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Decreasing Wait Times for New Referrals to an Outpatient Specialty Clinic

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Decreasing Wait Times for New Referrals
to Outpatient Specialty Clinic

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NURS 653 – Internship: Clinical Nurse Leader

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Clinical Leadership Theme

This project focuses on the CNL curriculum element of Care Environment Management. The CNL competency role that is the framework for this project is Team Manager. As the CNL, I will utilize the team resources and serve as a leader in the interdisciplinary health care team by identifying clinical outcomes that improve the safety, timeliness and efficiency of the authorization and referral process in the outpatient clinical setting. This will be achieved by improving the timely access of new patients to the CHOC Children's Outpatient Specialty Clinic – Allergy and Immunology.

Statement of the Problem

The question that establishes the purpose of this project is “Will decreasing the wait times for an initial visit to the allergy specialist result in improved patient satisfaction?” When patients are referred by their primary care providers to see an allergy specialist, they should be able to gain access to this specialty care within a 30 – 45 day period. Early and easy access to the allergist is of utmost importance so that appropriate testing can be done, resulting in the proper diagnosis and treatment. However, patients referred to the CHOC Children's Outpatient Specialty Clinic for Allergy and Immunology are experiencing a minimum wait time of 60 days to access seeing the specialist.

This delay is a concern since many children have allergies to various items such as food, dust, pollen, preservatives, latex, insect venom and medications. Many of these allergic reactions can be minor and may include the skin, respiratory, digestive or cardiovascular systems. Some allergic reactions, however, are more serious and need immediate intervention, the most serious being anaphylaxis, which can be life threatening (Levin, 2013). Delays can be contributed to both patient and clinic factors and could have a financial impact on the clinic due

to the possibility of losing these patients to competitors resulting in possible decreased patient volume.

The wait time for new patients to see an allergist can be decreased by ensuring that referral requests received are properly completed and by adding two additional patients each day to each provider's schedule. The purpose of this project is to address the wait time for new referrals to gain access to see the specialist and to decrease this time by a minimum of 15 days or 25 percent.

Project Overview

The goal of the project is to decrease the wait time of newly referred patients to the CHOC Children's Outpatient Allergy/Immunology Clinic. This can be done by ensuring that the referral/authorization requests are properly completed, with all the required codes, and the scheduling pattern for the clinic is adjusted to allow for more new patients to be seen on a daily basis. Introducing other changes to the current referral process will also help with decreasing wait times. This will involve a change to each provider's schedule, where instead of seeing two new patients each day, they would have three to four new patients scheduled each day. Patient satisfaction scores and insurance status will be viewed to ascertain if there are any correlations with wait times.

The aim of this project is to reduce the wait time by 25 percent or 15 days for all newly referred patients to the CHOC Children's Outpatient Specialty Clinic for Allergy and Immunology by August 1, 2016. This relates to the global aim statement of identifying clinical outcomes that improve the safety, timeliness and efficiency of the referral process in the outpatient setting by decreasing the current wait times and improving patient satisfaction.

Rationale and Cost-Analysis

To identify the factors leading to this increased wait time for an initial appointment, a root cause analysis was conducted (See Appendix A). A flow chart (See Appendix B) was done to look at the current referral/authorization process. A review of the strengths and weaknesses of the clinic referral process was conducted (See Appendix C for SWOT Analysis). Data was obtained from observation of the clinic processes, including phone calls from new patients and the electronic patient matrix for new patient appointments which showed the next available appointments for a new patient was 60 days or greater. Staff was observed verbalizing to patients on the phone that the next new patient appointment was not for 60 days.

The costs associated with this project are minimal. Decreasing the wait times of newly referred patients for an initial visit to the allergy specialist provides earlier access to care. This is important because these patients are experiencing mild, moderate or severe allergic reactions and need proper diagnosis with allergy testing and appropriate treatment. If the patients are unable to gain access to the clinic in a timely manner, they may choose to find another allergy provider leading to decreased potential revenue or access the emergency department which would lead to unnecessary accessing of emergency services at a very high cost.

The hours spent with staff is factored into their current salaries, meaning that no one will be paid overtime for any meetings regarding the project. The current practice of these longer wait times is not currently costing the organization since all time slots are filled with follow-up appointments or annual checks.

The costs for my involvement as a CNL are calculated as a student since my practicum is not associated with my employer. Time spent on the project include 293 hours, allocated as

follows: planning for the project – 10 hours, researching for evidence to support the project – 15 hours, time spent in clinical setting related to the project – 220 hours, consultation with nurse managers – 8 hours and writing reports to present finding – 40 hours. With a median hourly rate of \$50 per hour, based on my nursing experience, the cost savings to the clinic is \$14,650 (293 X 50), since they are not paying for these hours (See Appendix D for Projected Cost Analysis). Minor expense includes paper and copying which is estimated to be \$20.

