PRACTICE MANAGEMENT MATTERS:

Speaking Volumes:

Seeing High Patient Volumes with Heart and Strategy

Synopsis with Hyperlinks: You will want to jump around!

(Click on green text to read more about each topic)

Situation:

Adhering to our Promise "to improve the well-being of every child in our care and our communities," Cook Children's takes care of a high volume of patients (i.e. A LOT OF CHILDREN) every day. However, seeing high patient volumes can present its challenges, given the limitations of human capability and physical space, a growing population, fluctuating seasonal demands, and specialist shortages. This report aims to look at the way different individuals, clinics, and departments within our organization, both within primary and specialty care, are meeting these challenges.

Background:

1. **Setting the Stage**
    a. We are seeing higher and higher volumes
    b. The Clinician's Template and yearly calendar, with its expected element of surprise.
    c. Capacity: The Basic Terminology
    d. Dr. Kara Starnes, Urgent Cares and Maximizing Surge (Yellow Zone) Capacity

2. **How are some of your highest-volume general pediatricians doing it?**
    PCPs: Dr. Jeff Day, Dr. David Goff, Dr. Rachel Hamilton, Dr. Mark Jones, Dr. Scott Katz, Dr. Vanita Shori, Dr. Justin Smith
    NHC: Dr. Christina Ateek

3. **How are our busy pediatric specialists doing it?**
    Cardiology, Endocrine, ENT, Gastroenterology, Neurology, Nephrology, Orthopedics, Pain, Pulmonary and Rheumatology, and Urology

4. **Patient Volumes and Efficiency as Seen through Different Lenses**
    Technology, Physician Wellness, Compassion, Education, Patient Experience, and Quality

Assessment:

Meeting the care needs of high volumes of patients presents challenges and requires planning and mindfulness in addition to adaptability and flexibility. This report represents a sharing of ideas so that we can all become more efficient in serving our children.

R: Recommendations

Here is a summary of some of the tips (generalizing-- you will have more fun in the body of the report!).

Hopefully this is just the start of the discussion!

PRACTICE MANAGEMENT MATTERS

Speaking Volumes:

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S: Situation

- **Adhering to our Promise "to improve the well-being of every child in our care and our communities," Cook Children's takes care of a high volume of patients every day. However, seeing high patient volumes can present its challenges, given the limitations of human capability and physical space, a growing population, and fluctuating (sometimes seasonal) demands.**

- **In primary care**, the challenge is how to care for our ever growing population, both at baseline and during the busy seasons, and then to be able to accommodate still increased sick volumes during surges.

- **In specialty care**, the challenge is how to see the most patients, in the most efficient possible way in a setting of constant high demand, specialist shortages, sometimes intermittent/seasonal variation. This goal is complicated by high-cost visits with a need for insurance clearance where possible, and frequent patient no-shows.

  This document will share information about how different individuals, clinics, and departments within our organization, both within primary and specialty care, are meeting these challenges.

> "The greatest challenge of modern medicine is not just curing disease, but having enough time to care for those who suffer from it."
>
> – Dr. Abraham Verghese,
>
> Physician, Professor, and best-selling author

B: Background

How high are Cook's volumes? (Thank you, Kevin Briscoe and Dr. Matt Dzurik)

Answer: High and Rising.

- **How many patients did we in Cook Children's see in Fiscal Year Oct 2023-Oct 2024?**

Visits by Group ($T)

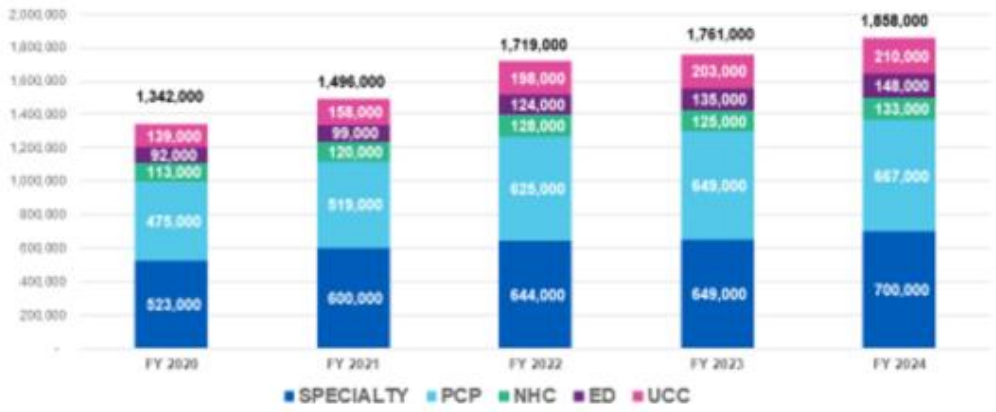
Visits	For the 12 Months Ended Sep 2024			
	PCP	Specialty	NHC	Total
Current Year	666	848	133	1,647
Prior Year	648	785	125	1,558
Fav / (Unfav)	18	63	8	89
% Fav/(Unfav)	3%	8%	6%	6%

- **How did those volumes translate into collections?**

Collections by Group ($M)

Collections	For the 12 Months Ended Sep 2024			
	PCP	Specialty	NHC	Total
Current Year	$ 151	$ 129	$ 17	$ 297
Prior Year	$ 138	$ 117	$ 15	$ 270
Fav / (Unfav)	13	12	2	27
% Fav/(Unfav)	10%	10%	15%	10%

Volumes



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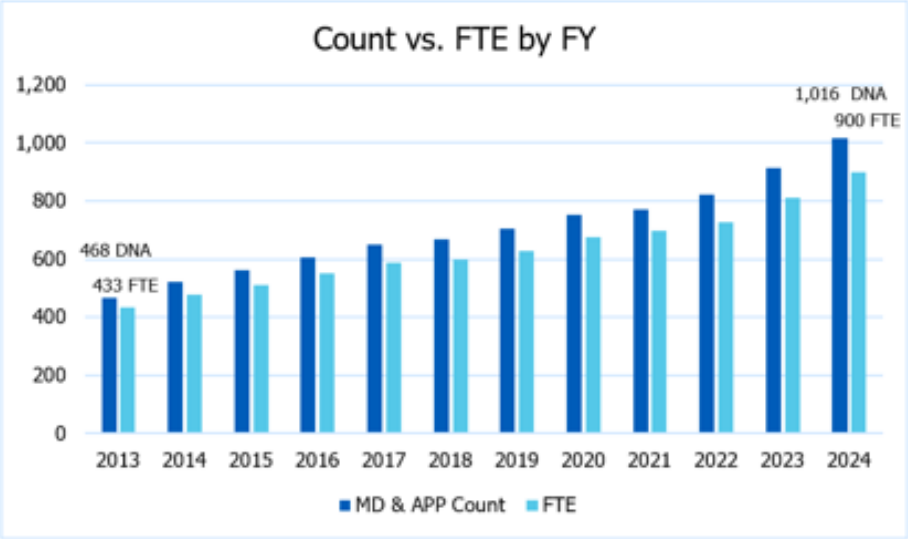
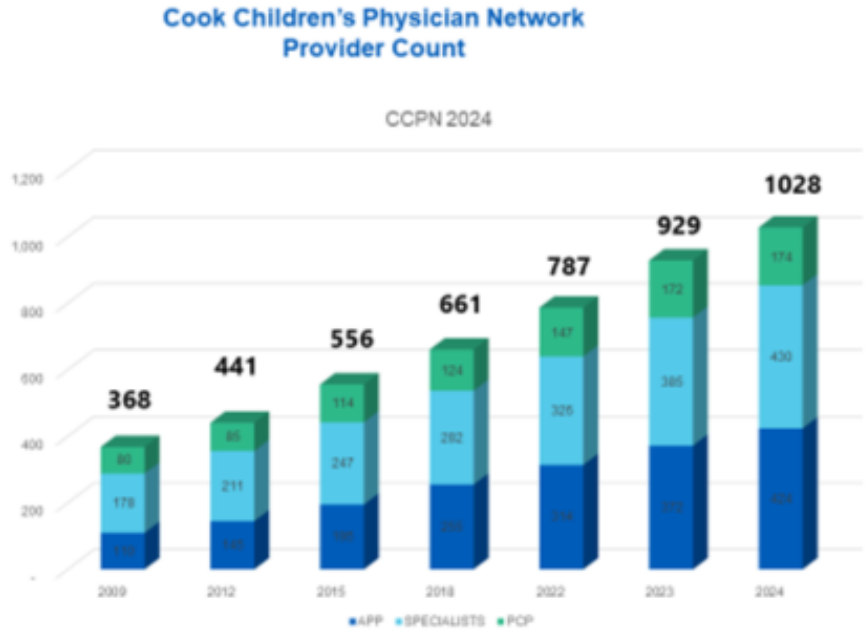
- **Our clinical count is growing as well (our team is getting bigger in order to better serve the growing numbers--thank goodness!)**

