BY ROSEMARIE WEISMAN AND
MEREDITH B. FEINBERG, MBA

Bedside Scheduling Improves Patient Access

Recognizing that there were both issues with and opportunities for improvement of scheduling coordination and patient flow, an integrated team of clinicians, schedulers, and administrators came together in 2012 to conceptualize a patient access initiative called "Bedside Scheduling." Fueled by a desire to provide a higher level of compassionate service to inpatients newly-diagnosed with cancer, the initiative was a significant process and culture change for the hospital and cancer program. Here's our story.

The Players

North Shore-Long Island Jewish Health System is the largest healthcare system in New York State with a service area of 8 million people in the New York metropolitan area. With more than 2,750 employed physicians and 54,000 employees, the Health System is the largest private employer in New York State. The Health System comprises 19 hospitals: 5 tertiary, 9 community, 3 specialty, and 2 affiliate. It is at one of these tertiary hospitals—North Shore University Hospital—that the Bedside Scheduling initiative was rolled out.

Monter Cancer Center, Lake Success, N.Y., is the largest of the cancer center program sites within the North Shore-Long Island Jewish Health System's North Shore-LIJ Cancer Institute. It is an 80,000-square-foot, free-standing outpatient hematology and medical oncology physician practice and ambulatory chemotherapy and transfusion treatment center. The center is staffed by 35 disease-site-specific board-certified medical oncologists and more than 270 staff. With 38 exam rooms and 64 treatment bays, our 2014 annualized volume was projected at approximately 40,000 physician visits and more than 75,000 lab and treatment visits. Our onsite services include social work, nutrition counseling, laboratory, pharmacy, clinical trials, cancer genetics, and a fellowship program with 15 fellows in training.

The inpatient setting is where the Bedside Scheduling story begins. Inpatient services for Monter Cancer Center are provided in two locations: North Shore University Hospital, Manhasset, N.Y., and Long Island Jewish Medical Center, New Hyde Park, N.Y. North Shore University Hospital has a 24-bed dedicated hematologic malignancy specialty unit, a 10-bed FACT-accredited stem cell transplant unit, and a 32-bed dedicated solid tumor oncology unit; Long Island Jewish Medical Center has a 23-bed oncology unit. Both North Shore University Hospital and Long Island Jewish Medical Center offer consult services. There were 23,000 projected annualized inpatient visits for 2014. Every weekday, seven physicians round on all services at both institutions. It is this group of patients that inspired the Bedside Scheduling initiative.

Our "Before" Process

Prior to the Bedside Scheduling initiative, when an inpatient received a new cancer diagnosis, hospital staff would contact medical oncology to consult. A medical oncologist would evaluate the patient and, if the patient required follow-up, the medical oncologist would direct the patient to call and schedule an outpatient appointment with a disease-site-specific physician. Patients were given a Monter Cancer Center business card with instructions

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to call the office post-discharge. Since the scheduling process did not start until after discharge, the burden of responsibility for making follow-up appointments was on newly-diagnosed cancer patients. Our team resolved to remove this burden from these patients by improving our scheduling coordination and patient flow.

Drivers Behind the Process Redesign

As we began to look into our scheduling process, staff identified a number of issues. For example, when answering post-discharge

Table 1. Examples of Bedside Email Sent by Fellow to Schedulers

EXAMPLE 1

Patient Name
DOB

44-year-old female with HIV/AIDS, non-adherent with HART. Admitted with UTI, neutropenia (chronic), and iron deficiency anemia. Had bone marrow biopsy done. Inpatient needs to have outpatient follow-up appointment for bone marrow biopsy results in one week. Okay to schedule with [PHYSICIAN NAME] in clinic; follow-up one week.