In addition to these cost savings, other benefits to the clinic involve improving patient flow, more patients are to access the clinic providers, thereby increasing revenue, improved patient satisfaction scores with decreased wait times for an appointment and improved quality of life since the patients are able to decrease their allergic reactions as a result of proper diagnosis and treatment. This potential increase in revenue resulting from seeing additional patients on a monthly basis is calculated as follows: a new patient billable visit is averaged at \$350 (See Appendix E); 20 new patients currently seen each week = \$7,000 (20 X \$350) weekly income; proposed increase to 36 new patients weekly; weekly revenue would increase by \$5,600 per week to \$12,600 (36 X \$350). This represents an annual revenue increase of \$280,000 based on 50 weeks (5,600 X 50), time subtracted for vacations, sick time, et cetera. By not seeing these new patients, the clinic would experience a potential revenue loss of \$280,000 annually.

When patients are not seen timely and access emergency services, the cost ranges from \$4,500 to \$12,000 depending on the treatments and/or lab work ordered. Although this cost is not directly related to the clinic costs, it represents an unnecessary cost to private or public insurance and ultimately to taxpayers (for publicly insured patients) and is a good example of the astronomical increasing costs of health care.

Methodology

The objective of the project is to decrease the wait time of newly referred patients to the CHOC Children's Outpatient Allergy/Immunology Clinic. The specific change to be tested is the reduction in the wait time by 25 percent for all newly referred patients. This will represent an improvement in access to the specialist by new patients who will have to wait no more than 45 days to see the specialist.

One of the reasons cited for patients not gaining timely access to an allergist is that there is a delay in the referral process when authorization codes are incorrect or incomplete on the authorization request. A brief in-service will be conducted with the main referral sources to review how to correctly complete an authorization request to the outpatient allergy/immunology clinic. The first step is to meet with the staff to discuss the project, ask for and receive their input, and to engage them as participating stakeholders. The next step is to analyze the referral sources to determine which primary care providers make several referrals to the clinic and choose the top ten providers making the most referrals (See Appendix F). This is because the outpatient clinic receives at least one hundred referrals each week and so it will not be possible to contact each referral source within the limited timeframe for this project.

Each of the selected referral sources will be contacted by phone so that a complete list of the required codes needed on the authorization request can be sent via facsimile to their office. The next step involves scheduling and conducting a brief phone in-service with the office manager or the person in each office responsible for requesting referrals.

There will be copies of this required list of codes available in the financial coordinator's office so that when an incomplete authorization is received, a copy can be sent detailing all the

required codes. It will be stressed to each referring provider's office that the patient cannot be seen in the clinic until the authorization request had been properly completed with all the necessary codes.

The scheduling matrix will be adjusted to include each provider seeing three to four new patients daily instead of the current schedule of two new patients daily. Currently, providers are scheduled to see eight to ten patients in each half day session or 16 to 20 patients each day. New patient visits have been limited to two for each provider in the morning session since a new patient visit can last up to three hours if comprehensive skin testing is required. By adding two new patient visits to the provider's afternoon schedule, an additional 16 patients can be seen each week. This approach will decrease the backlog of patients waiting to be seen.

The change theory that will be used to guide this project will be Lewin's 3-step change process – unfreeze, movement and refreeze. Unfreezing involves introducing the new idea, expecting resistance in this step but being aware that as the momentum for the change increases, resistance will decrease (Manchester et al., 2014). Movement involves guiding the staff to perform the changes, resistance continues to decrease (Manchester et al., 2014). Refreezing will be accomplished by reinforcing this change through organizational support and having it become a part of day-to-day operations (Manchester et al., 2014). This final step is critical in order to maintain the sustainability of the change.

Once the project has been implemented, the actions that will be taken will include the evaluation of the project. The new patient schedule matrix will be reviewed weekly to ensure that new patients are being scheduled and seen weekly, and increase from the current 20 patients

to 36. The insurance categories of the new patients will be reviewed monthly to see if there are any disparities noted for those with public insurance.

Patient satisfaction scores will be reviewed at monthly intervals to see if there is a trend of increasing satisfaction as the wait time decreases. The feedback from the providers and the office staff will be evaluated at the monthly staff meetings to see how this increase in new patient volume is affecting the clinic in regards to work flow process, staff attitudes and morale.

My predictions are that the staff will become more effective and efficient in obtaining authorizations that have been properly completed, that 36 new patients will be scheduled each week to see the allergy specialist and patient satisfaction scores will reflect improving satisfaction. I will be able to evaluate these predictions when the collected data reflects the increase in new patients seen weekly, the decrease in wait time to no more than 45 days and improving patient and staff satisfaction scores.

