NYC HEALTH+ HOSPITALS | BREAKTHROUGH

Re-thinking Residency Training Using A3 Methodology in Ambulatory Care at NYC Health + Hospitals/Kings County

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Disclosures

- No potential conflicts of interest to disclose

Residency Training Program
Adult Outpatient Department (AOPD)

- In the 2015 - 2016 academic year, there were 21 general psychiatry residents of either PGY-3 or PGY-4 level working in the AOPD at Kings County Hospital
  - Residents are part of SUNY Health Science Center program, though Kings County is their major training affiliate
- These residents spent the majority of the year functioning as outpatient clinicians, with an caseload of patients that is both individual and shared
- The ongoing developments to increase access to care in the AOPD required collaboration with the Residency Training Office, with the aim to best meet resident training needs and while increasing resident productivity
  - Context:
    - KCHC is preparing for Managed Care
    - Access challenges remain within adult ambulatory care clinics. Currently, KCHC AOPD has a 30 day wait list to see a provider.
  - Factors Contributing to Access Challenge:
    - 2014-2015: LOS for the adult inpatient service went from 33 days to 17 days
    - Goal: Reduce LOS to 12 days by the end of 2016
    - Care provided is not evidenced based, team coordination is a struggle
    - Moving away from a private practice model
    - Clinic patients are more acute due to shorter LOS from inpatient service

Box 1: Reason For Action

Currently, resident's time in the AOPD clinic at KCHC may not be adequate for training and is not sufficient to meet the needs of our patients. It is unclear how much supervision the residents are receiving and what teamwork looks like for the residents.

AIM:

Ensure that residents are well prepared to enter the workforce in a changing environment.

Priorities include exposure to evidenced based practices and understanding of managed care while meeting the needs of the Adult ambulatory care services.

This requires restructuring of the residency program with a particular focus on integrated care (mental health, substance use & physical health) in our various ambulatory clinics.

Box 2: Current State

- Group activity minimal and does not count toward productivity.
- Targets for residents are not being met
- Centralized intakes not as high as would like and these cases not best for picking up variety.
- Soarian (scheduling software) becoming more accurate.
- Supervision takes time away from clinic hours.
- Residents not attached to teams.
- Intake slots for residents small due to attending needing to be present.
- Question: How frequently are patients seen? Variety of diagnosis?

Box 3: Target State

- Explore group modality
- Targets increased and met
- CIU intakes/AOPD intakes explore group intake model
- Ensure Soarian templates reflect new changes
- PGY4: Evaluate independently in future and intake not tied to on-going care and screen cases for PGY3s
- Attach residents to teams
- Both Pgy3/4 require wide variety; different intensity/frequency; modalities.
- Monthly data reported to supervisors

Box 4: Gap Analysis

	PGY3			PGY4		
Categories	**Target**	**Gap**	**Solution**	**Target**	**Gap**	**Solution**
TIME	2 full days =14 hours			Max 1.5 days = 11 hours Min 1 day = 7 hours		
INTAKES	22-24 per year per resident	12 due supv limits	Sign off on competency/use of WIC	Currently none		
SUPERVISION	4 hrs now		Standardize supv: clinical and administrative	2.5 hours now		
TEAM	None now			None now		
CONTACTS	12			7 (chief =5)		

Box 4: Gap Analysis (cont.)