Name of Inpatient Attending
Name of Fellow

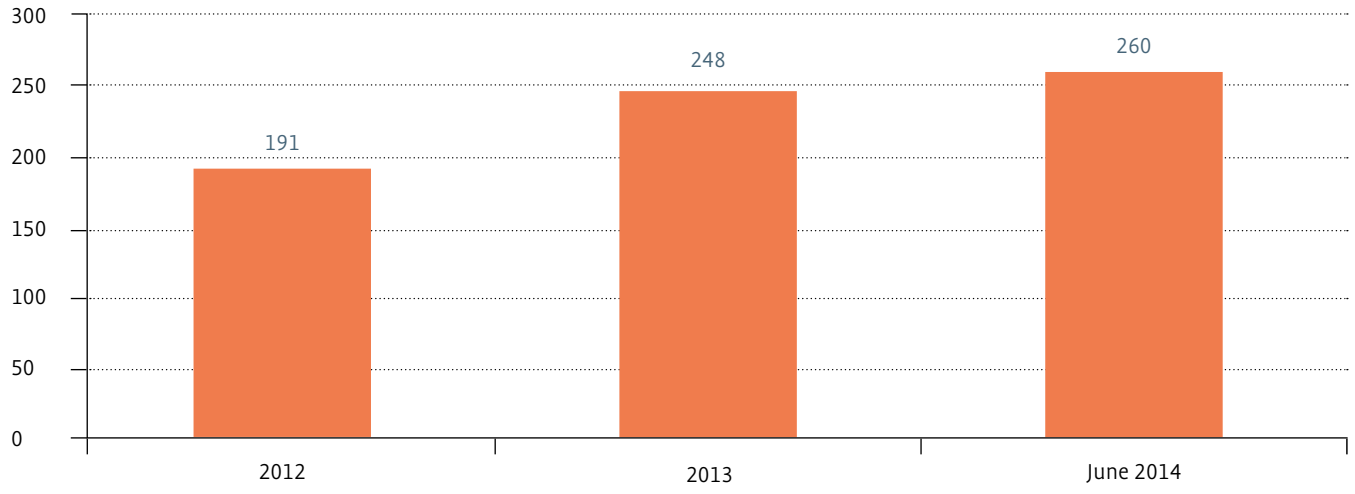
EXAMPLE 2

Patient Name
DOB

51-year-old male with possible diagnosis of multiple myeloma by [PHYSICIAN NAME] last year. Had IgGK ~ 4000 mg/dl, and presented with back pain. MRI with central epidural soft tissue abnormality (questionable etiology). Also mild anemia ~ 10. Getting RT to T7 and L2. Inpatient needs to have a multiple myeloma outpatient consult. Follow-up in one week.

Name of Inpatient Attending
Name of Fellow

Figure 1. Monter Cancer Center New Patient Hospital Consult Referrals, 2012–2014



consult appointment calls, our staff found that many patients were unclear or uncertain about their cancer diagnosis. This finding was a concern not only because our physicians are disease-site-specific, but also because it is important that patients are empowered with information about their diagnosis. These patients often did not know the name of the physician with whom to schedule an appointment, which presented the same challenges in terms of scheduling patients with the appropriate disease-site-specific team.

Often patients were calling at the last minute to schedule their appointments. Delving deeper into this particular issue, our staff found that many patients were interpreting the physician's instructions to "schedule an appointment in two weeks" as "call the office to schedule your appointment in two weeks." The end result was a growing demand to fit these visits into already full physician schedules. On several occasions, patients assumed an appointment had already been made, and just showed up at the physician office in two weeks.

Another staff concern was lack of a way to track and confirm that all patients were, in fact, calling to schedule the recommended—and potentially life-saving—follow-up care. No process was in place to let our staff know when patients were being lost to follow-up.

In addition to the process-flow challenges and clinical drivers addressed above, our staff suspected that improvements to the inpatient scheduling process might have a positive impact on our cancer program's bottom line. Inpatient consults are a major volume driver for the outpatient cancer program, and our team wanted to maximize referrals from the inpatient to the outpatient setting. With the existing process, there was simply no way to reconcile how many patients were scheduling their follow-up outpatient care with our cancer program or seeking care elsewhere.