Clinician Growth Trend





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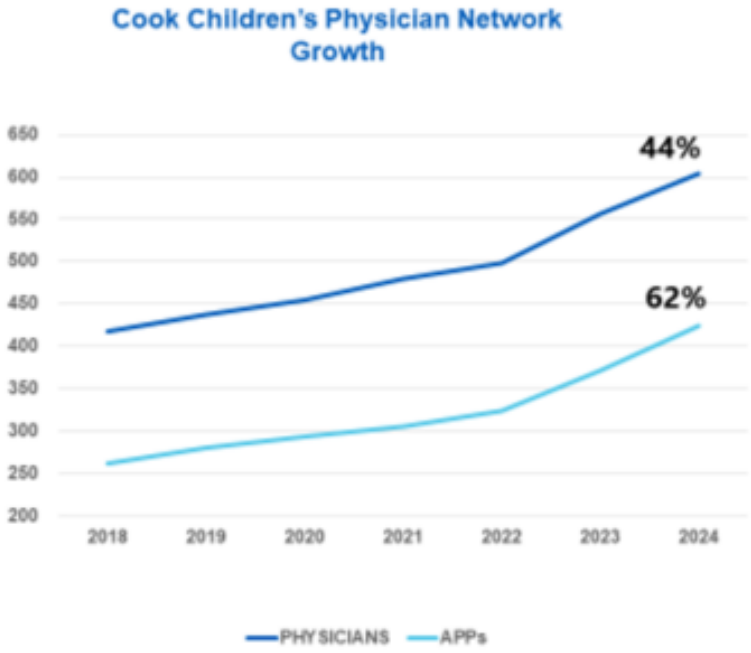

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The Primary Care Physician's Template

- Even before the year starts, a pediatrician needs to have a working daily template that is open for scheduling and attempts to meet needs for well and sick care. EPIC requires designation of a visit slot as Sick or Well, and this guides office staff in booking appointments.

- **Is there a definitive number of patients a clinician must see for profitability?**
  - This is complicated, as so many factors are at play, including insurance coverage, well vs sick numbers (well being generally better reiumbursed), and the complexity of visits as well as additional charges such as vaccines, labs, and procedures.
  - That being said, **18 patients per day is an average cut off** to be "positive" for the day in a collections-based system. It is more typical to see **the low to mid 20s (23-26).**

- **What are the ratios of sick v well visits for Cook CCPN Primary Care?**

CCPN PC Avg.	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	12 Mon. Total
Sick	67	71	54	64	55	40	38	42	51	46	35	38	602
Well	41	39	39	44	43	45	55	55	41	39	27	27	494
Nurse Only	5	4	3	3	3	3	3	4	11	18	8	5	71
Nursery	0	0	0	1	0	0	0	0	0	0	0	0	4
Other	0	0	0	0	1	1	2	2	1	0	0	0	9
	114	115	97	112	103	89	99	103	104	103	70	70	1,180
Sick	59%	62%	56%	57%	54%	45%	38%	41%	49%	45%	50%	54%	51%
Well	36%	34%	40%	39%	42%	51%	56%	53%	40%	37%	38%	38%	42%
Nurse Only	5%	4%	3%	3%	3%	3%	3%	4%	11%	17%	11%	7%	6%
Nursery	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Other	0%	0%	0%	0%	1%	1%	2%	2%	1%	0%	1%	0%	1%
	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

In summary, Cook PCPs are essentially seeing 60% sick, 40% well in the winter and the reverse (40% sick, 60% well) in late summer. Kids are sicker when school is in session and especially during the fall/winter viral season, and they come and get their well-care visits for school in late summer, when forms are due (as much as we pediatricians might love for them to come for well care in May and June, when we are slower) .

Capacity: The Basics

This section is drawn in part from AAP President Dr. Susan Kressly's presentation at the AAP National Conference 2023 and the reference from the National Academies of Sciences, Engineering, and Medicine, 2010, "Medical Surge Capacity: Workshop Summary."

- **Conventional Capacity: GREEN LIGHT ZONE (comfortable)**

  - Things in a clinical setting are running smoothly, with regularly available staff, space and supplies
  - Resources meet demand: patients can be seen for non-urgent concerns and for reasons that you as clinician initiate (ex. "we see that you are behind on well care and recommend you schedule an appointment")
  - Usual high standard of care
  - Your office/department meets patient expectations without having to turn them away (such as sending them to urgent care/emergency dept).
  - You are not running too behind (a little behind may be difficult to avoid in this line of work, but running significantly behind day-to-day may indicate a problem with staffing or workflows)
  - Some staff may have at least a little time to do "extra" activities, such as organizational or improvement projects which are put off during busier times
  - **Says PCP Dr. Amy Stockhausen about systems present for GREEN ZONE that later help for the YELLOW ZONE, "I typically set myself up with office and staff resources to be as efficient as I can on the good days, so that as things get busier my patients' experience of the office and of me is as close to 'regular' as it can be."**

- **Contingency Capacity: YELLOW LIGHT ZONE (somewhat uncomfortable but ok); Think SURGE situations.**

  - Things are busier than normal but manageable with some degree of strategy
  - With some adaptations, you can deliver functionally equivalent care
  - Usual standard of care is mostly delivered, with perhaps minor impact due to minor adaptations/creative workarounds
  - A busy flu season might push a pediatric office into this zone
  - **Potential adaptations for Increased Volumes During Surges:**
    - **Implementing Schedule/Template Changes to accommodate more sick patients (expanding access):**

- Starting earlier, staying later, working through lunch, double-booking, and using any open well visit slots for sick visits. Open up more slots.
- In general, pediatrician templates tend to change in the winter months, as offices plan for more sick visits relative to well. So some of these adaptations are already in place
- Potentially postponing older kids' well care visits or offering families a choice of a shorter visit today versus a more standard visit next month
- Offering telemedicine where appropriate, to see more patients without the need of full staff. This may allow for the clinician to see more patients even when staff is not available to help with visits. It offers flexibility for patients and also for the physician, who can do some of these visits from home if desired.
- Consider block scheduling, moving well care to the beginning of the day and sick to later day so as to mitigate contagion

- **Enhancing Triage Protocols:**
  - **Hightlighting triage questions and education** for staff and families geared to the particular infectious disease surge, with guidance for home management vs telehealth or in-person visits vs seeking emergency care
  - **Says Cook PCP Dr. Jason Terk, "We do the best we can and do so with optimal efficiency of process and monthly staff meetings to push out needed information and changes." He continues, "We also invite staff to make suggestions on how to do things better with everyone aligned for the winter mission."**
- **Using Technology**
  - **Providing social media guidance** on when to come in or not, how to manage illness at home, and when to seek higher level care
  - **Using portal messaging** to blast out alerts when needed
  - **Says Cook PCP Dr. Diane Arnaout, "Social media has been a huge tool for me to communicate our needs as a staff/office as well as patient needs during the hard times!"**
- **Applying Testing Protocols, Standing Orders:**
  - Clinicians may institute automatic testing (ie standing orders for respiratory viral testing) for patients presenting with certain symptoms
  - Clinicians may also opt NOT to test children, if for example flu is going around and there has been known contact with it. Not testing also adds to efficiency in some cases, especially if not affecting management.

- **Using Space Wisely:**
  - Increasing clinically available space by using an office space as a makeshift exam room or a hallway as a testing area (nasal/throat swabs)

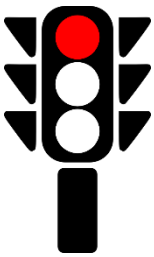
- Having contagious families stay in their cars is an option to prevent contagion. In the pandemic, neb treatments were performed in the car in some cases (with attachment set-up).

- **Workforce Flexing**
  - Instituting rotations of nursing/clinical staff so that clinicians can see patients during lunch while still giving people some break time
  - Calling in prn employees or ones who usually are off to perhaps work from home triaging calls (for bonus pay)

- **Implementing Schedule/Template Changes to accommodate more sick patients (expanding access):**
  - Starting earlier, staying later, working through lunch, double-booking, using any open well visit slots for sick visits. Open up more slots.

- **Crisis Capacity: RED LIGHT ZONE**

  Think Big Time Emergency, *a la* Pandemic. This is beyond the scope of this report.