Data Source/Literature Review

The microsystem is an outpatient specialty clinic – allergy and immunology. The clinic is an affiliate of CHOC Children’s (Children’s Hospital of Orange County), and is located approximately a half mile from the main hospital campus. The services provided include the diagnosis and treatment of varied allergy and immunology conditions. There are currently three physicians on staff, eight exam rooms and approximately 750 patients are seen monthly, with 80 patients being new to the practice. Although this clinic is part of a children’s hospital, it is the only outpatient specialty clinic that provides service to adults as well as children.

Data was obtained from observation of the clinic processes, including phone calls, the electronic patient matrix for patient appointment scheduling and staff observation. The data

reflects that the current wait time for new patients to get an appointment is approximately 60 days or more.

The articles included in this literature review described the inadequacies of the referral process for specialty care, the relationship of increased wait times to patient satisfaction and the importance of improving access to specialty care. The PICO search question of ‘Will decreasing the wait times for an initial visit to the allergy specialist result in improved patient satisfaction?’ was the basis for the data search. A search of the Fusion database was conducted using the PICO search strategy of specialty care, patient satisfaction, outpatient specialty care, wait times for appointments, access to specialty care, outpatient referrals, specialty referrals and solutions for long wait times. Six articles with dates that range from 2011 to 2016 were found and all were timely for this essay and selected for review.

Adolph, Wu, Feldman, and Balkrishnan (2012) performed quantitative research using an internet convenience survey with a large sample (n=22,626) to explore patient satisfaction scores with primary or specialty care physicians. The participants provided a rating for their physicians based on a scale of 0 (not at all satisfied) to 10 (extremely satisfied). Results showed that the wait time to see a specialist ranged from 6 days to 2 months, with the satisfaction scores getting lower as the waiting time increased. This research shows the importance of patient satisfaction as a quality indicator in measuring healthcare quality from the perspective of the patient.

Aeenparast, Maftoon, Farzadi, and Mohammadi (2015) conducted quantitative research using a cross-sectional study to obtain data by telephone interviews to the office of specialists to study the factors that were related to the wait time for outpatient specialty care. The participants consisted of accessible physicians (n=3098). Results showed that the average wait time for the first visit to a specialist was 2 days, with a few waiting for 10 days and even fewer waiting for 30

days. Various factors affected this wait time such as type of specialty, location of office and whether the specialist was a faculty member. This research shows that wait time is an important factor in determining patient satisfaction and is an indicator of quality care by measuring access, with increased wait times viewed as a barrier to accessing the specialist.

Jaakkimainen, Glazier, Barnsley, Salkeld, Lu, and Tu (2014) performed quantitative research using an observational or Cohort study of family medicine in the electronic medical record (EMR) to calculate the wait time from the time the referral was made by the primary care physician (PCP) to the time the patient was seen by the specialist and to examine patient and provider factors related to these wait times. The data was obtained from the Electronic Medical Record Administrative Data Linked Database (EMRALD) in Ontario, Canada. The participants consisted of a small sample (n=54). The actions taken included calculating the actual wait times using the EMR referral data including the referral letter with the referral date. The results showed that the average wait time for seeing a medical specialist (not requiring surgery) was 39-76 days, with patient and physician factors not consistently associated with the delay. This research shows that improving the access to specialty care is important since any delay could have serious consequences for the patient.

Ray, Ashcroft, Kahn, Mehrotra, and Miller (2016) performed qualitative research using purposive sampling of 21 participants within 24 outpatient sites to develop a framework for high quality, patient-centered referrals by looking at the patient and family perspectives of the inadequacies experienced in the referral process to specialists. The interviews uncovered 5 desired outcomes of subspecialty referrals and 6 key steps to supporting these outcomes. The actions taken were to identify the knowledge gap of healthcare system interventions of patient-centered improvements in the quality of the referral process without considering the

perspectives of the patients and families. This research shows the importance of using the model developed to guide any future attempts in measuring the quality of the referral process by placing emphasis on the domains of importance to the families who have experienced inadequate service in this process and that the processes, outcomes and structures identified can be used in an improvement of the quality measures for the referral process of children to specialists.

Zuchowski, Rose, Hamilton, Stockdale, Meredith, Yano, Rubenstein, and Cordasco (2015) performed a combined quantitative and qualitative research using an on-line cross-sectional survey and semi-structured interviews to measure the ease of communication between primary care physicians (PCPs) and specialists to evaluate the challenges involved. A purposive sampling was used across three VHA healthcare systems. The interviews and survey uncovered great difficult in communicating with the specialist by the PCPs and primary care staff involved in the referral process. The actions taken were to study the problems encountered including the rejection of referral requests which occurred when all the requirements for a consult were not met. This research shows the importance of building relationships to help to facilitate improving the referral process since optimal communication is needed for achieving the goal of patient-centered care. This is important since the national trend is towards increased referrals to specialty care.

