Clinic Efficiency Webinar #2: Increasing Capacity to Provide Quality Family Planning Services Transcript

Katie Saul: Hello, everyone, and thank you for joining us today. This is Katie Saul from the Title X Family Planning National Training Center. I'm happy to welcome you all to today's webinar on Increasing Capacity to Provide Quality Family Planning Services. This is the second webinar in our three part series on clinic efficiency. Just so you know, the recording and the slide deck with talking points from the first webinar, which was on Strategies to Improve Patient Experience has been posted on FPNTC.org and the third webinar in this series, which will be on August 23rd, will focus on some of the tools that we're highlighting during today's presentation so please also register for that webinar if you're interested in learning more after today.

A few things before we begin. Everyone on the webinar today is muted given the large number of participants that we have. Please use the chat button at the bottom left of your screen to ask questions at any time. We will answer all questions at the end of the presentation, but you can send those questions in really at any point during the presentation today. As I mentioned, we're going to introduce several tools and resources to you today, and links to all of those resources are included at the end of the slide deck today. We'll also post our recording of today's webinar as well as the slide deck with talking points and a transcript of today's webinar in the next few days so please keep an eye out for those as well.

Okay, I'd like to introduce you to our speaker today, Jennifer Kawatu, who is a technical assistance provider with the Family Planning National Training Center. She's worked in women's health for over 20 years, first as a direct service provider then with the Region 1 Training Center and then the National Training Center for Quality Assurance, Quality Improvement and Evaluation. Over the years, she's worked with dozen of family planning clinics around the country and more recently, in the last couple of years, she's focused on clinic efficiency and improving access to contraception. Jennifer's led three national learning collaboratives on these topics and has led onsite participatory workshops on clinic efficiency with upwards of 40 Title X grantees and clinics in their network. She's developed many of the tools that we'll share with you today, and we look forward to hearing more from here this afternoon. Jennifer, with that, I'm going to turn it over to you.

Jennifer Kawatu: Great. Thanks, Katie. Today we'd like to talk about clinic efficiency for family planning services and increasing capacity to provide quality services. We're going to try and touch on the importance of clinic efficiency at family planning service sites, how to engage staff in activities to identify waste and causes for inefficiency and talk about some strategies to improve clinic flow, clinic systems and staff productivity to increase efficiency.

Throughout the webinar today, as Katie said, I'll be introducing a number of resources that you can use to help work with your staff and lead clinic efficiency improvement efforts across your networks. First, during our previous webinar in this series, if you joined for that, which focused on improving the patient experience, we defined quality from both the provider and then the patient's perspective. According to the Institute of Medicine, quality of care is care that is safe, effective, patient centered, timely, efficient and equitable. We all know about quality metrics and performance measures and this is how quality is generally viewed from the provider's perspective. Quality according to the patient, on the other hand, is defined by the extent to which the patient's expectations were met. In other words, did they get what they expected, and if they got what they were expecting, then to them this means the services were of value. They were effective.

If effectiveness is how well you meet provider, but particularly patient expectations, then efficiency is how many resources you spend doing this. A common misconception is to think of efficiency as just being all about speed. A lot of people assume that efficiency is how quickly a task is accomplished but efficiency doesn't mean just turning up the speed dial and doing things the same way but faster. Efficiency is doing more with the resources that you have without comprising quality and sometimes, or hopefully, even by improving quality. This is a key point because over the years as we've started the process of working with service sites to improve efficiency, there's usually some level of trepidation and sometimes even pushback from some staff and providers. If the perception is that they're just going to be asked to do the same things but to turn up the speed dial, then they're unlikely to be too enthusiastic about making changes.

I really want to stress that this is an important place to start and start with this point. The idea is to work smarter, not harder. Again, it's about doing more with resources without compromising quality. That's really what we want to focus on today. How can you ensure effective and efficient care? Today we just want to take a little bit of a deeper dive into a few of the domains of clinic efficiency so we want to talk about capacity and demand and then how that relates to staff utilization and productivity and clinic flow. For each of these, we'll review some of the best practices identified in the literature and from experts in the field as well as some practical strategies that have come out of the Title X network itself, and from some of our experience working with many of you over the years. We'll discuss some of the tools you can use to implement and assist clinics in your networks as we said.