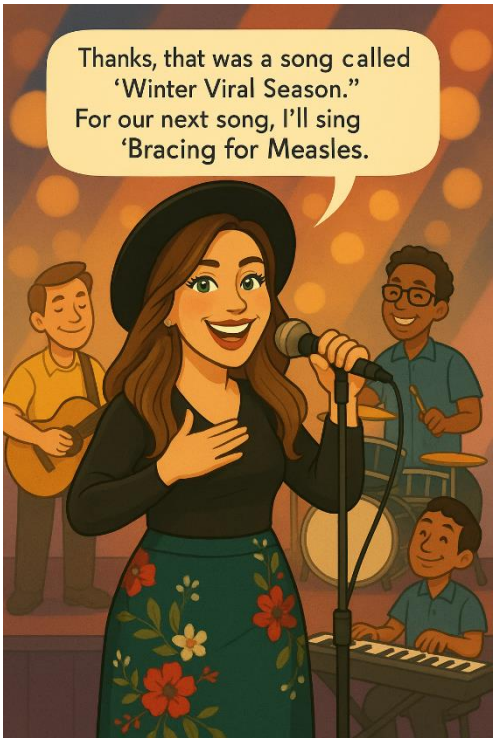


  - Large increase in demand puts huge stress on the system
  - Extreme resource constraints such that the aim becomes doing the greatest good to the greatest number
  - Standard of care provided does not meet usual expectations

SURGE CAPACITY IN OUR URGENT CARE:
Dr. Kara Starnes

Dr. Kara Starnes, Cook UCC Director

- **"At our Fort Worth Urgent Care on the campus of the main hospital, which is the location that is most tight on space," Dr. Starnes says, "we make sure every square inch is being used to take care of the patients in the most efficient way possible."**
- During surges, she institutes **Fast Intake** from the waiting rooms
  - Converts part of the waiting room into two patient intake bays with the supplies for getting vital signs, scales, and WOWs
  - Patients are designated as Red Flag or Not
  - **Pre-emptive (Standing) Orders** go into effect for automatic lab testing (flu tests, for example), with the goal to have answers even before an examination room opens up, while patients are still in an internal waiting area. If lab positive, the history, physical and management plan is completed quickly, and patients can be discharged directly from this makeshift area.
  - The UCCs use **refreshable note templates** which have about 75% of the note completed by the time the physician presses refresh, once pre-emptive orders are completed
  - Dr. Starnes must always assess numbers of visits and wait times, and she rearranges staffing accordingly, moving clinicians from one location to another if need be
  - She keeps her ears and eyes open for any impending outbreaks and aims educate her team andto be prepared



Dr. Starnes, UCC Director and Singer/Musician, Has Many Surge Strategies in her Repertoire

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How are some of our highest-volume general pediatricians doing it?

Dr. Jeff Day, Cook S. Denton

Dr.. Jeff Day

- **Patients in a Day:** Ideally, he sees 35-38 patients during his workdays, which run 8a-12 and 1:30-5pm. In his words, "At this number, I am neither bored nor running around with my hair on fire." However, in flu seasons and times of stress he can see 45-50 patients. During the office lunch hour, he takes a 30 minute break and uses the rest of the time to finish AM charts and manage his inbox.
- **Template:** He has 10 minute slots on his template. He constructs his template so that he has well-care visits on the hour and half hour, with sick visits in between. This known structure helps him keep pace. Some visit slots (not all) can be booked through online caregiver scheduling.
- **Surge Capacity:** His record is 55 in a day. Occasionally if needed he buys pizza for the whole office staff and tells them they will get overtime pay but must team up to work through lunch.
- **Seasonality:** He does not change his template for the winter months as opposed to summer, but this happens naturally. When patients call needing well care in the summer, his office will start putting the well visits in the sick slots if needed. He also tries to encourage teens and their families to schedule their well visits in spring, when there is more time to give to them due to lighter scheduling in general.

- **Dr. Day's suggestions for seeing high volumes of patients efficiently:**
  - **Keep an eye on the daily schedule**: As per his schedule design, he should be seeing a well patient on the hour and half hour—with two sicks thereafter. This structure in itself allows him to quickly know if he is running on time, at least over the course of an hour. "I know that well visits take more than 10 minutes," he says, "but then sick visits frequently take less than 10, so it works out."
  - **Encourages booking well care appointments for the slower times.** When he sees teens for sick visits, he encourages them to book their well care appointments in the spring rather than in the summer, so that they (and he) can avoid some of the craziness that can otherwise happen in mid to late summer.
  - **Schedule mental health consults and new ADHD appointments for the last slots of the morning and afternoon** so that, if they should run long, it doesn't impact any (or hardly any) patients.
  - **Have some rules/protocols for lab tests for sick visits to be run before you go into the room.** "It speeds things up," he says, "if you already have some answers when you walk in the room.
  - **He is not a perfectionist about his charts/note-taking:** "My charts are not lovely," he says, "but they have the necessary facts—why they were there, what we found, and what we did about it."
  - **He has a system for reviewing each chart before walking in**: for example, he scans growth chart, vaccines and med list quickly

Dr. Day's Schedule (Well-Sick-Sick each Half Hour) Helps Him Know his Pace

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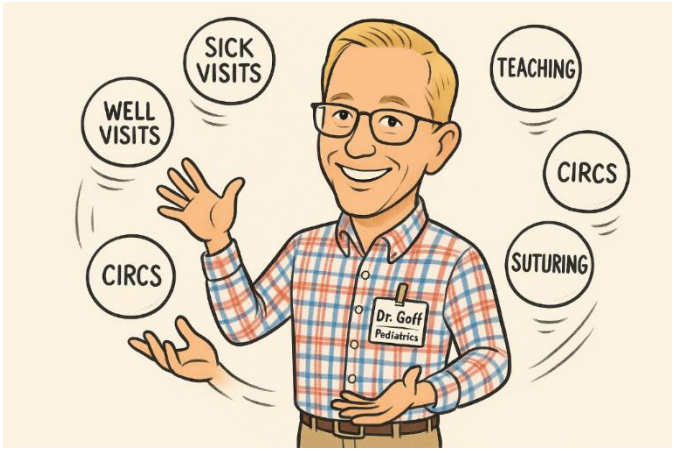
How are some of our highest-volume general pediatricians doing it?

Dr. David Goff

Dr. David Goff, Cook S Denton

- Of note, Dr. Goff is scaling down on clinic time now, devoting 80% of his time to teaching.
- **Patients in a day:** 40-60 patients a day, although EPIC/EMR has made things LESS efficient for him and has moved his daily average down a bit. "Before EPIC, I coule see more patients and document better," he explains, adding "I had organized paper charts and dictated my notes as I left a patient room, in the hallway." He explains he had an excellent transcriptionist who provided typed printed stickers of his notes the very next day, which he would then stick into the charts. His charts were organized so that it was very easy to flip quickly through and see, for example, how many ear infections a patient had, without a lot of clicks and computer tabs.
- **Extended Hours:** He starts early-- at 7am. "Patients and families love it," he says in reference to early appointments, "because they can come in before work and daycare." He often works until 6pm because he works in same-day sick appointments and doesn't want his patients to go to urgent care.
- **Template:** His template is made of 10 minute slots of mixed sick and well visits, and he runs 3-4 rooms at a time. The only exception to his 10 minute appointment slot a "new consult" slot on Tues and Thursdays at 11:30am for patients with mental health issues which, by design, can run long into the lunch period. Once stabilized on a plan (such as ADHD or anxiety/depression medication), he will see them every 4-6 months in one of his regular 10 minute slots. He assures good compliance with follow-up because he issues a warning at the 5 month mark that they need to schedule a follow-up appointment at 6 months or will not be able to get their refill. "I love mental health, even though initially I didn't think I would," he says, "and I like seeing these kids in person." He feels that laying eyes on these patients and tracking vitals allows for a more complete picture of their mental health than telemedicine does.
- **Procedures:** He enjoys doing circumcisions, incision and drainage procedures, suturing, and splints in the office.



Dr. Goff Juggles and Enjoys Many Aspects of this Work

- **Dr. Goff's suggestions for seeing high volumes of patients efficiently (continued on next page):**
  - **Have good communication with your clinical staff and consistency, so that they know the evaluation you will do when a patient presents with certain symptoms.** Dr. Goff explains that he has been lucky enough to have the same nurse for 26 years and that they make a great team. "She knows that when a patient has lost weight I am going to want other growth parameters, a urine, and a hemoglobin, and this is done before I get into the room."
  - **Limit the number of lab tests you do**. "I am not a tester," he say. "I don't do flu tests often because I am not a frequent Tamiflu user," he continues, "and I don't order a test (such as an RSV test) if it is not going to change what I am going to do."
  - **Prioritize face to face time with patients and eye-contact.** Dr. Goff explains his view that so many physicians these days spend so much looking at a computer that they lessen the quality of their interactions. "If you truly look at your patient and engage 7 minutes out of a 10 minute visit, they feel like they have spent 30 minutes with you."
  - **Uses templates and finds they help his teaching,too**: He uses templates not just for the different well-visits but for the various chief complaints (such as ear pain, runny nose and cough). These come in handy not just for him but for his medical students-- he mentors 2 at any given time. He prints out paper copies of his templates, and students can use these when they go into patient rooms to guide their visits. They present to him from the template, and Dr. Goff enters the notes as they do so. Overall, med students do NOT slow him down.
  - **Use a system-based template for complex care patients,** including lines for every specialty involved and including information that is then easy to refer back to about how many hours of tube feeding, how frequent a child is getting physical and occupational therapy.