Zuckerman, Cai, Perrin, and Donelan (2011) conducted quantitative research using a cross-sectional study design to assess the rates of incomplete referrals (which were those referrals that did not result in a visit to see a specialist), and the related risk factors. The study uncovered that approximately one-third of the children referred to a specialist were unable to complete the process timely and that both patient and health care system factors contributed to this problem. Health system factors included inappropriate physician referrals and inaccurate or untimely

referral communication. Patient factors included lack of chronic health condition and appointment rescheduling. The actions taken included the use of a novel approach to address pediatric specialty referrals by using data from an integrated electronic health record (EHR) system involving 2 community health care centers and 19 pediatric specialties affiliated with a tertiary healthcare facility. This research shows the importance of healthcare professionals improving the access to specialty care by providing more support to these high risk patients and seeking a remedy for the problems encountered in healthcare systems.

The themes inherent in these articles were that patient satisfaction is determined by the wait time and is an important quality indicator in measuring healthcare and decreasing the wait times is paramount in improving access to specialists.

Timeline

The project began in May 2016 and will conclude in August 2016 (See Appendix G for Timeline). The outpatient clinic receives at least one hundred referrals each week and so it will not be possible to contact each referral source due to the limited timeline for this project. An analysis of the referral sources will be done to determine which primary care providers make several referrals to the clinic and the top ten providers will be selected. Then initial contact will be made by phone with the office manager or person responsible for making the referrals in the offices of those primary care providers and a short in-service will be scheduled for a future date. The training information will then be developed and will consist of the required codes needed on an authorization request (See Appendix H for Required Codes). The scheduled in service will then be conducted.

The provider's schedules will need to be adjusted to accommodate more newly referred patients on a daily basis (See Appendix I for Proposed Provider schedule).

Expected Results

The expected outcome is that a minimum of 36 new patients will be seen on a weekly basis, each provider will be scheduled to see three to four new patients daily (See Appendix J for Proposed New Patient Schedule). Providers have varying schedules (See Appendix K for Current Provider schedule) and other responsibilities such as hospital in-patient consultation, working in other clinics occasionally and attending meetings, so they may be scheduled to see three new patients on a particular day instead of four. However, the schedule has been planned to allow for 36 new patients to be seen weekly. It is also anticipated that the clinic will be much busier seeing more new patients and continuing to see patients for follow-up visits and annual checks.

The conclusions that might emerge from the study are that the sustainability of the results will need the ongoing support of the organizational leaders as the change becomes an integral part of the daily operations of the clinic. Also, the office staff will need to be effective and efficient in getting these patients checked-in, roomed and seen by the providers.

Nursing Relevance

Patient-centered care is the focus of nursing today. This will be achieved by accomplishing the goals of this project – reducing the wait times for newly referred patients to see the specialist. A reduction in wait times will lead to improving patient satisfaction scores which is a key indicator of the quality of care being provided. Nurses have a responsibility to be actively engaged in the measuring, evaluating and improving of the quality of nursing care that is provided to patients. A nurse-sensitive indicator refers to a patient outcome that is dependent on

the quality of care provided. The patient's satisfaction with their overall care is a quality indicator inherent in this project and very relevant to nursing.

Summary Report

The aim of this project was to reduce the wait time by 25 percent or 15 days for all newly referred patients to the CHOC Children's Outpatient Specialty Clinic for Allergy and Immunology by August 1, 2016. The microsystem is an outpatient specialty clinic – allergy and immunology and has been affiliated with CHOC Children's (Children's Hospital of Orange County) for the past 20 years. The clinic is located approximately a half mile from the main hospital campus. The services provided include the diagnosis and treatment of varied allergy and immunology conditions. There are currently three physicians on staff and eight exam rooms.

The clinic sees an average of 750 patients each month, with approximately 80 patients being new to the practice. Although this clinic is part of a children's hospital, it is the only specialty clinic that provides service to adults as well as children. This is because the clinic was originally a private practice clinic owned by physicians before its affiliation with CHOC Children's. Many patients have been on service long-term, some for several years, as many have chronic respiratory conditions and many receive allergy shots on a regular basis. This is a thriving practice with a constant stream of new patients who have been referred to the clinic by their primary care physicians.

Data was obtained from observation of the clinic processes, including phone calls, the electronic patient matrix for patient appointment scheduling and staff observation. The data reflected that the current wait time for new patients to get an appointment was approximately 60 days or more. This wait time reflected a problem because many children have allergies to

various items such as food, dust, pollen, preservatives, latex, insect venom and medications. Many of these allergic reactions can be minor and may include the skin, respiratory, digestive or cardiovascular systems. However, some allergic reactions are more serious, with the most serious being anaphylaxis, which is a life threatening event that can lead to fatality (Levin, 2013). There is a legitimate reason that the patient was referred to an allergy specialist and every effort should be made to have them seen and evaluated quickly.