Let's start with capacity and demand, or in this case, it's really demand and capacity since we're going to flip this around and talk about demand first. Demand is patient requests for care. We talked in the last webinar about the patient experience and some ways to improve patient experience, which are often things that influence your level of demand for care. The demand is influenced by lots of things. Your appointment systems, your reputation, outreach and of course, patient experience. It can also be influenced by things

like your location, from competition from other providers, funding, third party payers in the area, etc, etc. It's not just one thing, but as most of you probably already know, when family planning patients are surveyed, and this really has been found to be true over and over again, but the single most common source of referral for services when patients are asked the question "Where were you referred from?" The single most common source is family or friends.

In other words, word of mouth because clearly, heavily influenced by the experience that that patient has in your setting. They're unlikely to refer their friends and family if they've had a bad experience. All right. Demand is patient requests for care. Capacity, then, is the ability to meet those requests for care. In other words, the ability to see the patients who want to be seen, when they want to be seen, and in the time frame in which they want to be seen for the services for which they want to be seen. Capacity is influenced by a number of things, as well, including the appointment systems, staff utilization and productivity, clinic flow, as we'll talk about, but also some of the other same things like funding and policy issues, etc. It really comes down to the fact that it's all about balance. You want to identify your capacity and match it to your demand. A client that matches capacity and demand is one that's working to its full potential and is seeing as many patients as possible.

Too much capacity, and not enough demand, and you have under-utilized staff and facilities. Unfortunately we know that numbers have dropped in some locations. Patient volume can fluctuate for a number of different reasons. It can be due to funding and policy changes, increased coverage, the ability to go elsewhere. It can be an increase in LARCs used, changes in clinical recommendations. There are lots of different factors. You can only address the aspects that you have control over so this is why it's more important than ever to focus on the patient experience for those of you with this side of the balance. Then, there's the other side. If you don't have enough capacity and you can't meet your demand, or you have a hard time meeting it, this can result in limited access to care and poor patient experience. Of course, you want to balance your capacity and demand in general for the whole service site, but also in terms of specific days and times when possible.

You want to match your resources and staff with predictable variations in demand. By that, we mean many sites have the same staffing model every day of the week or every day that they're open with no variation in throughout the day. Just all of the hours that they're open. On a given day, or week, or in months in some communities, you can identify busier and slower times. This means just be creative. Try to find ways to expand and contract the staff that are available so that there's enough help during the busy times and staff are fully utilized during slower times. What you're going for is, of course, higher productivity without compromising visit cycle times or quality of care. Instead of scheduling everyone nine to five, for instance, can you stagger schedule or double up on certain days when you know you have a higher volume?

Capacity can be assessed by doing real time studies. We recommend doing patient tracking and observation, and you can use the Clinic Efficiency Dashboard to analyze and track this, which we'll talk about in the third webinar in August as Katie referred to before. What we hear from a lot of clinics as we get started working with them is that we hear "Well, we're seeing as many patients as we can." When we look closer at the data, we sometimes find that there's room for improvement. That's why it's so important. We really want to make sure that we are looking at the data and making this a data driven process and using the data to inform our efforts. It's really easy to feel overwhelmed when systems are not efficient. Staff can be really busy but without being productive.

Let's look at staff utilization and productivity. Again, it's just really important to look at your data and have the data drive your improvement efforts. You're going to view past volume, past patient volume data. I encourage you to look at trends over time for at least a year and have your numbers gone up or have they gone down? Maybe think about and identify possible reasons. Look at the number of patients scheduled versus the number of patients seen. We encourage you discuss patient scheduling and no show data with staff. Identify priority areas to address with all clinic staff. Are there particular days or times of the day when demand is higher, for instance? Look at your percentage of no shows, of course. If you're trying to schedule three patients per hour, and you have a no show rate of 30%, then the maximum number of patients that the provider can see is two per hour. No shows really do factor into productivity. For no shows, most sites are trying to get a no show rate of under 20%. That's the most common goal that we hear.

What the literature consistently tells us about staff utilization and productivity from many different sources is that it's important to increase clinician support and cross train staff. Review your job descriptions of the different staff roles. Talk to staff about whether these descriptions accurately reflect what they do and make adjustments as necessary. Narrowly defined roles result in more patient handoff and that's always an opportunity or cause for delays for both patients and staff. Remember that the clinician is the limiting resource. Staff should support clinicians to do what only they can do. We always say that if someone other than the clinician can do a task, then they should do it. Your clinicians should primarily spend their time doing what only they can do because the goal really is to work as a unit or a team. Encourage teamwork and cooperation. Team based care is all the rage in primary care these days, as you know, but take the time to build those teams and make sure that you're using each and every person's talents and skills to the maximum.