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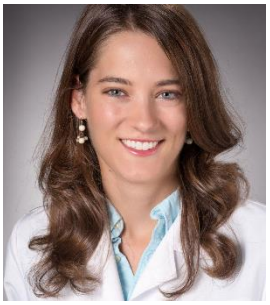
How are some of our highest-volume general pediatricians doing it?

Dr. Rachel Hamilton, Cook Henderson



Dr. Rachel Hamilton

- **Patients in a day:** Sees about 32-36 patients per day but will see 40 if needed
- **Template:** She does her check-ups in the first part of the each half-day, and then sick visits for the latter part. This block design was a template she established during COVID, and she found she liked it. The rooms/office stay "less germy" for the well-care patients, and she tries hard to stay on time for these visits. Once she gets into the sick part of the day, she adds patients who need to be seen and isn't as worried about running a bit late for them, as she finds they are just happy they are able to be seen same-day (in contrast to folks who might have waited a couple of months for well-care).
- **Schedule:** 9am to 5 pm if working the full day; the office is open a half day on Saturdays, with one physician in office on rotating weekend call.

- **Dr. Hamilton's suggestions for seeing high volumes of patients efficiently :**
  - **Prepare ahead of time: Yellow Sheets.** Dr. Hamilton prepares on Sundays (at various times in the day, such as when her boys are napping) for her entire work-week of already-scheduled patients. This involves writing notes on yellow lined papers about each patient, listing for herself which issues came up at the prior visit which she will want to follow-up on, figuring out which vaccines they will need (particularly important if not straight-forward, like on an alternative schedule) and which labs she will want and reminding herself if they had ER/UCC visits since she last saw them. Her notes keep her organized and ready and allow her to give her nurse a heads up, if needed, on what they will do before the patient is there. **"I never come to work without having prepared and having my yellow sheets—it would be a different ballgame if I didn't."**

Dr. Hamilton Prepares on Yellow Sheets and has Built-in Checklists in her Notes

Continue-->

Dr. Hamilton (cont)

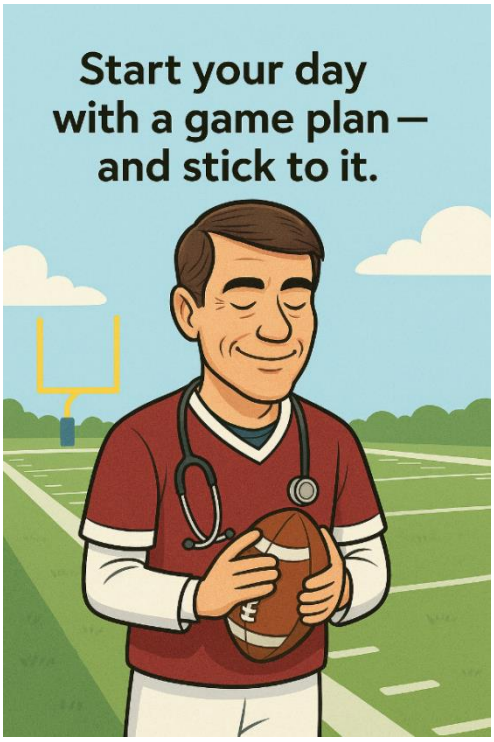
- **Bullet points in her templates serve as checklists on the topics she most wants to cover at each well care visit.** Although she does distribute Bright Futures handouts, she has prioritized topics she wants to be sure she has discussed with all of her patients. She has these points listed in her templates and erases them as she discusses them. Then, as she is finishing up the charting on a patient, if she sees some points not crossed off, she will call the family or ask a nurse to call and remind them of that point. This way she can say with confidence that her patients have been educated on those priority topics. Foods/habits to avoid constipation is one example of something she wants to know she has discussed with every patient family.
- **Invite the family to ask their questions first.** If she sees a caregiver unscrolling a long list of questions at a well-visit or knows the family tends to do that, she invites those questions and tries to answer them first so as not to be surprised at the end. She will try to be brief in her answers if the list is super long but prefers to get to them rather than asking them to return another day to discuss them. At times, particularly if the visit is getting too long, she tells them she will call them later to discuss.
- **If trying to move things along, examine the patient while the caregiver is talking. It's ok to say, "Please continue-- I'm just going to starting taking a look as you talk."**
- **Do not let finding handouts slow you down.** While Dr. Hamilton has some favorite printed handouts on hand, in general she feels handouts often end up forgotten in the room or in the garbage. And she does not want searching for a handout to slow down her flow. She tries to verbally review the most important educational points. If she feels the patient or family will benefit from an educational handout which she does not have on hand, she advises them that she or her nurse/MA will provide it via the portal later in the day.

How are some of our highest-volume general pediatricians doing it?

Dr. Mark Jones, Cook FWP Henderson.

Dr. Mark Jones

- **Hours:** Sees patients Mon-Fri 8- 5 minus one half-day off. Office is open on Saturdays for a half-day with partners rotating coverage, also some Sunday half days. Caregivers call to schedule with Dr. Jones--- no online scheduling.
- **Patients in a day:** He sees 30-35 patients per day on average, more as needed (low40s) in winter.
- He uses very little telehealth due to a personal preference for in-person.
- **Dr. Jones's suggestions for seeing high volumes of patients efficiently:**
  - **Prioritize running on time-"Start the day telling yourself that you will not get behind and try your best to make that happen"**: "I prioritize running on time even if sometimes I have to go faster than I would like, as I find getting behind makes some families angry and causes me to be stressed and distracted (hence providing worse care)."
  - **Prepare**- Dr. Jones reports he spends a lot of time before-hand (like the day before) preparing for checkups and for as many sick visits as possible. He knows which vaccines and labs patients will likely need and reviews their remote and recent medical history and thereby has a **game plan** walking into the room.
  - **Schedule Mental Health/ADHD visits, if possible, at the end of the day to allow for more time**
  - **Reserve two visit slots if needed for some patients who tend to have more questions** (this is the exception, not the rule, however)
  - **Recommend another visit**: If a visit risks running long due to chronic or multiple concerns, advise setting another appointment to continue the discussion and give more time to that concern. If the topic maybe needs just a little bit more time, he sometimes offers to call them later in the day.



Dr. Jones Sets an Intention To Stay On Time and Has a Game Plan

How are some of our highest-volume general pediatricians doing it?

Dr. Scott Katz, Cook Plano.

Dr. Scott Katz

- **Hours:** Sees patients between 8:15-5pm Mon-Fri with a 45 minute lunch. He rounds on newborns in hospital nurseries before work. He used to offer Saturday hours, but this changed in recent years (during COVID) without plans to restart.
- **Online scheduling:** He allows some appointment slots to be scheduled through the portal, others only to be scheduled by calling.
- **Patients in a Day:** Likes to see 38-45 patients per day at baseline, including 24- 30 well-care visits among them. Can see up to about 52 patients if need be.
- It is important to him to be able to accommodate **same day sick visits**.
- He prefers **in-person** with no telemedicine, due to its physical exam limitations.
- **Dr. Katz's suggestions for seeing high volumes of patients efficiently:**
  - **Have enough staff.** Dr. Katz feels having enough staff makes all the difference. Rather than asking how many clinical staff members an office should have per physician, the question should be phrased in terms of number of clinical staff members per patients seen. He approximates one clinical staff member (to room and tend to patients) per 20-25 patients seen. Since he sees twice that, two nurses doing rooms is a good estimate. His clinic additionally has 1 -3 phone nurses per day, usually 2. Of note, Dr. Katz's office does not assign nurses to any one doctor, as rotation is required. This way the team knows how each of the physicians functions.
  - **Have enough rooms.** While many offices within CCPN have 3 rooms per physician, he feels 4-5 rooms allow clinicians to see more patients more efficiently.
  - **Expect clinical staff to do for the patients the maximum allowable under their qualification so that the physician is essentially doing just the doctor part (see cartoon).** Non-physician team members (nurses, MAs) take vitals, measurements, and history (including history of diet, sleep and elimination on well visits). They do most of the information gathering for well-care visits. Things are well orchestrated.