Early access to the allergist is very important so that appropriate testing can be done, resulting in proper diagnosis and treatment. Patients can also end up in the emergency room with delayed access to the allergist, which leads to the unnecessary accessing of emergency services at a very high cost, which could have been avoided. A review of the literature for this project showed inherent themes of the length of wait times determining patient satisfaction, which is a quality indicator in measuring healthcare and decreasing the wait times is paramount in improving access to specialists.

The implementation of the project included no changes made from the prospectus. One of the reasons cited for patients not gaining timely access to an allergist was that there was a delay in the referral process when authorization codes were incorrect or incomplete on the authorization request. The steps in this implementation process included meeting with the clinic staff to discuss the project, asking for and receiving their input, engaging them in the process, analyzing the referral sources to choose the top ten primary care providers making the most referrals, contacting these referral sources by phone and faxing them a complete list of the required codes needed on each authorization request, scheduling and conducting a brief phone in-service with the office manager or the person in each office responsible for requesting referrals. Copies of the required list of codes were made available in the financial coordinator's

office so that when an incomplete authorization was received, a copy could be sent detailing all the required codes. The scheduling matrix was adjusted to include each provider seeing three to four new patients daily instead of the usual two new patients daily.

Evaluation

Review of the electronic new patient schedule matrix showed that there were four ‘new patient slots’ created for each provider daily, two in the morning session and two in the afternoon session. This new matrix has been in place for one week and 36 new patients were scheduled (See Appendix L). This schedule matrix will be reviewed weekly to ensure that a minimum of 36 new patients are being scheduled and seen weekly. The insurance categories of the new patients will be reviewed monthly to see if there are any disparities noted for those with public insurance.

Patient satisfaction scores will be reviewed at monthly intervals to see if there is a trend of increasing satisfaction as the wait time decreases. The feedback from the providers and the office staff will be evaluated at the monthly staff meetings to see how this increase in new patient volume is affecting the clinic in regards to work flow process, staff attitudes and morale.

The data collected from the electronic new patient schedule matrix supports the projection that 36 new patients will be scheduled on a weekly basis. The staff has been observed during the first week of project implementation to be effective and efficient in rooming the patients and in completing all preliminary procedures so that they can be seen by the physician. The authorizations that have been received in this past week have all had the correct codes so that there are no further delays in the scheduling of new patients.

The staff has been observed talking with new patients on the phone and scheduling them for their first visit in 43 – 45 days. There is no data available at this time for patient satisfaction scores, this data will first be available at the end of August after the project implementation has been in place for one month.

Conclusion

Implementing change in any healthcare setting involves hard work which includes a thorough analysis of the microsystem, including an in depth knowledge of the 5 P's – purpose, patients, professionals, processes, patterns. This analysis then leads to the 'need' that will be the focus of the process improvement. This is followed by a myriad of other related factors such as development of aim statement and PICO question, review of the literature, development of the methodology which describes how the project will be completed step by step, and development of a timeline for the project.

After completing all the processes of this project, the results clearly show that the wait times for newly referred patients to the allergy/immunology clinic has been decreased by 25 percent from 60 days to 45 days on average. Decreasing this wait time has been accomplished by increasing the number of new patients seen daily and by decreasing the amount of authorization requests that were received incomplete. The patient satisfaction scores are not yet available until after the first month that the project has been in place. The results that have been obtained show that the goal of the project has been achieved and there is a plan in place to maintain the sustainability of the project results.

One of the challenges experienced in this project was that selecting the top ten referral sources revealed that there were 33 contacts to be made, not the anticipated ten. This was due to

the authorizations coming from medical groups which could have several participating providers making referrals. The majority of the office managers/supervisors in the PCPs offices were not cooperative and did not feel that they needed any kind of in-service on procedure codes, nor that they had the time for an in-service. This issue was handled by limiting the in-service time to five minutes only and being flexible to the times they were available, even if the time was outside the normal business day.

Another challenge was that the providers want to keep their current days of work, not wanting to change to provide better coverage for the clinic, citing childcare as the reason. This means that there will still be one day when only one provider is in the clinic. An attempt to deal with this barrier by appealing to the medical director of the clinic proved unsuccessful. At this time, the schedule will remain unchanged, however, the proposed amount of new patients will be seen weekly, meaning that the two days each week when there are three providers in the office will be extremely hectic and the day that there is only one provider will be extremely quiet.

Working on this project has utilized many of the required competencies for the CNL such as advocate, systems analyst/risk anticipator, outcomes manager, information manager, clinician and educator. I have come to recognize and understand the varied roles of the CNL in horizontal leadership, interdisciplinary communication and collaboration and lateral integration inclusive of the components of communication, collaboration, coordination and evaluation. I feel that by completing this project, I have acquired the skills and competencies required to function in the CNL role.