Again, create broad work roles and cross train staff, remembering that your clinician is your limiting resource. We've also found that it's really helpful to have staff shadow each other so that they're aware what each other is doing and can avoid some of that duplication of effort. This really allows staff to observe each other's strengths, as well, and fosters empowerment. When we've gone on site to do clinic efficiency in the past, I've observed patient visits from

beginning to end. That's part of our process. Often, what I find is that patients are asked the same thing over and over by staff. Unintentionally, but it's just what's happening. The front desk asks her a question and then the clinic assistant asks the same thing, maybe the nurse and then the provider. If they were all communicating with each other better, then they could reduce this kind of duplication, save time and also reduce frustration on the part of the patients. They don't enjoy being asked the same thing over and over either.

What we've found is that often staff don't realize that they're duplicating some of the same questions or topics. They don't realize this until they observe each other doing counseling sessions or going through the visit. That's often the opportunity to recognize this and to make improvements, so I encourage you to have staff of all different levels and roles to shadow each other. Then, another important aspect to look at is optimizing your EHR for efficiency. Documentation is one of the most common complaints and reasons that providers can't see more patients than they do. This is an example we'd all it's a penny wise and a pound foolish. Try to get your EHR organized and user friendly so it doesn't take so long to document. Ideally, a provider should really be able to do all of the documentation in the room in front of a patient and shouldn't need additional time after the patient visit. If this isn't happening, try and see what can be done and if any adjustments can be made and ask your providers. Definitely ask your providers.

They usually have lots of ideas about how to make documentation more efficient, and it's worth every second and every penny that it takes to listen and implement other suggestions. We could probably do a whole webinar on this easily, and maybe someday we will, but right now we're just going to leave it at that. All right. Basically, you want to remove the burden off the provider whenever possible. This is because really the majority of reimbursement is from the number of patients that the provider sees. If a provider sees just one more patient per day, if you use the UDS average of $114.00 per patient ... That's just an average per visit ... If you use that average, multiplied by one extra patient per day, that's about $30,000 a year. That's significant. We want to encourage you to recognize that even small increases in the number of patients seen, small increases in productivity really make a big difference.

In terms of calculating productivity, this is something we are asked about a lot. The thing is that Title X sites and networks calculate productivity in a wide variety of ways. Some of you are FQHCs, or hospitals or belong to large organizations that calculate RVU's and have sophisticated dashboards for productivity. Others are small, with just one provider, and even sometimes that provider may not be full time. There's a big range and there are also vast differences in levels of support staff. Some sites have a provider and a front desk person and that's it. Others might have several clinic assistants, nurses, a certified coder that handles the coding, etc. It's very hard to come up with standards across the board. What we can say is that there are no established national productivity standards and goals set for the family planning setting. Some organizations have set their own, and some go up to a goal of having up

to six patients served per hour. That would include non-exam visits, but up to four patients an hour including patients who see a provider.

We know that the other sources that we can look to, for instance, the National Family Practice Productivity studies and the literature show us that family practice providers see 2.74 patients per hour on average. These are just some of the places that we can look to for reference and a common productivity, MGMA, as well, ACOP. We've looked at several different sources and a common productivity or improvement goal for family planning agencies that we have heard is three to four patients per hour. Again, it's really important to actually calculate and to look at your data. We've gone to some sites where the staff and providers were really busy all day long and they were running from place to place and they had no downtime. They've been just sure that they couldn't see any more patients and sometimes have been hesitate to even engage in discussions about efficiency or about seeing any more patients.

However, sometimes when we've looked at the data, and we've measured how many patients were they actually seeing per day based on the number of hours in the clinic and the number of providers, we found that in some cases, they might only be seeing sometimes one, or one point something on average patients per hour. Sometimes when they've looked at these data and they started to become more aware, they also become more open to the idea that maybe they could see more patients if they were following the principles of clinic efficiency and were really working hard to work smarter, not harder, that maybe they could do it. We've seen many clinics increase their productivity substantially by making some relatively simple changes. They usually need that data to begin with before they get started.