Jan-16									
Year	Provider	Total Scheduled	NoShows	Days Worked	Total Seen	Average Scheduled by Day	Average Seen by Day	Current KCH Target	PC Access Target
PGY3	PROVIDER	56	20	8	36	7	4.5	6	4
PGY3	PROVIDER	46	14	8	32	5.75	4	6	4
PGY3	PROVIDER	41	8	8	33	5.125	4.125	6	4
PGY3	PROVIDER	64	26	8	38	8	4.75	6	4
PGY3	PROVIDER	53	18	8	35	6.625	4.375	6	4
PGY3	PROVIDER	38	11	8	27	4.75	3.375	6	4
PGY3	PROVIDER	57	14	8	43	7.125	5.375	6	4
PGY3	PROVIDER	36	8	8	28	4.5	3.5	6	4
PGY3	PROVIDER	62	17	8	45	7.75	5.625	6	4
PGY3	PROVIDER	58	15	8	43	7.25	5.375	6	4
PGY3	PROVIDER	46	13	8	30	5.75	3.75	6	4
Average PGY3						6.329545455	4.431818182	6	4
PGY4	PROVIDER	44	13	8	31	5.5	3.875	4.7	8
PGY4	PROVIDER	29	6	8	23	3.625	2.875	4.7	8
PGY4	PROVIDER	9	1	6	8	1.5	1.333333333	4.7	8
PGY4	PROVIDER	33	10	6	23	5.5	3.833333333	4.7	8
PGY4	PROVIDER	33	9	6	24	5.5	4	4.7	8
Average PGY4						4.325	3.183333333	4.7	8

- meeting KCH target
- meeting PC Access Target
- Not meeting either target

Box 4: Gap Analysis (cont.)

Currect KCHC Productivity Goals									
Title	Expected per week	Expected Time	Expected Per Day	Nov Avg. Scheduled by Day	Nov Avg. Seen by Day	Dec Avg. Scheduled by Day	Dec Avg. Seen by Day	Jan Avg. Scheduled by Day	Jan Avg. Seen by Day
PGY3's	12/week	2 days	6/day	5.5	3.9	4.8	3.7	6.3	4.4
PGY4's	7/week	1.5 days	4.7/day	3.7	2.7	4.7	3.3	3.7	2.7
Chiefs	5/week								
Attendings	60/week	5 days	12/day						

Per PC Access Initiative									
PGY3's productivity expectation = 1/2 of attendings									
PGY4's productivity expectation = 2/3 of attendings									
Title	Expected per week	Expected Time	Expected Per Day	Nov Avg. Scheduled by Day	Nov Avg. Seen by Day	Dec Avg. Scheduled by Day	Dec Avg. Seen by Day	Jan Avg. Scheduled by Day	Jan Avg. Seen by Day
PGY3's	8/week	2 days	4/day	5.5	3.9	4.8	3.7	6.3	4.4
PGY4's	12/week	1.5 days	8/day	3.7	2.7	4.7	3.3	3.7	2.7
Chiefs	NA	NA	NA						
Attendings	60/week	5 days	12/day						

Box 5: Solution Approach

- Assess whether PGY-4 residents can conduct independent intake evaluations
- Assess access for patients, better ways of getting patients in?
- Assess models of ways in which PGY-4 residents could assess intakes for PGY-3 residents from our PHP and WIC programs, work with current “overbooking” model
- Standardize resident supervision to include clinical, productivity, and caseload discussions
- Connecting residents to teams
- Compare submitted productivity logs from residents with Soarian (billing) software’s computed schedules
- Assess residents’ schedules for “true” availability → Maximize available time in clinics?
- Share resident supervision model with SUNY Downstate Training Office
- Draft out intake process, continue to examine attachment of residents (both PGY3 and PGY4) to teams Continue to strengthen PGY3 intake model
- Determine exact contact hours for PGY 3 and PGY4 residents, should expectations be altered?
- Walkthrough of our second floor → Search for more office space to increase potential productivity

Box 5: Solution Approach (cont.)

- Continue to strengthen PGY3 intake model
- Determine exact contact hours for PGY 3 and PGY4 residents, should expectations be altered?
- Walkthrough of our second floor → Search for more office space to increase potential productivity
- Idea to incorporate residents into our Walk In Clinic
- Additional OPD experience where PGY4s can screen patients
  - Consider exact hours, supervision, how will this affect ongoing caseloads?
- Consider whether PGY-3 intakes should be double booked
- Determine outreach process for no-shows for intakes, who is responsible for contacting?
- Develop system for tracking contact hours
- Space allocation for PGY-3 and PGY-4s
- SOW for WIC to be finalized by incoming OPD Chief Resident
- Explore SOW for PCC for the future
- Develop and schedule Managed Care Transformation and DSRIP training for residents
- Add additional computers and phones to the residents' shared conference room to increase productivity

Box 5: Solution Approach (cont.)

