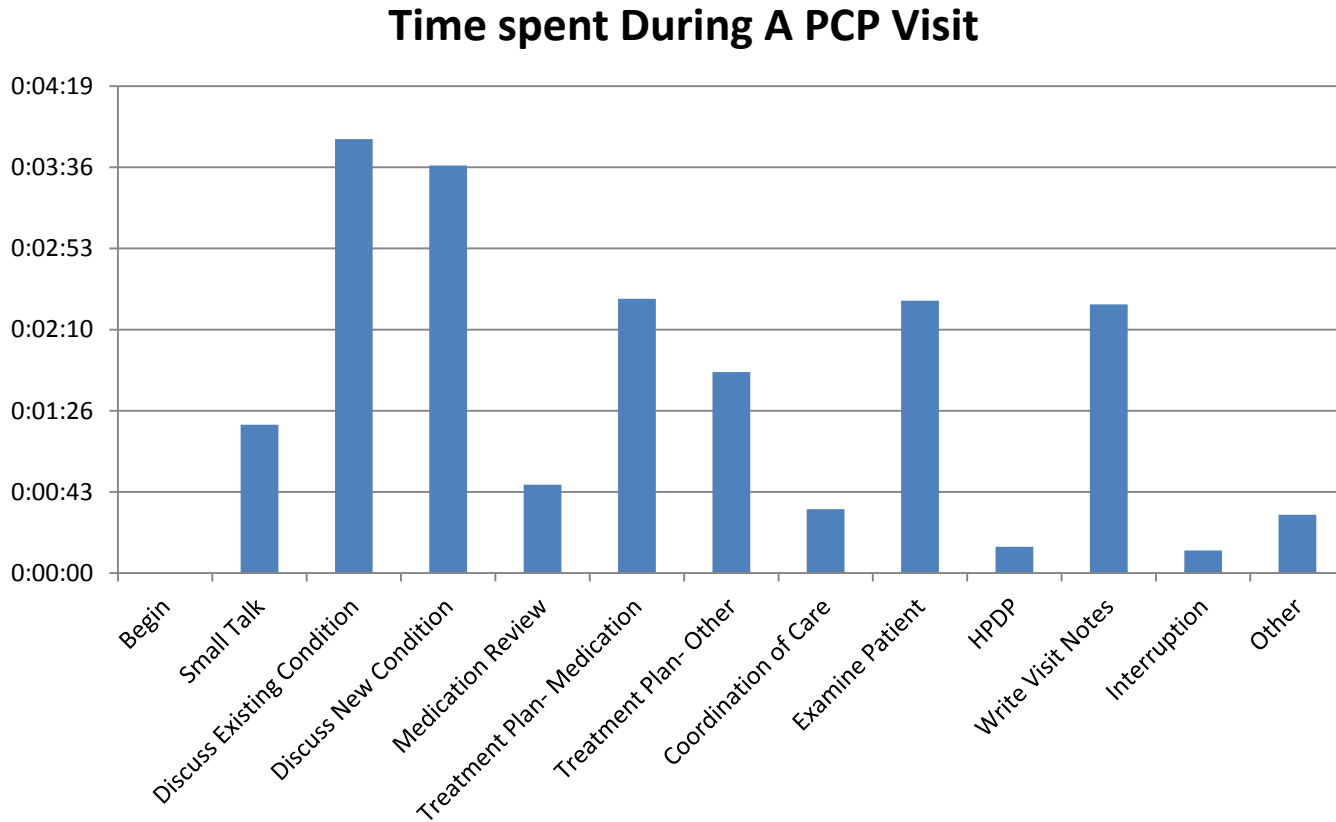
* Based on 32 patient encounters from 9 providers at PVAMC

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Analysis 2: Redesigning Care Delivery

Care is provided by

	Doctor	Extender
Onsite	Status quo	PCP extender onsite Example: patient education, discuss weight loss
Remotely	Emails and follow-up calls Example: "Do you want to come in for your follow-up appointment or talk on the phone?"	PCP extender calls Example: "do you need refills of certain medications?"

Presently, all activities (time) was spent by Doctors onsite (upper left cell)

Opportunity to redistribute
> From Providers to Extenders
> From Onsite to Remote

Analysis 2: Redesigning Care Delivery Process

Time [min]	Activity
0	Patient enters
1	Pt asks about glucose levels and insulin shot levels
2	Dr. looks up prescription information on pc
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31	Pt leaves

As before, using the videos broken up into "episodes"
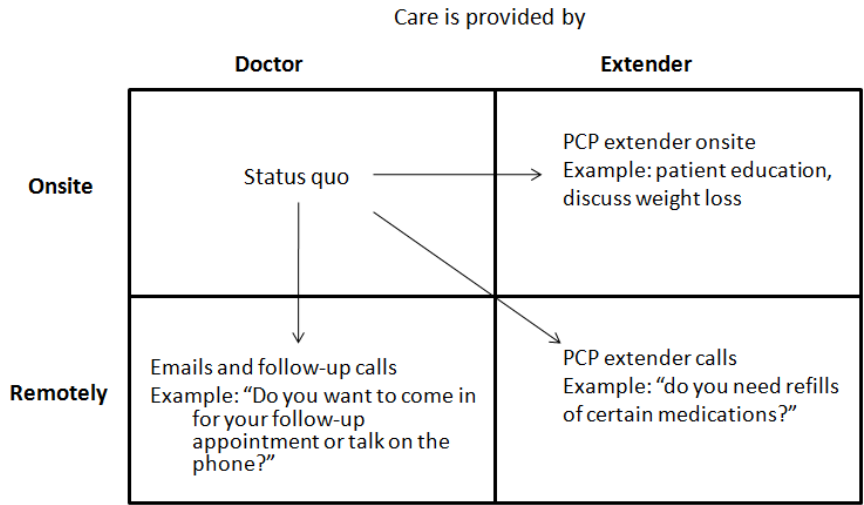
Each episode categorized to:
- onsite / off-site
- provider vs. extender

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Analysis 2: Methodology

Care is provided by

	Doctor	Extender
Onsite	Status quo	PCP extender onsite Example: patient education, discuss weight loss
Remotely	Emails and follow-up calls Example: "Do you want to come in for your follow-up appointment or talk on the phone?"	PCP extender calls Example: "do you need refills of certain medications?"

Classification is based on subjective evaluations done by three physicians

Physicians were instructed to use their clinical judgment to categorize into one of the four cells

In the case of disagreement (2:1), we assigned activity to cell based on majority vote

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Analysis 2: Results

Care is provided by

	Doctor	**Extender**	Total
Onsite	19%	3%	22%
Offsite	59%	18%	78%
Total	78%	21%	100%

21% of the work could be done by an extender: 78% of the work could be done off-site

* Based on 9 encounters from 7 providers

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Analysis 3: When Should We See This Patient Again?

- Our analysis assumed that the visit had to happen – but why is the patient in the office today?

- In most cases, an appointment was made several months ago

- Revisit frequency is critical for panel sizing / doctor's capacity

- Objective: how do physicians determine the time to the next appointment?

Analysis 3: Agreement on Revisit Frequency: When Should We See This Patient Again?

When should we see this patient again (in [months], response by three PCPs)?

Patient	Doc 1	Doc 2	Doc 3
1	3	3	1
2	4	9	8
3	6	6	8
4	4	3	12
5	6	2	12
6	6	9	12

Large disagreement among physicians

Future research: How does revisit frequency change with new primary care work-flow (expanded care team, off-site communication)

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Future Work / Next Steps

- Increase sample size

- Compare these results across sites (PACT and non-PACT)

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