Many of those changes have had to do with clinic flow. I'm going to spend a little bit more time on this one. Clinic flow is the process by which a patient moves through his or her visit. Improvements to clinic flow can be made by applying principles of what we call Lean. Lean is an approach to process improvement that focuses on minimizing waste. Waste being time, energy, resources, anything that's a cost to the patient. Minimizing waste and maximizing value, remembering that value is defined as what is valued by the patient. A few examples of what we mean by waste, some different types or examples are, for example, time spent on people or processes. This could be a provider waiting for a clinic assistant to finish their part of the visit before starting theirs or waiting for a room to open up or waiting for supplies to be gathered before you can do a procedure.

Waste can also be non-utilized skills or knowledge, so under-utilized staff. An MA who might be able to do more than just take vitals and yet, is sometimes just waiting around the clinic for the next patient to com and need their vitals taken instead of being given more to do. I'm sure there are some clinic assistants out there right now who are saying that never happens. I'm always busy. It's certainly not all but we don't want to have under-utilized staff. We want everyone's skills to be used to their max. Extra movement around the

clinic. For example, leaving the exam room to find supplies or to hunt down the educational materials that a patient is going to need. Waste can be unused inventory. For instance, if you have expired IUDs or expired medications. Waste can be extra processing. For process improvement, extra processing means doing something more than once or more than it needs to be done.

For example, having patients fill out forms that are not really required or it could be something like doing pregnancy tests on all patients routinely or doing pelvic exams that are not indicated. Finally, waste can be defective equipment. For example, a photo copy machine that always breaks down or a printer that seems to have problems or a cloud based EMR that's trying to function where the bandwidth is insufficient. Those are some examples of waste. We do have a worksheet, which is posted to FPNTC.org that we will include with the recorded webinar, along with the other resources, and this is a good activity to complete. You can do this at a staff meeting and see what staff think or you can do it as a waste walk where you walk around the site together as a staff, or as a group, and identify things as you move around.

It's just one way, kind of a first step self-assessment and can help empower your staff to identify and prioritize some of the more obvious inefficiencies in your clinic. Pretty much all sites have some kind of waste. There's pretty much always something that can be an opportunity for improvement. Some of the other strategies to reduce waste are to review and update polices, so making sure that you're not doing things that are no longer recommended, reduce documentation and paperwork. You can verify patient information, so if you already have the information, it's much faster to verify than to ask for it all again. Again, cross train staff and avoid duplication, so making sure that you're using your limited resources to the best of their ability.

All of these strategies and more are discussed in this little video that we've produced and, again, is available on FPNTC.org, which is a little video about clinic flow and wait time. Clinic flow is important because of the productivity issues as we've discussed, but it's also important because wait time is the number one patient complaint among family planning patients. It's a patient experience concern, as well, as most of you know. Those of you who've ever done patient satisfaction surveys, this is consistently a number one, or at least a top concern. We developed this short video on wait time, patient wait time, that offers a few helpful tips and it's a fun way to get the conversation started so we highly encourage you to check it out on FPNTC.org and share it with your staff. It'd be a great launching place for a staff meeting or a conversation with others.

All right, so some of the clinic flow indicators that you'll want to look at are cycle time, so the time that the patient arrives until the time they leave. A goal of less than 45 minutes or less than 60 minutes per visit is recommended. That's just a range. Different sources have different standards. Wait time, so the total amount of time that the patient waits during the visit. That includes in the waiting room, at the front desk, in the exam room. Anytime that they're not in

direct contact with staff. This should total less than 50% of the amount of time spent face to face with staff, or another way to calculate it is less than 15 minutes per visit. Those are the two standards that we see utilized. Finally, the number of patient stops, or patient transitions from one location to another. We're going to talk a little more about that, but again, these are in the clinic efficiency QI guide as well as ClinicEfficiency.com. Again, we'll share all of these resources at the end and talk more about them in the August webinar as well.

All right, so continuing with clinic flow. Another way to minimize patient wait time and to improve flow is to make sure that you're starting all appointments on time every time. Almost every clinic that I've been to working on issues of clinic efficiency has told me that "Well, our patients are late all the time," or "Our patients are frequently late." That's pretty much true in almost every service site that I've ever been on, but statistically, this is not actually true. Some patients are late in every site for sure, but the majority have not. We see that when we actually track them that relatively few patients are late. Clinic managers and staff are often surprised to hear this or to find this out. The feeling, the impression, is often that their patients are late often or all the time. It's important to say this or share the data on this, not so that we can say I told you so or prove anyone wrong, but because it's a different problem to solve so it has a different solution.

