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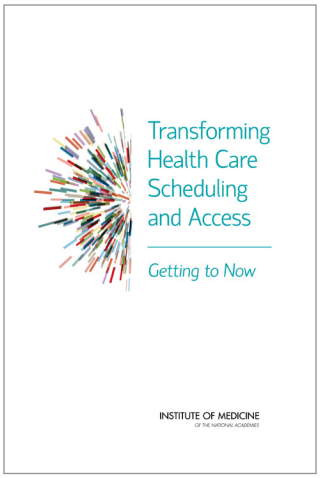
# Transforming Health Care Scheduling and Access

## Getting to Now




In 2001, the landmark Institute of Medicine (IOM) report *Crossing the Quality Chasm* identified six fundamental properties of high-quality health care—that it be safe, effective, patient-centered, efficient, equitable, and timely. Of these fundamental aims, timeliness is, in some ways, the least well-studied and understood.

With support from the Department of Veterans Affairs (VA), the IOM convened an expert committee to review what is currently known about health care access, scheduling, and wait times nationally and to make recommendations for the development, testing, and implementation of standards around this topic. Although prompted by attention to a high-profile crisis in a health center operated by the VA, the resulting report, *Transforming Health Care Scheduling and Access: Getting to Now*, focuses broadly on the scheduling of and access to health care throughout the nation. The report offers preliminary observations about emerging best practices and promising strategies (including virtually immediate engagement), concluding that opportunities exist to implement those practices and strategies, and it presents recommendations for needed approaches, policies, and leadership. Serving as the underlying principle of the IOM committee's work is the view that strategies to address issues in access, scheduling, and wait times in health care must always be patient- and family-centered and implemented as a goal-oriented partnership (see Box).

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## Scope of the Problem

Access and wait time challenges exist for patients and families—as well as for providers—throughout the nation. The problems resulting from access and wait time issues generate negative effects on health outcomes, patient satisfaction with care, health care utilization, and organizational reputation.

At the patient level, long wait times may be associated with poorer health outcomes and financial burden from seeking non-network care and possi-

bly more distant health care. Conversely, timely delivery of appropriate care has been shown to reduce death and disease associated with a variety of conditions. Long wait times may also cause frustration, inconvenience, suffering, and dissatisfaction with the health care system.

Timeliness in providing access to health care varies widely in the United States, ranging from same-day care in some circumstances to several months' wait times in others. This is the product of generally unstructured, non-systematic approaches to the design, implementation, and assessment of scheduling protocols. Furthermore, there are multiple causes at the root of the problem, including mismatched supply and demand, a provider-focused approach to scheduling, outmoded workforce and care supply models, priority-based queues, care complexity, reimbursement complexity, financial barriers, and geographic barriers.

Further compounding the problem is the lack of available evidence on which to provide setting-specific guidance on the timeliness of care. Reliable performance standards, which are needed for assessment and improvement of health care scheduling, cannot be established without better data. To develop the evidence base, health care organizations will need reliable information, tools, and assistance from various national organizations with the requisite expertise—as well as inter-organization coordination to ensure the harmony of reporting instruments and reference resources.

## Basic Principles for Change

Despite the many challenges, the opportunity now exists to develop systems-based approaches to scheduling and access that provide immediate engagement of a patient's concern at the point of initial contact. Using systems strategies, best practices have improved health care access and scheduling in various locations and could serve as promising bases for research, validation, and implementation. With further research, these models have the potential to be adopted more widely and to become a foundation for standards of care.

Given the complexity of the health care system and the interdependence of participants and processes, no single stakeholder can bring about the necessary changes. The IOM committee offers 10 recommendations, aimed at national leadership as well as heads of individual health care facilities, to accelerate progress toward the health care goal of immediate responsiveness to patient need. At the heart of the recommendations is a focus on the needs of the patient and the family, as well as the development of the skills and tools needed to lead an organizational culture of service excellence in the execution of that focus.

The unifying goal of the recommendations is widespread adoption of the following basic principles of access to health care:

- **Matching supply** with projected demand through formal, ongoing evaluation.

### BOX
### Patient- and Family-Centered Care

Patient and family-centered care is designed, with patient involvement, to ensure timely, convenient, well-coordinated engagement of a person's health and health care needs, preferences, and values; it includes explicit and partnered determination of patient goals and care options; and it requires ongoing assessment of the care match with patient goals.

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- **Immediate engagement** and exploration of patient's needs, at the time of their inquiry.
- **Patient preference** on the timing and nature of care, invited at inquiry.
- **Need-tailored care** with reliable, acceptable alternatives to clinician visits.
- **Surge contingencies,** or provisions for accommodating patients' acute clinical problems or questions that cannot be addressed in a timely manner.
- **Continuous assessment** of changing circumstances in each care setting.

All national initiatives to address scheduling and access issues, as well as the front-line scheduling practices of primary, specialty, hospital, and post-acute care facilities, should be anchored in these basic principles.

## Recommendations

Six of the IOM committee's recommendations are geared toward leadership on a national scale, including federal agencies, professional societies, and public and private payers, as well as employers who pay for care.

The committee states that federal agencies such as the U.S. Department of Health and Human Services, the VA, and the U.S. Department of Defense should spearhead national initiatives to draw on the leadership and resources of the multiple federal departments that are important to realizing the basic access principles. All such coordinated efforts at the national level should include representation from leaders of health care delivery systems, patients and families, and industrial engineering, all of whom should work collaboratively with leadership of the federal departments.

Professional societies and organizations should work with standards and certification organizations to advance professional awareness, understanding, and application of systems approaches, tools, and incentives for implementing systems strategies to assess and improve scheduling and access.

Finally, public and private payers, and employers who pay for care, should be active participants in system improvement through initiatives that encourage creativity and innovation in the implementation and achievement of the access principles.

At the level of health care facility leadership, the IOM committee recommends that the leadership and governing bodies at health care delivery sites demonstrate commitment to implementing the basic access principles. All decisions involving access assessment and reform should be informed by the participation of patients and their families. Patients should be able to contribute input on their expectations, experiences, and preferences for scheduling practices and wait times, through patient and family advisory councils, surveys, and focus groups.

Furthermore, care delivery sites should continuously assess and adjust the match between the demand for services and the organizational tools, personnel, and overall capacity available to meet that demand. This process should leverage alternate supply options, such as alternate clinicians, telemedicine consults, patient portals, and web-based information services and protocols.

### Study Sponsor

U.S. Department of Veterans Affairs


## Conclusion

"How can we help you today?" Each of us would like to hear these words when seeking health care assistance for ourselves, for our families, or for others. It should not only be our wish, but our expectation. Health care that implements such a philosophy is care that is patient-centered, takes full advantage of what has been learned about systems strategies for matching supply and demand, and is sustained by leadership committed to a culture of service excellence and continuous improvement. Care with this commitment is feasible and can be found in practice today. Implementation of the IOM committee's recommendations would serve to accelerate progress toward a culture of service excellence, to ensure that patients and their families receive the right care at the right time.


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500 Fifth Street, NW
Washington, DC 20001
TEL 202.334.2352
FAX 202.334.1412

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