Implementations:

- All incoming PGY-3 residents will be assigned to teams
- PGY-3 residents will conduct about 5 or 6 intakes per week beginning July 2016
- Increased productivity numbers, 15 contact HOURS per week
- Residents will have THREE full days in the clinic to see pts.
- PGY-4s to spend 0.5 days / week in the Walk In Clinic beginning July 2016
- PGY-4 contact hours confirmed as 5-7 contact HOURS depending on residents' individual schedules

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Box 6: Rapid Experiments

Please indicate all approved discipline activites (listed on attachment) on schedule.

Provider Name: _____			Year: _____PGY4_____		
TIME	Monday	Tuesday	Wednesday	Thursday	Friday
8:00			Elective		Elective
8:15					
8:30					
8:45					
9:00	No pt scheduled	Interview at		Didactics	
9:15		Downstate			
9:30					
9:45	Supervision				
10:00		Therapy pt			
10:15					
10:30					
10:45					
11:00	No show intake	Phone calls			
11:15					
11:30		Supervision			
11:45	Documenting				
12:00				Lunch	
12:15	Lunch	Lunch			
12:30					
12:45					
13:00	Elective	1PM Pt is late	Grand Rounds		
13:15					
13:30		Therapy + Med			
13:45					
14:00		Therapy + med			
14:15					
14:30			Chief Meeting		
14:45		Accesaride forms			
15:00					Supervision
15:15					
15:30					
15:45					
16:00					
16:15					
16:30		Evening Clinic			
16:45					

Patient care	
Group	
Supervision	
Grand Rounds	
Educational (Didactics, Journal Club)	
Meetings (Clincal or Administrative)	
Phone calls, Faxing, Clerical Work	
Note Writing, Tx plans, clinical documentation	
On another Service	
Off Service	
Idle Time	
Transit between sites	
Meals	

Box 7: Completion Plan

What	When
Revise KCH policy to allow PGY4's to conduct intakes independently.	1/14/16
Discuss access initiative and current workgroups with residents.	1/14/16
PGY4 residents to conduct intakes and screen for PGY3's. Design system for PGY4's to conduct intakes for patients from PHP and WIC. System to hand off cases to PGY3's for ongoing care. Determine process if patient is identified as inappropriate for resident (define "inappropriate"). Maintain communication with Access group to align with AOPD overbooking intakes. Adjust templates accordingly.	1/21/16
Standardize resident supervision to include clinical, productivity, and caseload discussions. Discussion of increasing intakes. Monthly data reports to be given to supervisors to inform supervision. Share with residency training.	1/28/16
Connecting residents to teams – feasibility assessment for PGY3's and PGY4's. Identify necessary steps.	2/7/16
Group intake model design.	2/7/16
Compare resident's productivity logs with Soarian reports. Review resident non-billable hour logs – standardize collection process.	3/3/16
Break down resident templates/schedules to define true clinical availability. Determine availability for PGY3's & PGY4's. Define "administrative time" and reflect in templates.	3/3/16
Review resident clinic attendance submission process for accurate productivity calculations.	3/3/16
Share resident supervision template with residents, resident supervisors, and SUNY training office. Gather feedback for next meeting.	3/17/16
Draft resident intake process, informed by clinical availability, for PGY3's, PGY4's, and chief residents. Outline process for attaching residents to teams.	3/17/16

Box 7: Completion Plan (cont.)