If the perception is that your patients are late all the time so you're trying to impact that as the way to improve efficiency, but that's not actually the root of the problem, then it's going to be hard to make those improvements that you're looking for. Again, patients are not late all that often, even though staff feel like they are. What happens is that we notice the one late person. If there are 10 patients seen in a morning, or in a day, then they'll notice the one late person, or the two late people, but they don't notice the eight or nine that are on time. That's one. We do encourage you to collect the data for yourselves, for your own sites, but it's been surprisingly consistent across the country that we've found this is, I think actually, 100% of the time ... It's at least been a lot less than the perception.

Then, the other thing to keep in mind is that it's often that preparation and clinic flow issues get in the way of visits starting on time. This is especially the first visits of the day, or the first in an afternoon session. We've looked at a lot of schedules and a lot of data and we've often been surprised by how many times the very first appointment of the day, or the first in the afternoon, starts late. This also often surprises clinic managers because most clinic managers and administrators are assuming that things get backed up over time and that that's what is causing late starts, actually not even starting on time for the first visit and that cascades and ends up making everything else late. It's important, or a good idea, to look at this first visit.

This can be due to a number of things. Unfortunately, it can be sometimes because providers are late to begin the day. Emergencies happen and everyone has things come up, but it shouldn't be the norm to be chronically late as we've

seen become common in some places. The other thing is that often if you ask providers why their starting late, most of the time the providers will tell you well, that's because there's never a patient in the exam room for me to see until after the clinic begins. That's something that we've observed as well. The first visit of the day, and the first after lunch, should be addressed and can be just treated differently than the other visits to keep this from happening. For instance, some clinics have decided that for the first visit of the day, the provider will just take the patient back and won't even have a clinic assistant do the vitals first. They'll just start right in and do it as they're talking to them.

Others have found that it's more useful to stagger breaks, for instance, or stagger start times. If there's a break in the schedule and all staff are taking lunch from 12:30 to 1:00, for instance, but the first afternoon appointment is at 1:00, well, they're obviously going to be starting that appointment late on a regular basis, so many places have found that if they stagger lunch breaks or stagger breaks and start times to make sure that someone's there to check in and get the patient in the room and ready for the provider at the start time that that can really help. It just has to become the cultural norm to start on time. There are different ways to do this, but we encourage you to just make this someone's job description to be the flow coordinator or the time clock task master. Depending on the make up of the staff, this could be the clinic manager. It could be a front desk person or a provider who's really concerned about flow. Whoever it is, it's important to just make sure that that person is empowered to do this and make it a clear expectation among staff.

All right. Another clinic flow best practice that makes a big impact is to move around your patients instead of moving them. You want to be patient centered literally. Organize care and services around the patient. The hours, the feel, what services are provided. You also want to organize your space around the patient, so making your patients move as little as possible. Many times we see that patients are taken to one place in the clinic to take their vitals. Then, they might be sent back to the waiting room, or they might go to a counseling room, and finally they get into an exam room. Try to get them into that exam room and stay there. The best practice is bring the services to them and avoid segmentation of the visit. By doing this, you decrease the number of stops that a patient makes during a visit and this is really a key principle of Lean, to have continuous flow because usually the more stops a patient makes, the more they'll wait at each stopping point and then the longer the visit will be.

Every single stop is an opportunity for waste and delay as well as a chance for errors and problems in communication and so forth. By the way, we want to give credit to, and encourage all of you to check out the Patient Visit Redesign resources and training from Coleman and Associates. There's a link here to Coleman and Associates. We've been doing this for over a decade now, but we did pull a lot of the original ideas and concepts from them originally so we want to make sure to give them full credit for being a source of ideas and inspirations and encourage you to check out that site for more tools and resources and opportunities.