I would like to express my appreciation to my preceptor, the senior management at CHOC Children's Ambulatory Care and the staff at the allergy/immunology clinic. It was a pleasant

experience working with each one, learning from them and being allowed to practice as a CNL in their environment.

Sustainability Plan

The sustainability plan for my CNL project will include the factors of having a champion, perceived benefits of the staff and continued support from the physicians. Choosing the right person to champion the project outcome is crucial in maintaining sustainability. A champion is someone who is respected by their peers and is passionate and committed to the continued sustainability of the project outcome. It is important that a champion has some leadership skills and conveys a sense of empowerment (Creehan, 2015). It will also be important that this champion's role is clearly defined as an added support to staff.

The staff will have the opportunity to provide their input at the monthly staff meeting on their perception of how this new process is working and any changes that they feel would further benefit the process. Ongoing data to show the project's success and any further developments of the action plan would also be presented at these staff meetings by the clinic supervisor or the nurse manager. Since the sustainability of the results will need the ongoing support of the organizational leaders, the nurse manager will meet with the physicians monthly to seek their input and provide updates on the data collected. She will also keep the senior management of the Outpatient Specialty services updated and enlist their continued support.

Standardization is 'holding the gains' that have been achieved and incorporating them into the daily work process (Nelson et al., 2007). I am expecting the work from this project to be standardized so that it is an integral part of the daily work flow, with a minimum of 36 new

patients being seen weekly and new patients not having to wait for more than 45 days to gain access to the allergist.

