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Institute of Medicine, Committee on Optimizing Scheduling in Health Care
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Institute of Medicine, Committee on Optimizing Scheduling in Health Care : Transforming Health Care Scheduling and Access: Getting to Now before purchasing it in order to gage whether or not it would be worth my time, and all praised Transforming Health Care Scheduling and Access: Getting to Now:

0 of 0 people found the following review helpful. Systems strategies finally coming to healthcareBy Arete-ZoeThe Institute of Medicine (IOM) report Crossing the Quality Chasm identified six fundamental aims for health caremdash;that it be safe, effective, patient-centered, efficient, equitable, and timely.The Committee assessed some

established conceptual models and systems-based engineering approaches that have been successful in other sectors. The success of these methods depends upon their holistic application simultaneously in every part of an interconnected system (p 2). Timeliness in providing access to health care varies widely, due to mismatch between supply and demand, provider-centered approach, prioritization, complexity of care and reimbursement procedures, outmoded workforce and care supply models, and financial and geographical barriers. Negative consequences of delays in care include suboptimal health outcomes, healthcare utilization, and damaged reputation of an organization (p 3). The 2014 VA/VHA OIG audit of the VA Phoenix Health Care System confirmed false reporting its scheduling queues and wait times. 1,700 veterans in need of a primary care appointment had been left off the mandatory electronic waiting list (EWL). Even worse, according to the VA/VHA final report, Review of Alleged Patient Deaths, Patient Wait Times, and Scheduling Practices at the Phoenix VA Health Care System, 40 of these veterans had died while on the EWL without getting an appointment (p 7). The VA/VHA reacted by deploying a 90-day program to improve the system and gave veterans the option to seek healthcare in the private sector (p 8). The Committee looked into ambulatory, rehabilitative and acute care settings to make the report relevant to the whole healthcare system. Chapter 2 describes the current system with all its challenges. Strategies for improvement and application of these models in other sectors are discussed in Chapter 3, followed by emerging best practices and alternative approaches in Chapter 4. Chapter 5 then summarizes the Committee's findings and recommendations. The most commonly used scheduling techniques in the U.S. healthcare system are block scheduling, modified block scheduling, and individual scheduling. Primary care is typically fairly predictable. Due to financial constraints there is a need to find ways to make better use of the existing provider capacity rather than hiring new doctors (p 17). Scheduling of appointments for specialty care may be affected by external factors, such as insurers' preauthorization, tests and procedures performed by third parties, and co-location issues (p 18). Consistent delays in emergency departments and failure of improvement programs are caused by lack of focus on the system in a holistic manner and accommodate staff behaviors and organizational culture. Using systems strategies, industrial models and optimization techniques, health care institutions can serve more patients treated in hospitals without increasing the number of beds (p 19). Assumptions of clinical urgency contribute to delays in priority-queue models. Systems strategies for continuous improvement presented in Chapter 3 include Deming Wheel or Plan-Do-Study-Act (PDSA), Six Sigma (define, measure, analyze, improve and control), Lean (focus on non-value-adding activities), Queuing theory (mathematical study to minimize queues), Flow management (dynamic control of processes), Human factors engineering (safety, effectiveness and ease of use of various designs), Theory of constraints (focus on limiting constraints) and Statistical process controls (used to identify bottlenecks and to reduce delays) (p 28-29). Number of best practices emerged from experimenting with systems approaches: organization-specific benchmarks such as standards pertaining to emergency department boarding times or hospital discharge risk assessments; Advanced Open Access Model in Primary Care as implemented in Southcentral Foundation's Alaska Native Medical Center and academic primary care practice Baylor Family Medicine; Smoothing Scheduling Flow Model as applied in St. Thomas Community Health Center (Primary Care) or Cincinnati Children's Hospital and Medical Center Outpatient Clinic (Specialty Care); Team-Based Approach used in Group Health (Primary Care) and Thunder Bay Regional Health Sciences Center Shared Care Clinic (Mental Health Care); Technology-Based Alternatives as used by Teladoc, Kaiser Permanente Northern California or Virginia Mason Medical Center in Seattle; and Smoothing Patient Flow in Inpatient and Emergency Care as implemented in Mayo Clinic, Florida for their operating room use or Cincinnati Children's Hospital Medical Center. These and numerous other examples are presented in Chapter 4. The commonalities in success include (p 57):

- Supply-demand matching through formal ongoing evaluation.
- Immediate engagement and exploration of need at time of inquiry.
- Patient preference on timing and nature of care invited at inquiry.
- Need-tailored care with reliable, acceptable alternatives to clinician visit.
- Surge contingencies in place to ensure timely accommodation of needs.
- Continuous assessment of changing circumstances in each care setting.

In Chapter 5 the Committee offers 10 recommendations shall accelerate progress toward greater system responsiveness: supply matched to projected demand, immediate engagement, patient preference, care tailored to need, surge contingencies, and continuous assessment (p 69). Recommendations for National Leadership shall lead to spread and implementation of basic access principles. Federal implementation initiatives involving multiple departments shall broadly promote systems strategies in healthcare as well as development, evaluation and application of standards. Professional societies shall lead the way in application of systems approaches, whilst the main role of public and private payers should be in providing financial incentives and other tools. Health Care Facility Leadership shall focus on front-line scheduling practices anchored in the basic access principles, governance commitment to leadership on basic access principles, patient and family participation in designing and leading change and continuous assessment and adjustment at every care site (p 71). In essence, the report introduces a concept that is well worth the time.

According to Transforming Health Care Scheduling and Access, long waits for treatment are a function of the disjointed manner in which most health systems have evolved to accommodate the needs and the desires of doctors and administrators, rather than those of patients. The result is a health care system that deploys its most valuable

resource--highly trained personnel--inefficiently, leading to an unnecessary imbalance between the demand for appointments and the supply of open appointments. This study makes the case that by using the techniques of systems engineering, new approaches to management, and increased patient and family involvement, the current health care system can move forward to one with greater focus on the preferences of patients to provide convenient, efficient, and excellent health care without the need for costly investment. Transforming Health Care Scheduling and Access identifies best practices for making significant improvements in access and system-level change. This report makes recommendations for principles and practices to improve access by promoting efficient scheduling. This study will be a valuable resource for practitioners to progress toward a more patient-focused "How can we help you today?" culture.