How many stops do patients make at your clinic? We recommend that you get staff together and do a simple mapping activity. You can either print out your floor plan or sketch a rough floor plan on a flip chart. It does not have to be this detailed at all. I usually just use a marker and draw boxes and label them, so very simple. This is called a spaghetti map. You move through the patient visit using your marker as the patient, and keeping the marker on the page, just following that along and move through a theoretical patient visit from the time that they show up at the door to the time that they leave. This is an actual example of spaghetti mapping of a Title X visit. Just make sure that you involve all roles and all staff, because different staff members will have different insight, and have staff identify each step in the visit. Go through it together. This is a great way to identify bottlenecks and reveal inefficiencies from a number of different perspectives.

Another key is just make sure that you are honest when you do it because it's not the number that it should take. It's not the stops that they should be making but it's how many steps do they usually take. A few common contributors to patient stops are travel between the front desk for paperwork and intake and ideally, they should come to the front desk, get their paperwork, fill it out and come back, but a lot of times, what if there are frequent questions about the paperwork. Often, it's the same items that most people have questions about and if we can just clarify those few items, sometimes we can reduce the number of times that people have to come up and ask for clarification. Vitals. A common practice is taking height and weight measurements, taking vitals, in the hallway or in a lab down the hall. Can you just take vitals in the exam room? A lot of times the scale is the reason that they stop in the hall or that they have to go to a different room.

Does it really matter in a family planning setting if a patient is a 150 or 150.5 pounds? We don't need the level of sensitivity of a special, fancy scale. We've had a lot of sites that have just bought every day bathroom scales and have put one in each room. This can eliminate a whole stop. It also makes the patients happier because they're not being weighed in public and often they prefer that. At least for the average patient, using a bathroom scale is often just a way to quickly eliminate a stop and increase efficiencies, and very inexpensive as well. Also, conducting counseling in a different room, so before or after the exam. Moving the patient into the counseling room adds significantly to the length of the visit. Also, things like patients getting lost or confused about where check out is or how to exit. Sometimes, just adding signs that make it very clear where to go. Arrows that can help eliminate some of this confusion and extra stops in the hallways.

Finally, and this is a big one, that sending patients to the waiting room in between different parts of the visit, this is a huge contributor to overall number of stops and really reduces efficiency by a lot. You really never want to send the patient back to the waiting room to wait unless you just have no other options. Our goal is to get down to less than five or less than six stops. Maybe, front desk, sit down, bathroom, exam room, exit. Something along those lines, but

remember, even if a stop doesn't seem like it's taking that long and you're asking is it worth the pains to eliminate it? The answer is probably yes. Each stop contributes to the overall time and it all adds up. Again, there is a tool called the spaghetti map on FPNTC.org. That's a template that can help you do this. That's helpful.

Another tool that we have is the Patient Visit tracking sheet on FPNTC.org that you can use to help do patient tracking and observation. This can help you identify clinic flow issues around stops, but also around many other areas. I can't stress enough how valuable this is and I really highly recommend the process of observing and tracking patients and taking a look at the data. After just a handful of patients tracked, you often identify and uncover several areas that could be addressed. We often hear, for example, from clinic managers or administrators that the provider spends too long with the patient. That's a common perception. It's not universal but it is common, but what we find over and over is that the time the providers are spending with the patient is rarely the limiting factor driving productivity. It's much more often the time that the patient's waiting, the time the provider is spending on inefficient documentation or running around looking for supplies or for staff to help. That's much more often the cause, but it takes doing this patient tracking and observation to really find that out and to see that.

When tracking patients and measuring cycle time, you can measure as few or as many steps as you wish but you want to consider things like appointment time, time for check in, the time that the patient's taken to the exam, the time the staff enters the room, leaves the room, the time the patient enters the room, leaves the room, etc. Once you have these data, you can enter them into that clinic efficiency dashboard that we're going to be talking about in August during the webinar. I know that we are running short on time. I want to make sure there's a time for at least just a couple of questions so I'm going to fly through these last couple slides quickly. Another element for increasing efficiency and reducing time is to make sure that you plan ahead. Have all the tools and equipment staff and providers might need. Have them in the clinic or exam room, easy to find and easy to access. Stock the exam rooms regularly and consistently. Make sure that's someone's job. Use a checklist and make sure that it's just done consistently.