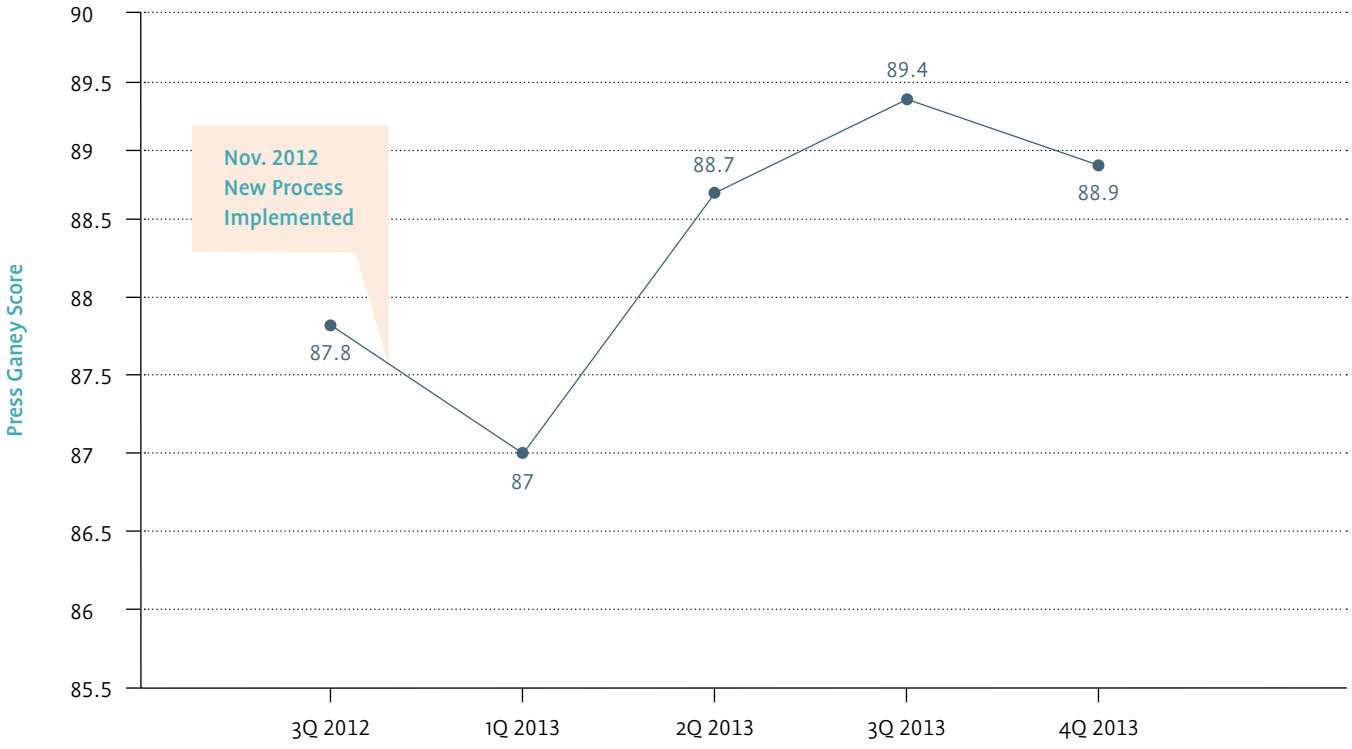
Goals & Process for Change

A small group of representatives from our leadership team met to formally review the existing scheduling process and outline all of the drivers behind the needed changes. Next, this group identified the following goals:

- Improve the outpatient scheduling process for newly-diagnosed cancer patients
- Improve the accuracy of scheduling new patient appointments
- Improve the patient experience
- Increase patient volume and decrease the outmigration of patients away from our healthcare system.

Leadership then assembled a team comprised of an attending physician, fellows, schedulers, and administrators and charged this team with implementing a solution to the scheduling process. After only two meetings, these stakeholders created a new process called "Bedside Scheduling" which:

Figure 2. Press Ganey Patient Satisfaction Score for "Scheduling Your Visit"



We no longer had issues with patients calling for last-minute appointments or, worse, showing up without a scheduled appointment.

- Moved the staff scheduling function to the patient's bedside
- Removed the scheduling burden from inpatients newly-diagnosed with cancer
- Ensured that the scheduling process for an outpatient consult for these patients occurred prior to discharge
- Improved patient access and coordination of care.