What	When
Design 3rd year resident intake model • Determine patient contact hours for 3rd and 4th years • Solidify team assignment (preferably 4 teams)	3/31/16
Second floor walk through – consider space for 4th years	3/31/16
Design model for 4th year residents in WIC and PCC • Consider how many patients 4th years will continue carry in OPD • Hours in OPD and WIC/PCC • Supervision	4/14/16
Determine whether or not to double book PGY3 intakes	5/12/16
Determine no show/outreach process for PGY3 intakes	5/12/16
Explore PCC admission criteria for patients seen by PGY4's in PCC	5/12/16
Develop system for tracking contact hours – script for attendings/supervisors.	5/12/16
Determine PGY4 schedules/opportunity for standardization. Determine space allocation for PGY3's and 4's.	5/12/16
Add 5-6 (alternating weeks) PGY3 intakes to centralized intake calendar. Dr. H to assign resident rotation. Current AOPD double book SOW to apply. Timeframe: 7/18/16-5/1/17	6/1/16
Develop SOW/process for PGY4 WIC coverage 5 days/week – determine resident rotation.	6/1/16
Develop process/SOW for PGY4 rotation in PCC. Discuss with Dr. Branch and Lance.	6/1/16
Add two computers and 2 phones to 4th floor resident lounge	7/1/16
Update on 2 offices on R2 for PGY4 use and potential date available.	ongoing
Develop and schedule Managed Care Transformation and DSRIP training for residents.	7/1/16

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Box 8:Confirmed State

January 2016 Productivity - AOPD							
Provider	**Total Scheduled**	**NoShows**	**%NoShows**	**Days Worked**	**Total Seen**	**Daily Average Scheduled**	**Daily Average Seen**
Residents							
Provider #1	14	3	21.43%	3.5	11	4	3.142857143
Provider #2	44	13	29.55%	7	31	11	4.428571429
Provider #3	56	20	35.71%	7.5	36	7.466666667	4.8
Provider #4	46	14	30.43%	12	32	3.833333333	2.666666667
Provider #5	33	9	27.27%	8	24	4.125	3
Provider #6	41	8	19.51%	8	33	5.125	4.125
Provider #7	64	26	40.63%	9	38	7.111111111	4.222222222
Provider #8	53	18	33.96%	10	35	5.3	3.5
Provider #9	38	11	28.95%	10	27	3.8	2.7
Provider #10	57	14	24.56%	10	43	5.7	4.3
Provider #11	36	8	22.22%	9	28	4	3.111111111
Provider #12	62	17	27.42%	15	45	4.133333333	3
Provider #13	12	5	41.67%	4	7	3	1.75
Provider #14	29	6	20.69%	8	23	3.625	2.875
Provider #15	9	1	11.11%	4	8	2.25	2
Provider #16	33	10	30.30%	6	23	5.5	3.833333333
Provider #17	58	15	25.86%	12	43	4.833333333	3.583333333
Provider #18	46	13	28.26%	10	30	4.6	3
Provider #19	16	3	18.75%	8	13	2	1.625
Provider #20	26	5	19.23%	15	21	1.733333333	1.4
Provider #21	4	2	50.00%	3	2	1.333333333	0.666666667

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Box 8:Confirmed State (cont.)

Resident May 2016 Productivity								
Year	Provider	Total Schedule	NoShows	%NoShows	Total Seen	Clinic Days	Daily Average Scheduled	Daily Average Seen
PGY3								
	Provider #1	60	20	33.33 %	40	8	7.5	5
	Provider #2	38	11	34.38 %	27	6	6.333333333	4.5
	Provider #3	39	7	17.95 %	32	6	6.5	5.333333333
	Provider #4	37	14	37.84 %	22	4	9.25	5.5
	Provider #5	36	9	25.00 %	27	5	7.2	5.4
	Provider #6	57	13	22.81 %	44	9	6.333333333	4.888888889
	Provider #7	59	22	37.29 %	37	9	6.555555556	4.111111111
	Provider #8	55	13	23.64 %	41	7	7.857142857	5.857142857
	Provider #9	52	15	28.85 %	37	7	7.428571429	5.285714286
	Provider #10	51	19	37.25 %	32	5	10.2	6.4
	Provider #11	60	17	28.33 %	42	9	6.666666667	4.666666667
	Provider #12	45	11	24.44 %	34	6	7.5	5.666666667
PGY4								
	Provider #1	64	19	29.69 %	45	8	8	5.625
	Provider #2	32	8	25.00 %	24	8	4	3
	Provider #3	20	7	35.00 %	13	4.5	4.444444444	2.888888889
	Provider #4	19	6	31.58 %	13	3	6.333333333	4.333333333
	Provider #5	34	9	26.47 %	25	6.5	5.230769231	3.846153846
Chiefs								
	Provider #1	19	3	15.79 %	16	5.5	3.454545455	2.909090909
	Provider #2	21	9	42.86 %	12	5.5	3.818181818	2.181818182
	Provider #3	16	4	25.00 %	12	3	5.333333333	4
	Provider #4	25	7	28.00 %	18	4.5	5.555555556	4
Totals:		839	243		593			
Accuracy		0.994915254						