Again, this is an opportunity. We don't want to be penny wise and pound foolish. We limit the availability of tools or supplies to save money sometimes, like having just one large blood pressure cuff or limited numbers of IUD insertion kits, but then we pay staff to conduct frequent searches and to hunt these supplies down. Only a small percentage of every dollar in your organization goes to equipment, and any service provider's expense is payroll. Do what you can to support staff by providing them with the equipment that they need to be efficient. All right. Communicate directly. I think notes, flags, charts and racks and indirect communication methods are discouraged. If they're working for you, that's great, but in general the more direct communication the better. Many sites find that using communication tools like

a walkie talkie can be really helpful. These are, again, inexpensive, like $25.00, $50.00 and there's really no cheaper investment that you can make but if it increases and adds to the ability to communicate directly, that's a huge addition.

Then, also just use general good practices for communication. Of course, a common strategy for direct and effective anticipation and communication is to do a huddle at the beginning of the day. Just a brief meeting with the staff that's going to be working that day and review any key and vital information. This way everyone hears it at the same time and you just know that Sally's sick or has to leave early or Jane needs a little extra time or whatever. Let's see. Clinic flow. I mean in terms of streamline revenue cycle management systems, there's not much to say except I'll just say I think basically utilizing the same Lean principles. I think if you put your eye to the processes using the same kind of Lean principles, you'll be likely to find increased efficiencies here, but using technology and using streamlined processes.

Finally, and again, this is another phrase that I'm borrowing from Coleman and Associates, but we really want to ruthlessly eliminate all unnecessary work. This is both in terms of clinical services and operations. Routinely offer what's recommended by the evidence and eliminate services that are not recommended. Many tasks are done because they've just always been done that way. Try to critically exam processes for waste. The goal is to use evidence based guidelines to determine routine, preventive and patient care and eliminate that which is unnecessary. More is not always better. There are still a lot of clinical services being provided that are no longer recommended and this does have a huge impact on efficiency. In some sites, I see providers routinely offering pelvic exams or breast exams on young women under 20, or doing pregnancy tests on each and every patient routinely. The QFP, the MEC, SPR and STD Treatment Recommendations are the best sources for current practice guidelines and I just encourage you to use those and free up more time for the patients, the services that the value and that they've come to your clinic for.

Remembering that the definition of waste is anything not valued by the patient. All right, we're coming to the end here. We've glossed over a lot of this, and I had to rush the end, but I hope that we've given you a few ideas that you can run with and I've point to some useful resources to get started. As with any improvement initiative, we hope that you'll first assess where you stand now, identify opportunities for improvement and work with your staff to come up with a plan and ideas so you can carry out small tests of change and finally improving ideas that work for your particular setting, because all of this is very site specific. I wish that I could describe the one formula that we've seen that works for everyone, but that just doesn't exist so what we've tried to do is provide some basic principles and then a lot of additional resources that are available to help figure out what's going to work best for you.

Basically, the goal is work smarter, not harder. You want to match your capacity and demand, concentrate on tasks and services that are of value to the patient,

tasks and services with no value are considered waste, so eliminate those and focus on providing the best patient experience and best quality care you have that you can with a seamless and smooth flow of services. Again, we encourage you to check out these resources. We will share the links to all of them. There are links here. Thank you so much for joining us. I think we have time for just a couple of questions or comments if you have any. I think you can write your questions in the chat box. Katie, did we get any questions?

Katie Saul: We're going to wait just a minute to see if some additional questions come in. Before we do that, and while folks are sending those questions, I just want to come back to this resources slide. As we mentioned at the beginning of this webinar, the third webinar in this series on August 23rd is going to dive a little bit deeper into some of the tools that Jennifer talked about today. Specifically, the Clinic Efficiency Dashboard and how you can use that to enter your data very easily. It provides some really cool data visualization around the clinic flow productivity indicators as well as patient experience. In addition to that, the Using Data to Increase Clinic Efficiency Guide, which is at the bottom of the list here, provides a lot of the strategies that Jennifer spoke about today as well, including some of those national averages or goals that you can either compare your clinic to or just have a look at.

One other resource actually that's not on here is the Data Guide. It's a companion to the Clinic Efficiency Dashboard and provides some more instructions on that as well. We'll take a deeper dive into those next time, but for now, we do have a few questions coming in. The first question from Christie is how many stops can a patient make and still be in compliance with Title X? Jen, I don't know, do you want to try and take that one? I don't know if there-

Jennifer Kawatu: Yeah, sure. There are no requirements for Title X to have a certain number of stops or not the certain number of stops, but it's just recommended for your own clinic flow and efficiency purposes that you would want to reduce and keep them to a minimum so that you can see the number of patients, but Title X specifically doesn't have any standards or recommendations around that specifically.