Dr. Katz Conducts a Well-functioning Team

  - **Review schedule ahead of time for glitches, and then correct them.** For example, if noted that siblings have visits, the office will be sure that they are coming for subsequent time slots and that the family knows to arrive before the earlier appointment.
  - **Don't talk for the sake of hearing your own voice.** Dr. Katz enjoys his patients and their families and wants to offer them same-day if needed, on-time service. He respects their time and tells them what is important to know without too much unnecessary background information.
  - **Provide patient information through the portal ONLINE.** Dr. Katz gets his patients accustomed to the portal and tells them to check the portal for the After-Visit Summary and instructions. He reports he used to supply families with paper handouts and then tried printing the AVS, but the printing wasted time and paper.
  - **Make use of time-saving charting strategies.** Dr. Katz has many smartphrases he uses for lists of referrals and patient instructions. He has never used dictation, as using the EMR with his smartphrases has proven efficient. He completes his charts as he goes and does not need to chart at home.
  - **Establish boundaries with an eye on staying on time.** If a family has questions beyond their allotted time, he explains to the family that the concern they have is really important and that he should see them again to talk about just that. He will offer them an appointment even the next day, if they would like. Also, if a family is late, he will see them for the rest of their appointment time but explains that he cannot encroach on others' appointment times and may have to ask them to return if they have further concerns/questions.

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How are some of our highest-volume general pediatricians doing it?

Dr. Vanita Shori, Trophy Club

Dr. Vanita Shori

- **Hours:** Sees patients between 8:45-5ish pm (schedules last patient at 4:45pm) M, T, Th, Fri (off Wed). She schedules mental health visits for the end of the day. No weekend hours. She has a PA she shares with one of her physician partners.
- **Template:** 15 minute appointment slots, mixed well and sick visits, sometimes has to double book.
- **Telehealth:** Offered as an option for mental health visits in later slots of the day, if needed, 5pm and/or 5:15pm.
- **Patients in a Day:** Usually in the 30s, max 35-37.
- Aims to provide **same-day sick visits**. "I feel guilty sending them to the Urgent Care, so I really try to work them in," she says. "They seem thankful to be able to see me even if they have to wait a while," she continues, "and they are thankful not to have to spend the extra money on an urgent care visit."
- **Dr. Shori's suggestions for seeing high volumes of patients efficiently:**
    - **Precharting**: "I prechart and prepare on the weekend for the whole week," she says, "as I won't have time the night before." She does about 1.5-2 hours on Saturday and again on Sunday to be ready. "So yeah I'm all Cooks, 7 days a week," she says, but she likes knowing what she will do and focus on in the visits."

Timers help Dr. Shori Keep Moving

- **Timers and Knocking:** Dr. Shori says her staff is so great and supportive. A couple of years ago, when she was trying to improve her efficiency, her staff began to time her starting the moment she stepped into a room. At the 7 minute mark (remember, this is in the context of a 15 minute time slot), they would knock on her door and say, "Dr. Shori, you have a call." She admits she stays in the room typically about 3-5 minutes beyond the knock, to the point that families ask her if she needs to go take care of the call! The system helped so much to keep her moving that they have continued this system.
- **Start physical exams while still discussing.** Thanks to DaxCopilot, she can continuing gathering history even as she starts her physical exam.
- **Standing labs:** she does use these and appreciates knowing results before walking into the room when possible.
- **Patient education:** Mostly she writes quick management notes on paper which she hands to the families, but she also has smartphrases for patient education which she can add to the notes. She never goes and gets paper handouts.
- **DaxCopilot:** "I use it, and it definitely makes charting easier." She especially likes the history taking and discussion notes from ambient listening, as she likes having the record of some of the more minor questions they discussed (which might not have made it to the chart otherwise, but which can be helpful later). For physical exam documentation, though, she prefers her template.
- **Portal Messaging:** she has been resisting the urge to write long answers to long questions in the portal. If she receives a long detailed question from a family, she has gotten better about simply advising the family to come in to discuss the issue. This has helped cut down on the back-and-forth and on chart time in general.

How are some of our highest-volume general pediatricians doing it?

Dr. Justin Smith

Dr. Justin Smith, Cook Trophy Club

- **Patients per day**: Likes to see 45 patients today—this is his sweet spot. Below 40 feels too slow. He could fill his day with well visits at any time of year but is careful about leaving more room for sick in the viral season, capping wells at around 18 in the fall/winter and at 26 in the spring and summer.
- **Template:** His template is built with slots every 15 minutes, with well visits stacked at the front end of each half day to separate infectious risk. That said, if a family calls with a chief complaint that has low infectious risk (like eczema or sports injury), this can be double booked into the same 15 minute slot.
- **Same day sick**: It is very important to him to accommodate his patients for **same day sick visits** and NOT to get them into the habit of going to the urgent cares for their sick needs.
- **Telehealth:** He does some telemed mixed in, but overall he finds patient concerns often do not lend themselves to televiews only. And he feels families often want to come in person.
- **Standing orders/tests**: He has standing orders and likes for testing to be done in advance of his entering a room if possible, since waiting for results slows the process.
- **Dr. Smith's suggestions for seeing high volumes of patients efficiently:**
  - **Establish a workplace/team mindset that values a family's time**: "I instill a culture and mindset in our staff that being on time is important. Just as our own time is important, our patient's time is too." He adds that—if he is available—he wants to see a patient as soon as they are ready. He does not want to finish up some other bit of office work before going in there, and he does not want staff to delay either. "If everyone takes a little time before getting the visit going, you slow the entire experience for the family," he says," which is not what I want-- I want them to know that we will get them taken care of promptly."
  - **Have a customer service example to strive for**: **"I want our office to be the QT (QuikTrip) of medical practice, where people are courteous and restpectful toward the people who come in but also efficient."** Dr. Smith has put a lot of time thinking about efficiency because "that's something I love—I consider myself to be running a small business, and I want our patients to feel well serviced.

Dr. Smith Works to Make his Office a Prime Customer Service Example in Healthcare

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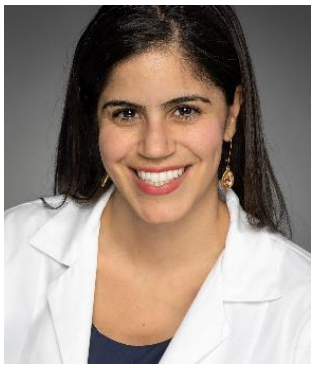
Dr. Smith (cont):

- **Avoid redundancy where possible**: "Let data that has already been gathered start your process." Dr. Smith says that he enters a room with pretty targeted questions, as his front staff and then his nurse have already collected some history. He does not want a family to have to keep telling the same story over and over again.
- **Give each family and patient what they need**: "If one patient has a straight-forward issue like a sore throat which can be managed quickly, help them efficiently and then borrow the remaining time for a family who needs more."
- **Be succinct in answering patient questions:** "I try to be efficient in giving patient answers and not to overtalk—I try to get through the family's whole list of questions but to do so succinctly if possible."
- **HIghlight key points of anticipatory guidance:** "I tell families that I will touch on the high points but that there will be more information for them to review on the portal. This way I help them to know what I feel are the most important points."
- **Communicate well with staff and with patients if there are hold-ups in the schedule:** If I do have an unexpected situation with a patient that I know will take more time and attention, I let my nurse know to inform parents that I am running a little late." He also notes that he has an APP helping him every day and can sometimes move patients from his schedule to theirs if needed, so that patients do not have to wait.

How are some of our highest-volume general pediatricians doing it?

Dr. Christina Ateek, McCartNeighborhood Clinic.



Dr. Christina Ateek

- **Dr. Ateek points out these Differences in the NHCs as compared to PCP offices: ("It's a different animal," she says).**
  - The payors- Medicaid/STAR/CHIP/Foster
  - The high rate of no-shows and the tendency to get behind on care
  - In some cases, the complexity of patients is higher
  - Reiumbursement for same day well care + sick care is good and reflects the true work of the clinician. In contast, in the private payor world, there can be some awkwardness in privately insured patient families being charged for what they thought was a covered well visit because of additional sick charges.
  - Phone/audio only visits are still reiumbursed. The NP reviewing her bucket will point out calls that could be phone visits, and Dr. Ateek will add these to her schedule.
- **Patients in a Day**: Dr. Ateek sees an average of 30-35 patients a day. However, she says that in the NHCs, there tend to be a lot of no-shows. She therefore tries to book about 40 to have a chance of seeing at least 30. This means she can be extremely busy with 40ish patients on those days when, for whatever reason, no one no-shows.
- **Template:** The NHCs have automatic 15 minute appointment slots, beginning with newborns in the morning. She tries to double book the newborn slots to get a good start on the day.
- **Sick-well ratios:** She sees 80% check-ups and 20% sick, most of the time. Since families no-show frequently, she looks for opportunities to convert sick visits to well visits. In that way, babies and children who are near the time of their well-visit (who would otherwise potentially wait months for a well care appointment) stay up to date on vaccines and get anticipatory guidance in addition to getting their sick concern managed. She explains that the Medicaid and other programs are not as strict about 365 days between check ups, so she is able to convert sick to well much more easily than someone in the private PCP world might.
- **High volumes and hustle as a personal choice:** She says she understands and respects others' personal choices to not see the volume she sees—she views it as a mindful decision that is not going to be everyone's cup of tea.