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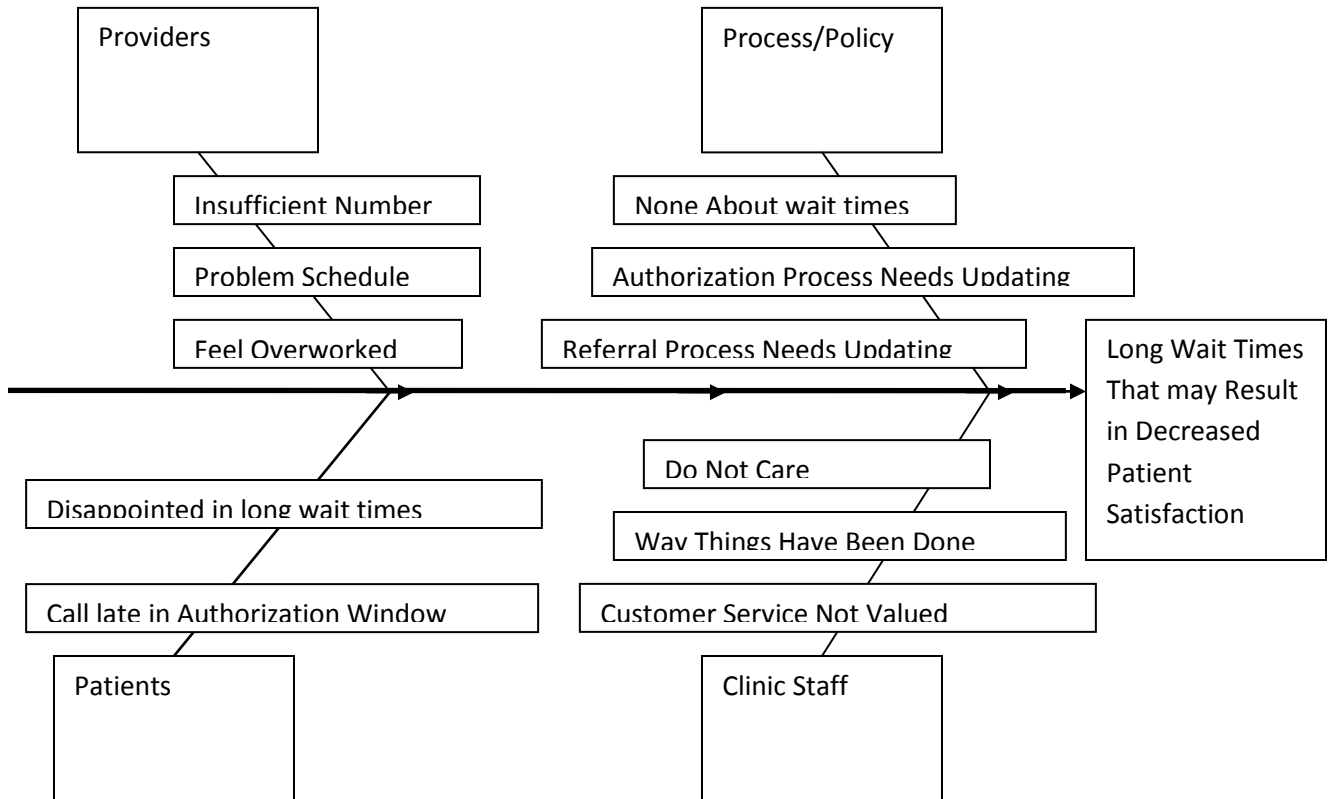
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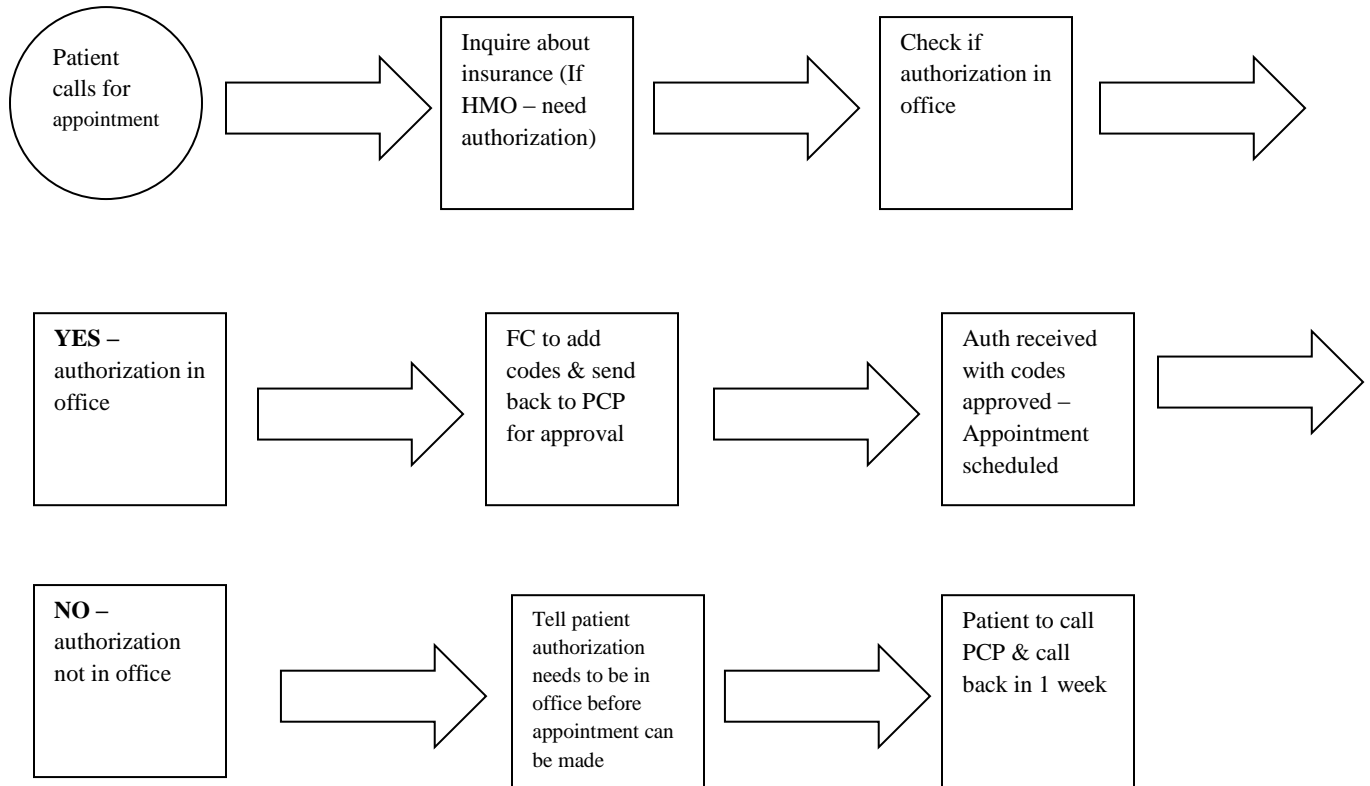
Appendix A

Root Cause Analysis (Fishbone Diagram)



Appendix B

Process Flow of Current Authorization/Referral Process



Note: Authorization is good for 90 days. If patient not seen in this timeframe for whatever reason, FC to request an extension

Appendix C

SWOT Analysis

SWOT ANALYSIS		
	STRENGTHS	WEAKNESSES
INTERNAL	Good reputation in community/county Loyal customers Good location –close to tertiary hospital	Long wait time for new referrals to get an appointment
	OPPORTUNITIES	THREATS
EXTERNAL	Improved patient satisfaction Increased revenue due to more patient volume	Recent loss of provider due to death Growing public insurance population leading to decreased reimbursement rate per visit Seasonality of allergies Possible loss of patients to competitors