Box 8:Confirmed State (cont.)

AOPD RIE: Team Structure	
TEAM 1 (General?)	
Discipline	Floor
MD	4
NP	4
Residents	
Therapist	4
Therapist	4
Therapist	4
Psyc Trainees	
Nurse	4
Peer Counselor	Pager
Case Manager	
TEAM 2 (Medical Need Specialty?)	
Discipline	Floor
MD	4
NP	
Residents	
Therapist	4
Therapist	4
Therapist	
Psyc Trainees	
Nurse	4
Peer Counselor	Pager
Case Manager	Pager

KEY	
	Discipline not on team
	Full time
	Part Time
	Shares team
	Changes

Box 8:Confirmed State

- As a result of a Rapid Improvement Event in May 2016, it was decided that residents would be fully incorporated into A-OPD:
  - Beginning July 2016:
    - All residents are attached to interdisciplinary teams, some specialized
    - 4th year residents would get an experience in the Walk-In Clinic, evaluating appropriateness of patients for A-OPD
    - 3rd year residents would have increased time in the clinic, without any "administrative days." Increases in amount of time led to higher instituted productivity numbers for residents.

IMPROVED LEARNING!

Box 9: Insights

- Work in progress, future ideas currently being considered:
  - A true experience in integrated care as senior residents would rotate through the Primary Care Clinic
  - Further increases in the amount of available space, allowing additional clinicians to meet with patients, and provide care in individual / group settings
  - Potential for further ambulatory sites in future years!

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A3

1. REASON FOR ACTION

What is the reason for this event?

What is the burning platform?

What is the real issue?

2. CURRENT STATE

The Initial State tells us where we stand now.

It is a reflection of what is happening at the present time.

It is the direct observation of something you have seen.

3. TARGET STATE

The Target is what you would like the new way or process to look like.

How much better did we make it from the Initial State, 50,75, 100%?

4. GAP ANALYSIS

What is the primary root cause for the issue (this is answered by asking "WHY" five times)?

This is what is keeping you from getting to your solution.

Problem (or Gap) Actionable Root Cause

5. SOLUTION APPROACH

These are the hypotheses and they should be very real outcomes because we will be testing them.

If we do... then we expect...

or

Solution (Do's) Expected Results

6. RAPID EXPERIMENTS

This is where we will test all of the hypotheses we have developed in the Solution Approach above.

Plan	Expected Results	Actual Results	Follow-Up

7. COMPLETION PLAN

There should be no more than 6 items on this list that you were unable to complete this week.

What (action has to be performed):
Who (is the person responsible):
When (does it have to be completed by day or date):
Where (only if this is appropriate):

8. CONFIRMED STATE

How do you know that what you have put in place is working? You have to measure it.

For the next 30, 60, 90 days, you will measure and align your Confirm State with your Target State to be sure that your are accomplishing what you set out as your goal.

Base Target Actual

9. INSIGHTS

Here is where you put your thoughts:

- What did you learn?
- How has it helped you see waste?
- What helped, What hindered you?
- What worked, what didn't work?
- What would you change?
- What can be done better?