- **Dr. Ateek's suggestions for seeing high volumes of patients efficiently:**
  - Mindset: "If you want this --and it's okay if you don't," she says, "be ready to hustle": "I talk fast—sometimes to the point that I tell my families to let me know if they don't understand me-- and am ready to move. My team knows it will be hard work, too."
  - Keep watch on your schedule: as above, she converts sicks to well if she can, preferably before she is in the room because she sees how old they are in advance. She also observes gaps in her schedule, and—if she sees a no-show—she sometimes can look at NP's schedule and find a patient of hers on their schedule that can be moved to her. Usually, there are plenty of patients to be seen, so the NP is still busy.
  - Use protocols for testing: to speed up the sick visits, allow for automatic testing, so that you have the results before you enter the room.
  - For complex patients, make use of the Care Coordination Note in the Problem List of a patient's chart in EPIC. You can work your way down a Care Coordination Note as an organized and efficient approach to these visits. She will continue reviewing these notes after the visit and bills the payors (as one should) for the time it takes to review.

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Dr. Ateek Uses the Care Coordination Note for Complex Patients

- Set expectations- she does run late**:** Passionate about seeing people and grabbing the chance to get caught up on well-care, she does run late. She feels this is a reality of the NHC, and she explains to families that she is giving people the time they need and will do the same for them. She says they appreciate that and know their visit to the clinic may be a 2 hour experience from start to finish.

- Know the ins and outs of billing**:** She explains that with Medicaid/STAR/Foster programs not reimbursing as well as private insurers, she has to be aware of billing criteria and codes in order to get paid for what she is doing

- Paper (preprinted AVS) handouts for Well Care: Dr. Ateek says so many of the answers to parents' questions at well care visits are right there in the packet. She likes having the paper in front of her and pointing/highlighting for the parents where they can find that information.
- Portal education: Dr. Ateek does use smartphrases with education and attaches Cook educational handouts to her visits and shows the families that she is making that education available on the portal. She tries not to waste time printing things out after visits, however.

How are our busy pediatric specialists doing it?

CARDIOLOGY: Insights from Dr. Dzurik, Dr. Schutte, and Dr. Moye

- **Seasonality:** yes. "Summer time is busy for cardiology," says Dr. Dzurik. "On the inpatient side, as many elective surgeries as possible are saved for non-viral season, which leads to an increase in summer volume," reports Dr. Dzurik, and "On the outpatient side we have the rush of sports clearance referrals that we have to get in to be seen."
- **Surprise Increases in Demand:** Although cardiology is busy all the time and have a large number of clinics, they can sometimes shuffle people around to add another downtown physician if necessary—says Dr. Dzurik, "At times this may mean say the cath or EP doc flexing to fewer days in the cathlab in order to add a clinic day and help cover." As for COVID, Dr. Schutte reports, "We did have an uptick in kids needing to follow-up for COVID, but we had fewer kids wanting to be scheduled for routine/regular visits, so it balanced out." On the rare occasion when someone has been out unexpectedly, making wait times longer, she says, "we have added a spot or two to everyone's template for a short period of time."
- **Higher and Higher Volumes:** If needed, the cardiology department recruits more cardiologists, and—within the group—outpatient clinic component is a part of the work that increases revenue for the group and for the individual clinician. Therefore, reports Dr. Dzurik, it is desirable and not hard to staff. "We have just tried to keep up with demand by adding additional partners or additional sites, trying to stay ahead of the competition."
- **Last-minute cancellations and No-shows:** Since cardiology outreach clinics are primarily commercial, they have a lower rate of last minute cancellations and no-shows. But Dodson with its different payor mix experiences this issue in full force. Dr. Schutte explains they have a waitlist so that if the dropped visit is noted within 24 hours or even the morning of an afternoon appointment, an appointment can be offered. "When we do notice a rash of cancellations," she says, "we may sometimes overbook the schedule knowing that 1 or 2 may drop off."
- **Adding more cardiologists:** An addition is considered, says Dr. Dzurik, "when there is felt to be enough volume for an additional cardiologist to become financially viable in one year or so." However, Dr. Schutte explains that hiring "is a complex issue because we are not just hiring for clinic positions but also for echo, cath, and transplant docs

- **Individual habits and strategies for efficiency:**

Dr. Matt Dzurik

- **Cardiologist Dr. Matt Dzurik**
  - **Drawings and Photos:** "I walk into every room and shake hands with the parents and the patient. I don't take a computer with me. I sit in every visit when taking history and discussing plan. I tend to draw the diagnosis on paper. I welcome families and children when old enough to take a picture of it and make a medical file in photos so they can review and know what their diagnosis is."
  - **Dax CoPilot:** doesn't use it because likes **Mmodal** to dictate
  - **Med students**: slow him down
  - **Precharting:** yes, as a morning person, he prepares in the mornings before clinic starts (and not the night before). This preparation can be added to billing for time. He enters the needed studies for the follow-up visit in the note.

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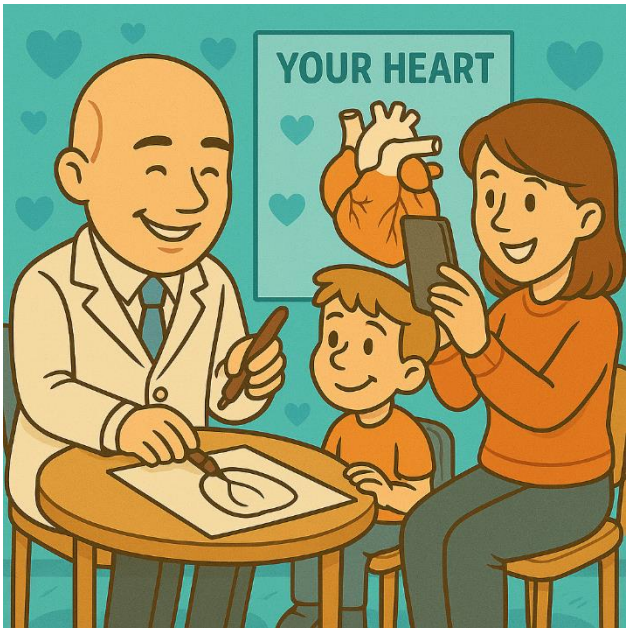
CARDIOLOGY, Dr. Dzurik (cont):



Dr. Dzurik Draws the Diagnosis and Advises Families to Take Pictures for Reference

Dr. Deborah Schutte

- **Cardiologist Dr. Deb Schutte**
  - **Helpful Habits:**
    - Relies on nurses take the interval history and do med reconciliations
    - Pulls old record notes forward to the new note to be updated with interim history and to indicate which studies where done previously. Good for crosscover!
    - Uses standing orders for new and established patients
    - **"Studies at next visit":** the whole department uses this section at the end of their notes to clarify plan and allow RNs to put in orders. This is helpful and time-saving for covering cardiologists and also for PCPs, other specialists and members of the care team.
    - **Dax Copilot:** she doesn't use it, but some in the department like it
    - **Precharting:** generally does not have time to prechart, and she is aware that this is the case for many of her partners -- "that's the reality," she says. Having built-in efficiencies and memory triggers really helps, though!

Dr. Schutte Writes and Reviews "Studies at Next Visit"

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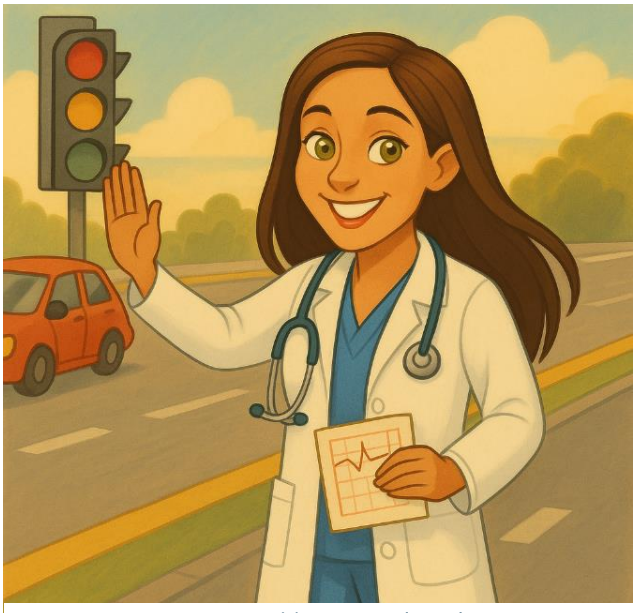
CARDIOLOGY (cont):