Appendix D

Projected Cost Analysis

Values	Alternatives		
	Cost to Clinic	Savings to Clinic	Revenue to Clinic
CNL cost to implement project		293 X 50 = 14,650	
Paper/Copying	\$20		
Current: 20 new patients per week			\$7,000 (20 X 350)
Future: 36 new patients per week			\$12,600 (36 X 350)
Increase in Revenue per week			\$5,600 (\$12,600-\$7,000)
Annual Revenue Increase		\$280,000 (\$5,600 X 50)	
Total Cost Savings 1 st Year		\$ 294,650	
Total Cost Savings 2 nd Year & Ongoing		\$280,000	
Total Cost to Clinic	\$20		
Total Savings to Clinic		\$294,630	

Appendix E

New Patient Billable Visits

Diagnosis Codes	Procedure Codes	Visit Type	Cost
R09.81, J30.1, J32.9, L20.9	99205/99245	Visit/Consultation – New Patient, High Complexity	\$ 450
R05, R09.81, J31.0, J38.7	99204/99244	Visit/Consultation – New Patient, Moderate Complexity	\$365
J30.89, J45.30, , J30.1	99203	Visit/Consultation – New Patient, Low Complexity	\$240
			\$350 average cost

Appendix F

Top 10 Referral Sources (In One Month)

CalOptima (3)

Dr. Reddy Dr. Hui Dr. Cobham-Brown

CHOC Health Alliance (15)

Dr. Luu Dr. Wu (3) Dr. Mussarat Dr. Chang

Dr. Hampton Dr. Hermann Dr. Fortades Dr. Choo

Dr. Choi Dr. James Dr. Lee Dr. Huoh

Dr. Perdoma

CHOC – Friends of Family Health Center (3)

Dr. Chang (3)

CHOC – Share Our Lives Corporation (3)

Dr. Hollander (2) Dr. Doyal

Edinger Medical Group (4)

Dr. Nguyen (4)

Monarch Family Medical Group (2)

Dr. Brown Dr. Monga

Orange County Pediatrics (2)

Dr. Bui

South Coast Pediatrics (3)

Dr. Ajmal (3)

St. Joseph’s Hospital Affiliated Physicians (8)

Dr. Zand (2) Dr. Fajordo Dr. Tucker Dr. Chan

Dr. Ferrey Dr. Shahin Dr. Gladstein

St. Joseph’s Heritage Medical Group (2)

Dr. Marino Dr. Wang

Represents 33 Primary Care Physicians & 48 Referrals

Appendix G
Timeline

Start of Project	-	May 25, 2016
Initial Meeting with Clinic Staff	-	June 1, 2016
Analysis of Referral Sources	-	June 13, 2016
Initial Contact with PCP Offices	-	June 16, 2016
In service Scheduled	-	June 23, 2016
Training Information Developed	-	June 29, 2016
In-service Session Completed	-	July 21, 2016
Provider Schedule Adjustment	-	July 28, 2016
Proposed End of Project	-	August 1, 2016

Appendix H

Training Information

Codes Needed for Referral Authorization to be Complete

- 99205 - New patient office visit - complex
- 95024 - Intra-cutaneous test with allergenic extracts immediate type react, specific number of test
- 95004 - Percutaneous test with allergenic extracts, immediate type react, specific number of test
- 94375 - Resp. flow volume comp
- 94664 - Demo and/or eval, Patient utilization of aerosol generator, nebulizer, inhaler, IPPB device
- 89190 - Nasal smear for eosinophils
- 99213 - Office outpatient visit - extended
- 94010 - Breathing capacity test

Appendix I

Proposed Provider Schedule

Provider	Monday	Tuesday	Wednesday	Thursday	Friday
1 Dr. F.	X		X	X	
2 Dr. C.	X	X			X
3 Dr. E.	X	X	X	X	X
Total # Providers Working	3	2	2	2	2
New Patients Seen (3- 4 per Provider)	9	7	7	7	6
New Patients/Week	36				

Appendix J

Proposed New Patient Schedule

Provider	Monday	Tuesday	Wednesday	Thursday	Friday
1 Dr. F.	3		3	4	
2 Dr. C.	3	4			3
3 Dr. E.	3	3	4	3	3
Total # Providers Working	3	2	2	2	2
New Patients Seen (3- 4 per Provider)	9	7	7	7	6
New Patients/Week	36				

Appendix K

Current Provider Schedule

Provider	Monday	Tuesday	Wednesday	Thursday	Friday
1 Dr. F.	X		X	X	
2 Dr. C.	X		X		X
3 Dr. E.	X	X	X	X	X
Total # Providers Working	3	1	3	2	2
New Patients Seen (2 per Provider)	6	0	6	4	4
New Patients/Week	20				

Appendix L

New Patient Schedule for Month of August

Provider	Monday	Tuesday	Wednesday	Thursday	Friday
1 Dr. F.	4		3	4	
2 Dr. C.	3		4		3
3 Dr. E.	4	2	3	3	3
Total # Providers Working	3	1	3	2	2
New Patients Seen (3- 4 per Provider)	11	2	10	7	6
New Patients/Week	36				