A Low Tech/No Tech Solution

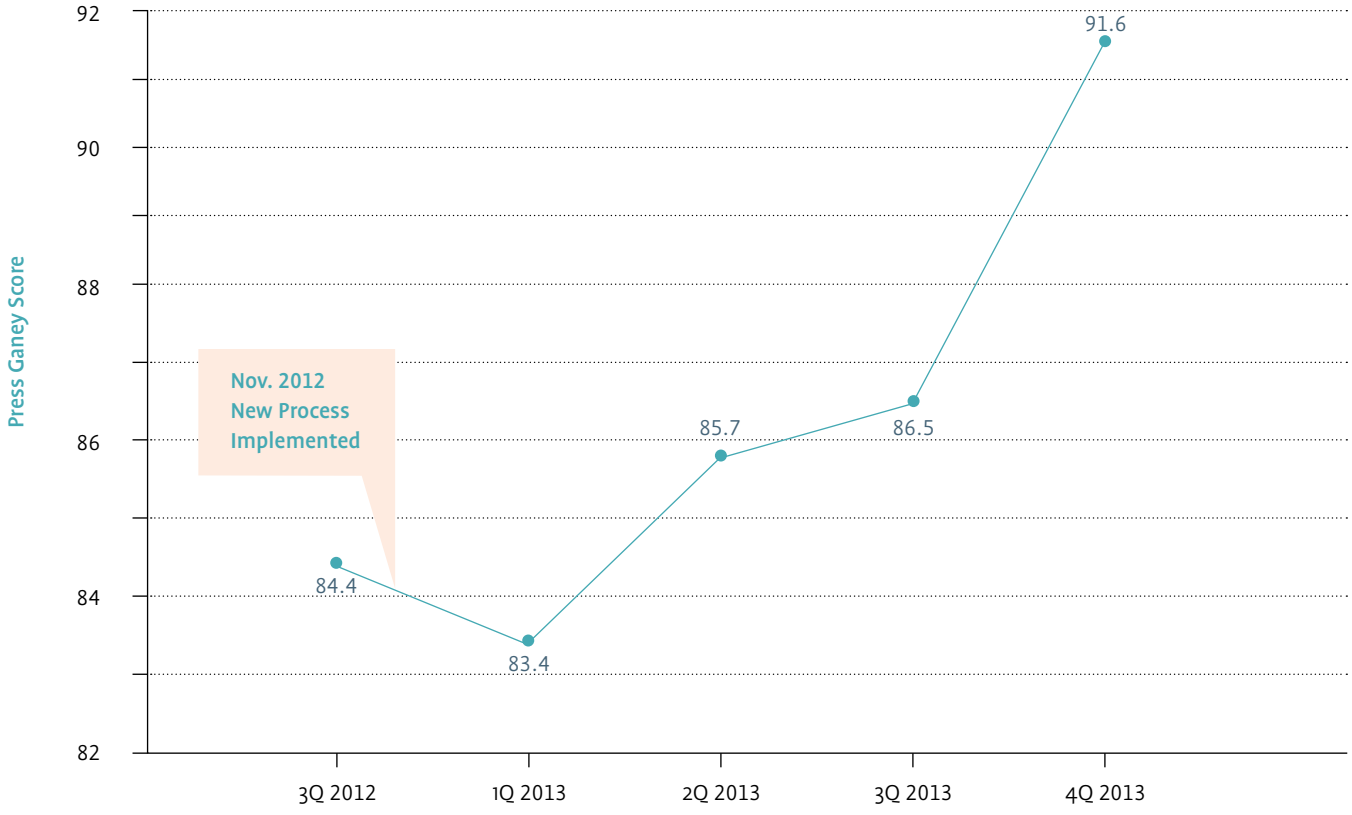
The new scheduling process is a simple, low tech solution, shifting the burden of responsibility from the patient and family to the cancer care team. Once an inpatient newly-diagnosed with cancer has been identified as someone who requires an outpatient follow-up visit, the fellow emails the following information to the schedulers:

- Patient name
- Date of birth
- Brief history and diagnosis
- Preferred contact (patient or family member)
- Preferred oncologist and/or disease-site-specific team
- When patient next needs to be seen.