Dr.. Danielle Moye

- **Cardiologist Dr. Danielle Moye**
  - **Habits, including charting/precharting:**
    - She **sits down** with all of her patients.
    - **Charting**: She **reviews clinic patients prior to clinic** and thereby knows what to expect and what tests will be. "I do most of my charting prior to entering the patient's room on the day of clinic," she explains, "I type up my HPI as the nurse gives me report." She explains that the nurses take most of the history while she reads their echocardiogram. She aims to close each patient's chart prior to moving to the next patient but—if this creates a bottleneck—she leaves the encounter open and closes it later.
    - **If running long, a knock**: If a patient is going over, her nurse/MA knows to knock on the door to allow her to excuse herself and hopeful expedite things.
    - **Forms Ready:** As part of the history, the nurses know to ask if the family will need forms (sports or dental clearance, hyper-hydration passes, etc). She tries to print handouts and have any forms ready when she goes into the room. This prevents trips into and out of the room to get papers, etc.
  - **Dax CoPilot:** doesn't use it or a scribe but **does use smart phrases** for physical exam and for assessment of plan for the more common/recurrent diagnoses seen.
  - **Minimizing Bottlenecks:** she and her team stay aware of bottlenecks and the need to minimize these. **"The echo tech and the physician are the bottlenecks of the system," she explains, "and the bottleneck can't be starved."** Intake, vitals and/or EKG must be done as quickly as possible," she says, "and if the echo tech is ready and waiting, we often allow the nurse interview to take place while the echo is being performed." She says she and her team try their hardest to never have a situation in which both the echo tech and cardiologist are waiting to see a patient.



Dr. Moye Mitigates Bottlenecks

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How are our busy pediatric specialists doing it?

ENDOCRINE: Insights from Dr. Hsieh, Dr. Thomas, Dr. Roy and Practice Administrator Mr. Ben Regalado

- **Seasonality:** not really seasonal, although Endo sees more referral for "elevated A1c" or "abnormal thyroid functions" in August and September, after their back-to-school physicals per their PCPs. Says Mr. Ben Regalado, Endo Practice Administrator, "We have not explored different templates for seasonal demand, and perhaps we should," he says, adding that "start-of-school physicals by PCPs tend to find new diagnoses, and referral volumes pop."
- **Surprise Increases in Demand:** Dr. Hsieh recalls a notable rise in Type 2 Diabetes in the year after COVID because of the weight gain during quarantine. But, really, she says "the demand is there all the time." Dr. Roy explains that when the on-call doctor is sick unexpectedly or has a family emergency, the doctors step up on their admin day and utilize extra help from the PA. "The addition of our PA is a HUGE help in reducing our burnout while on-call," she says, "and that has helped with some of the surprise demand."
- **Higher and Higher Volumes**: The endocrinologists explain that demand is always high and that, at the moment, there is a 6-7 month wait to see new patients. "Honestly," says Dr. Hsieh, "we are busy and even overbooked all the time." Templates are clinician-made independently, with many endocrinologists overbooking almost daily in an attempt to get patients in sooner. "The demand is HIGH HIGH HIGH all year long when it comes to outpatient," says Dr. Roy.

The endo team notes that it is not uncommon for them to hear from Cook PCPs via the Cook Direct Connect line who are very upset about the long wait and asking for an earlier appointment. "We are sadly having to firmly say no to 'squeezing' the patient in, because we simply cannot," says Dr. Roy, "but we try very hard to get truly urgent patients in. The endocrine team has had difficulty hiring more pediatric endocrinologists to join the group (see more below under – Other Challeges." However, they have **hired more APPs**, and that has helped tremendously. Here are some of the strategies the endocrine department has implemented to meet this challenge in demand:

Dr. Hsieh, Dr. Thomas, and Dr. Roy Love their APPs

- **HOORAY for APPs! APPS have started seeing some new patients who are more straight-forward, less complicated.** It used to be that only physicians saw new patients, but wait times were simply getting too long. APPs have really helped. An example of a new patient who might see an APP is "a seeming new Type 2 Diabetic, with A1cs high enough to treat but not so high as to need insulin or intense treatment," says Dr. Hsieh.
- **"New Urgent" Visits**: Endo has added these appointments to accommodate patients with high urgency (who cannot wait 6-7 months to be seen) but who are not so ill as to require hospitalization. There are two of these appointments booked for the inpatient on-call physician to see in the afternoon once finished with AM hospital rounds. "But it is a big struggle," says Dr. Roy, "to see those 2 patients when on a busy inpatient service." The endo team adds that it is a f
- **"New Patient" Clinic Day**—at this point, it is just Dr. Paul Thornton piloting this—he runs a new patient clinic once every month or two to help with endocrine new patient wait times. Others in the group have considered scheduling these, but finding a good spot can be challenging in at an extremely busy baseline.

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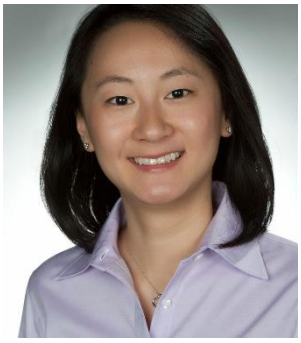
- **ENDOCRINE (cont):**
    - **APPs covering for those physicians out for medical/parental leave.** It used to be that physicians newer to the group would cover for those out.
    - **More specific critera for new appointments have been established.** Endo may turn away referrals not meeting these criteria. For example, patients with obesity/elevated BMI but all normal labs are not being seen by endocrine anymore (assuming no medical indication for treatment) and are instead advised to see a nutitionist. Other patients without a true endocrinologic reason for referral may be turned away out of necessity.
    - **Longer intervals for follow-up**. Dr. Hsieh used to see patient swith growth hormone deficiency every 4 months but is now seeing them every 6 months. If clinically allowable, patients with well-controlled diabetes may be seen every 4-5 months instead of the endocrine team's preferred and standard of care preference for every 3 months.
- **Last-minute cancellations and No-shows:** The Endo department—and especially Endo clinic in Abilene-- works hard to fill in cancellations with last-minute appointments. They have a **wait list** for new patients run by new patient coordinators. Per Mr. Maldonado, medical receptionists are encouraged to not only receive incoming calls and add names to waitlists but to actively draw people from wait lists when they see an appointment slot open up. Luckily, endocrine visits do not usually involve expensive testing necessitating complicated insurance clearance (like echocardiograms or EEGs for cardiology or neurology).

  No shows are another issue and currently sits at 13% of appointments. Dr. Hsieh says that out of 22 patients scheduled for a day in her endo clinic downtown, it is common for her to have 3-5 no shows. The endo department is actively searching for solutions to and has formed a **Task Force** addressing both late cancellations and no shows.
- **Other challenges—HIRING!** Dr. Hsieh explains that it has been difficult to hire a new endocrinologist because of the extremely busy in-patient and on-call responsibilities. Volume is very high, and clinic is fast-paced to the point of being intimidating to potential hires. The department has moved toward hiring more APPs because they help very much in reducing the outpatient load especially. Unfortunately, they do not ease the work of inpatient calls. At any rate, the department is delighted to say that they just obtained approval for more APPs!

- **Individual habits and strategies for efficiency:**
    - **Endocrinologist Dr. Susan Hsieh:**
        - **Work Hours:** She has long work hours, with the goal of keeping work at work—Dr. Hsieh's clinic starts at 7:30, and she works through lunch so as to be able to finish clinic closer to 3:15-3:30pm and then finish charts and make calls. She spends her admin day and ½ day off ("off") working her basket, making calls, doing paperwork, and doing peer-to-peers.
        - **Preparation:** She does not prechart the night before but arrives early each morning to review charts, especially the concern/labs for incoming new patients. For established patients, she often reviews last visit immediately prior to entering the patient room.
        - **Charting:** She has found she processes things better in typing/writing rather than dictating and types quickly, with a goal to be concise. Dotphrases for new patients has made charting on these patients more efficient.



Dr. Susan Hsieh

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- **ENDOCRINE (cont):**
  - **Med students**: She likes and feels a responsibilitiy to teach them, but having med students can slow her down so much that she is completing charts at home.
  - rather than at work. She wishes it were not the reality, but having medical students does cut into her off-time.
  - **Efficiency**: It is important to Dr. Hsieh that families not feel she is rushing them or limiting their time for questions. She sits with them and wants them to feel she values their time. That said, she steers them where possible away from tangents so that visits can be more efficient.

