Provider Capacity Limits

Question:

When we say “see your own and don't make them wait,” is there ever a number that we should tell providers that they should have as upper limit goal? Is there ever a number that is unsafe to continue seeing more patients? My guess is if your panel size is just right, that there are just variances. I would love your advice in terms of what to tell patients.

Answer:

There is a number. And this will, of course, vary, dependent on the clinical conditions (random events for the most part) and personal capacity of the providers.

On the other hand, if we use variation in personal capacity and variation in random patient events as a ready alibi to push work to others or to the future, we get systems that don't work well. Due to this variation, current system performance is often characterized by long waits, high levels of demand variation and daily practice turbulence. The consequences of demand or supply variation are commonly absorbed by patients as variable delays. If we understand that the consequence of patients absorbing the variation is delay and if we believe that all waits are bad, that all waits sub-optimize system performance in terms of satisfaction, cost and revenue, and clinical outcomes, then we must shift focus away from making patients absorb practice variation towards the practice absorbing the variation in order to work without waits.

To accomplish this, the practice and the individuals need to look at three key metrics:

1. The delay for the third next available appointment (TNA). Is the TNA stable?
2. The panel. How does current panel reconcile with the ideal panel equation?
3. The daily demand, supply and activity (DSA).

If these three metrics are favorable, then we can do the work. We just have to control the variation:

1. Get rid of backlog. This eliminates the "clutter" in the system.
2. Equitably divide the work from any absent provider(s).
3. Without using appointment type restrictions, develop and use a scheduling approach and system that looks at the pattern of the entire day (not the three next available appointments). Teach schedulers how schedule "smartly," that is, smooth the pattern of the return (internal demand) patients, and use a computer system that sets daily thresholds (not limits) on future scheduling.
4. Book return appointments late in the week, early in the day.

5. Schedule less return appointment on days with fewer providers present in order to ensure that external demand can be met.
6. Schedule as many return visits as possible as the patient leaves. This moves non-scheduled, random work to scheduled work.
7. Use signals. For example, if the provider indicates a specific return day, then schedule on that specific day. If, on the other hand, the provider uses the signal of a time frame (days, weeks, months), then this grants permission for the scheduler to smooth the return work within pre-set ranges.
8. Schedule return visits within a sweet spot, not so long as to increase no shows and not so short as to create re-work.
9. Take a practice pulse at 11 AM. At this time of the day, most practices can determine the pattern and scale of that day's workload and can decide to pick up the pace. Don't wait until the end of the day to make these decisions.
10. Use huddles and other daily communication strategies to keep providers and staff informed of daily activities and progress.
11. Trust the team to make scheduling decisions.
12. Employ a "we all work until done approach." In this approach the entire team works until the work is done. This strategy will improve communication, improve flow, and reduce batching of work and force teammates to work together for a common goal.
13. Avoid batching of non-appointment work until the end of the day. When providers or staff delay non-appointment work until the end of the day (documentation, phone calls, etc.), this bolus of non-appointment work competes with end of the day appointment work.
14. Develop strategies to manage all the non-appointment work. Use the entire team.
15. Study the patterns of patient demand. For example, is there demand at the end of the day? Then make decisions about how to meet that demand.
16. Agree in advance that each provider will absorb a pre-determined number of "over-books" each day. And agree in advance on how to communicate immediately with the provider and his/her team when that number is approaching the "limit." Make a plan for each provider to personally manage any patients over that "limit." Monitor the individual management decisions of the providers at the practice leadership level. Consider each over-limit as a defect and find ways to fix that defect.
17. Use past data to show variation in past performance. If the schedule has 20 appointment slots, how many days do we actually see 20? With past and expected future ratios of no shows and walk-ins, the likelihood of seeing exactly 20 is not high. So we "put up with" variation in the past and we will continue to do so in the future. Except that in the future we will have far more control over the variation.