Table 1, page 24, provides two examples of this type of email.

After receiving the email, the scheduler calls the patient (or the designated caregiver) while the patient is still admitted—at his or her bedside—to schedule the outpatient visit. The remain-

Figure 3. Press Ganey Patient Satisfaction Score for "Wait Time Between Calling and First Appointment Scheduled"



ing steps in Bedside Scheduling are as follows:

1. Financial counseling begins (if needed)
2. An email confirming the appointment date and time is sent back to the fellow
3. The appointment information is included in the patient's discharge form
4. An email, including all of this information, is put into the outpatient medical record for the first office visit.

Implementation Challenges

Our fellows were on board and motivated about the new Bedside Scheduling process, initiating emails the morning after roll-out. Our schedulers, on the other hand, had difficulty with the concept of Bedside Scheduling. Our scheduling staff is very amenable to and generally accepting of change; however, they are also highly-trained and sensitive to customer service expectations. The schedulers believed that it was intrusive to call patients while they were in the hospital, sharing concerns such as, "What if the patient is sleeping when I call?" or "What if the patient is out of the room having a test?" or "What if the patient has visitors?"

With persistence on the part of leadership, our schedulers were encouraged to forge ahead with the new process. Patients and their families were actually grateful to receive the call from the office coordinating their follow-up appointment, and when schedulers started to receive this positive feedback, they began to fully engage and get on board with Bedside Scheduling.

Outcomes

The entire team was quite pleased with the results of the Bedside Scheduling initiative. There was improved communication between fellows, oncologists, schedulers, and patients and their family members. Patients were now consistently being scheduled with the appropriate disease-site-specific teams. We no longer had issues with patients calling for last-minute appointments or, worse, showing up without a scheduled appointment.

We also met our goal of increasing patient volume. The medical oncology practice saw an increase in the volume of new patients referred from the inpatient setting (see Figure 1, page 25).

Finally, we experienced an increase in our Press Ganey patient satisfaction scores after Bedside Scheduling implementation (see Figures 2-4, pages 26-28). Today, inpatients who are newly-diagnosed with cancer receive their follow-up appointments with ease, allowing them the time to prepare for their outpatient visit. By removing this burden from patients, we have successfully met our most important goal: improving the patient experience. In addition, our Bedside Scheduling process has given us the opportunity to reach out to our patients and introduce ourselves and our cancer program and begin to offer our support before they even enter the building. OI

Rosemarie Weisman is director, Business Management, and Meredith B. Feinberg, MBA, is vice president, Cancer Service Line, North Shore LIJ Cancer Institute, North Shore LIJ Health System, Lake Success, N.Y.

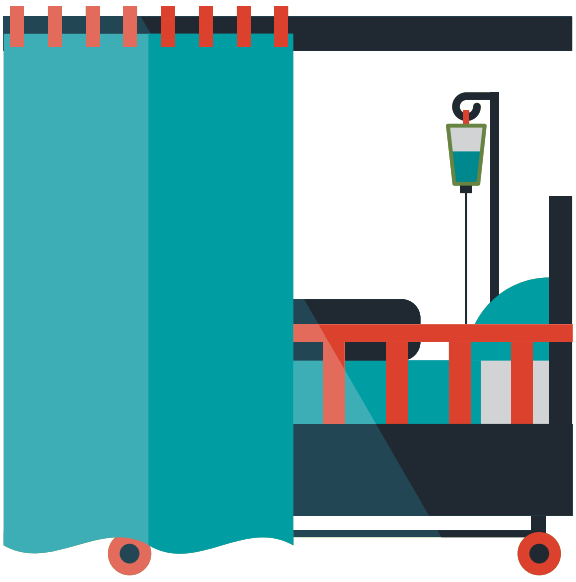


Figure 4. Press Ganey Patient Satisfaction Score for "Courtesy and Concern of the Staff Who Made Your Appointment"