Katie Saul: Okay. Another question from Pam is if you have two providers, and each have two rooms, how do you room the clients? Sometimes one provider gets a shorter visit than the other and a client is waiting in the room when another provider is available. [crosstalk 00:54:42] these both for the audience and just on Jennifer's behalf is that some of these questions here can be a little bit tricky to answer at the end of a webinar so we'll do our best to tackle as many of these as we can. Sorry. Go ahead, Jen.

Jennifer Kawatu: Yeah, I think in terms of [inaudible 00:55:04] how do you use your staff. That seems to me that those are two different questions. How you would room clients, we would assume that you would use two and two. Each provider would have their own two rooms, so I wasn't sure if you meant flipping one room where it could be used by either, but in terms of whether patients are assigned

to a particular staff member, a particular provider or whether they could be seen by any provider, that's really a different question and that's just a staffing model and a practice decision that you'll have to make for yourselves which one works better. Sometimes you can ask the patient, I'm sorry, you were here to see Dr. So and so or you were here to see Nurse Practitioner so and so, but that person is busy. There's another provider available. Would you like to wait for the person that you were originally scheduled with or would you like to see the provider that's available?

Often giving patient choices, then it really puts it in their hands and they are able to make the choice and are happier to wait if they choose to wait or are happier to just have the choice in their hands.

Katie Saul: Okay. I think we have time for one more. This is from Karen. When you have staff that have been on staff for a long time, how do you get them to buy in to changes in clinic flow and improving efficiency? Do you have any strategies?

Jennifer Kawatu: Yeah, that's a great questions and it's always a challenge. I think that we've found that a few things are key and are really helpful. First of all, emphasizing that point that I made at the beginning about it's about how many resources are you using to provide quality services. It's not about turning up the speed dial and just doing things the same way but faster. That really puts a lot of provider's minds at ease when they hear it put that way and that you're not just trying to speed them up. You're really looking at the services from many different angles. Also, using data, making sure to show them their data. Often, they don't realize how few patients they're seeing or they may not realize how long patients are waiting. Really sharing with them data around patient flow, patient tracking, productivity, those can often be really eye-opening and it takes some work to collect it but it's very much worth doing, and a lot of providers, even those who have worked and done it the same way for a long time will be much more open to making changes if they've seen the data.

Then, the third thing that I would say is just from our experience. It's just really important when making changes in a clinic or addressing clinic efficiencies to make sure to involve all staff and make sure that those providers or those staff who have been there a long time don't feel like they're being told what changes are going to be made, but are part of the decision making, that you strategize and plan together. You can set your expectations or your goals, as well. We need to increase efficiency or we need to see more patients per week or per day. You can set the goals but then it should be all of the staff involved in making the decisions about how you're going to get there. Providers often have great ideas and know how ... Actually, it can be any staff member. We've often had great ideas come from all different levels of staff. It's just really important to involve everyone in making those plans. Hope that helps.

Katie Saul: Thanks, Jennifer. A few of the remaining questions, I'm sorry we weren't able to get to everyone but several of the remaining questions, I think, if you all take a look at the Using Data to Increase Clinic Efficiency Guide, the one that's listed at

the bottom of the slide here. Take a look at that on FPNTC.org, and I think there's additional information about the best practices and strategies that Jennifer touched on very briefly today. Take a look at that and hopefully that will provide a little bit more guidance for you all in your clinic efficiency efforts. We also had a few questions about today's slides and slides from the first webinar in this series. For both, actually for all of the webinars in this series, including the one that we'll do in August, we're positing a recording, a transcript, as well as the actual PowerPoint slides with talking points for grantees and even sites out there who want to train their staff or other sites, you are more than welcome to use these slides with your network.

We encourage you to look those up as well. All of this is on FPNTC.org. Then, finally, I should add to the materials from today's materials, we hope to get up in the next few days, so probably either by the end of this week or very early next week so please keep an eye out. Finally today, we do encourage you please, to fill out the evaluation that's going to pop up at the end of the webinar today. We have been looking very closely at those results and will be tailoring the final webinar, as well as trying to figure out if there's other ways that we all can support you moving forward so please give us as much feedback as you can. That really helps us here at the Training Center. I think with that, we are at time, so we want to thank you all for joining us today and we hope to see you again in August.