- **Endocrinologist Dr. Sani Roy:**

1Dr. Sani Roy

  - **Setting expectations for a visit**: "I try to set expectations up front when able of what we will address this visit and what will be next," she says.
  - **Previsit questionnaire:** She uses this to help with HPI and history questions for new patients, as it cuts down on visit time. "It would bew great if we could find a way for clinical staff to do some of the history collection," she says, "but that is also a bottleneck in some of our clinics and so may be challenging."
  - **Smartsets and smartphrases:** Help a lot!
  - **Med students**: "Med students help me somewhat because I send them in to gather the HPI for one patient and keep that family engaged while I finish up another patient." However, she adds, "it is a more emotionally tiring day because I try to take a few minutes to teach them between patients rather than using that time to catch up on my inbasket."
  - **Precharting**: She precharts only for her complex multidisciplinary clinic patients. For the others, "my pre-charting happens one minute before I see the patient."

- **Endocrinologist Dr. Teena Thomas:**

Dr. Teena Thomas

  - **Charting**: Tried but did not like Dax Copilot. However, she loved the EPIC charting efficiency sessions offered a few years ago and would love to have more of these in the future. She was much faster after this one-on-one help. She does chart during visits but completes notes after the visit is over.
  - **Med students:** she enjoys having students but does feel they slow her down and prefers them on the inpatient side, as she can teach while walking patient to patient. On the other hand, when she teaches on her outpatient clinic days, she gets behind on charting.
  - **Speciality-specific issues which slow things down:** diabetics have data stored in various systems that require long-in processes and printing. In addition, there is a diabetic flow sheet which requires clinicians to enter a lot of data. Medical assistants are starting to take over some of this information gathering, accessing, and pringing, which is helping the endocrine clinicians.

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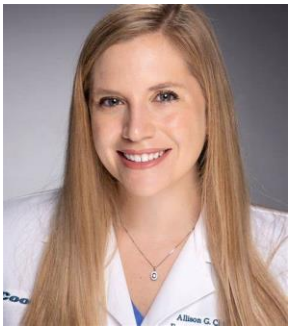
How are our busy pediatric specialists doing it?

ENT: Insights from Dr. Allison Chisholm



Dr. Allison Chisholm

- **Seasonality:** Our volume is steady with a bit of a lull in April due to school testing and September due to the start of school. Families try to schedule their surgeries over breaks—spring, summer, fall, Thanksgiving, and Christmas. "To be honest, since COVID, I tend to see ear infections year-round, along with nose bleeds and neck masses!" ENT clinic is always busy, and they do not change their templates.
- **Surprise Increases in Demand:** In order to absorb patients when clinicians are out, Dr. Chisholm reports they will use any "breaks" built into their schedule template—including both catch-up slots and lunch-- to see additional patients, and individual clinicians may opt for double booking of appointments.
- **Higher and Higher Volumes:**
  - **More and more APPs:** ENT keeps hiring additional APPs, which helps significantly. However, she explains that several of their APPs have dropped their hours just recently, and this creates some worry about how the group will see their high patient volumes.

Dr. Chisholm's Occasional Miniclinic after a Day in the OR

- **Add-on clinics.** ENT will arrange for add-on clinics on clinicians' admin days when things get super busy. **"I personally will add mini clinics after an OR day to try and accommodate patients," she says. (see cartoon)**
- **Telemed?** Not much used in ENT, since in-person exams are important and phone calls quicker.
- **Phone calls?** Yes ENTs often call families to discuss results rather than bringing them back for another patient visit, especially since there are long lists of patients needing to be seen.
- **Last minute cancellations:** ENT struggles with same-day cancellations, but even given one day of a head start, they often are able to get others into those slots. The front administrative team can find new patients seeking an appointment, and Dr. Chisholm says her nurse has **a list of established patients requesting sooner follow-up**. They reach out to these patients, and whoever calls first will get the appointment.
- **Hiring challenge:** ENT is ready for an additional physician, but recruiting has been challenging. They have new clinic space since moving to Dodson and can accommodate more clinicians.

Dr. Chisholm's tips for efficiency

- **For a visit going too long:** "Eight years and I have not figured this out," she says, "I struggle cutting them off and even though I give the signs of standing up and slowly moving to the door, it does not seem to shake certain parents." If she knows a family tends to have a lot of questions, she requests that they be scheduled last in the day.
- **MModal dictation.** She likes dictation. She does not use Dax-CoPilot.
- **Precharting.** "I prechart all of my charts or as many as I can,"she says, "as I find that this helps me take less time between patients and close my charts more efficiently." She explains that she can get through 2/3 of the charts in about an hour and a half every morning before clinic.

How are our busy pediatric specialists doing it?

Gastroenterology: Insights from Dr. Tony Anani

Dr. Tony Anani

- **Seasonality:** For Prosper, Dr. Anani says May to September is busiest, and then also December for procedures because of families' having met their deductiblities. Our clinic templates are set similarly all year," says Dr. Anani, "but there is the option of double-booking established patient appointments to try to accommodate a new." As for procedures, he says "you may need to be creative using some of your partners' slots that they don't use."
- **Surprise Increases in Demand:** thankfully they haven't experienced too many surprises. However, "one thing that happens in the Prosper market is that we get a few folks trying us out since we are the new kids on the blok," says Dr. Anani, "and so you get a wave of patients."
- **Higher and Higher Volumes:** GI keeps a close watch on the 3rd next available numbers in their considerations for hiring. The use of APPs has also helped meet excess demand. For Prosper it is a front and center challenge, since ready availability closer to families "is a necessity to keeping the competition at bay."

Dr. Tony Anani's Tips for Efficiency

Dr. Anani Displays the Visit Goals on a Whiteboard

- **Whiteboards:** Likes using white boards in the rooms—allows for listing concerns and striking them off together, as we address the issues collaboratively. A white board," he says, "allows me to explain complex GI issues, and they can then take a picture of this for the future."
- **Maintain a "to be continued" feeling**. He says, "Now that we have established a relationship don't feel rushed or that you have to tell me everything—if you get home and remember something, send me a mychart message." He says out of 16 seen in a day, maybe one will ask a follow-up question. However, an assurance that communication will be ongoing takes some of the pressure off their asking everything right now.
- **Use ancillary staff properly**—if it's dietary issue, I can get the dietician to see the family or ask my nurse to explain follow-up instructions
- **Dax Copilot**—he likes and appreciates it because "It frees me up to use the whole room and my whiteboards."

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How are our busy pediatric specialists doing it?

NEUROLOGY: Insights from Dr. Corbin and Dr. Herring

- **Seasonality:** For the most part there is not seasonality to neurology, with the exception of headaches, which get better in the summer. "I love how easy my headache patients are to manage in the summer!:)" says Dr. Herring. Templates don't change, with general steady flow year round in clinic. Dr. Corbin notes that the inpatient service does tend to get busier when the hospital itself is busy. "If there is a lot of respiratory illness, for example," says Dr. Corbin, "we may be seeing a lot of breakthrough seizures."
- **Surprise Increase in Demand:** There tend to be increases in workload during holiday breaks because many physicians can be out at once, so that a few have to do a larger than accustomed volume of patient calls and portal messages. However, most of the time when one doctor might be out unexpectedly, the neurologists report that their group is big enough to where they do not feel the effect very much. "Most people chip in quickly to take call and call weekends," says Dr. Corbin, "and the schedulers are great at getting patients seen when and where they are needed via cancellation spots and unfilled spots without its really affecting the daily work for any of us individually."
- **Higher and Higher Volumes:** The neurology department reports being able to recruit other neurologists whenever there is enough growth.

Dr. Corbin (Neuro) and Dr. Gandhi (Pain) recommend Fast Pass Scheduling

- **Last-minute cancellations**: Dr. Corbin explains that "the schedulers really do try to stay on top of the last-minute cancellations if there is a 1-2 days notice." The neuro group uses **Fast Pass**, whereby patieints get a notice via the portal with the option to fill last minute cancellations (Pain Clinic uses Fast Pass, too—see cartoon(. Dr. Herring says that Fast Pass works well except for with the New Onset Seizure Clinic, since these visits include an EEG and can include a very high co-pay. "Only a couple of neurologists have these types of appointments,"she explains, "so it is not as a big a problem as it is for Cardiology, where so many visits include an echocardiogram." In some cases, if expense is a problem, patients can go to an outlying, non-hospital-based clinic to get a cheaper EEG .

- **Other challenges with high patient volumes: Wait times.** Wait times to get an appointment are a challenge and can be an indicator of a need for a new hire (6-9 months' wait means more hiring should be considered). Dr. Corbin states that long wait times for appointments have a trickle down effect—they can translate into more no-shows and a drop in overall revenue. This is a cycle they hope to avoid.

NEUROLOGY (CONT):

- **Individual habits and strategies for efficiency**:

- **Neurologist Dr. Ellie Corbin:**
  - **Precharts:** She precharts every day and tries to add orders she is sure she will want (for labs or EEGs). "Precharting is necessary for me," she says, "Some of that is needing to know what I'm going into for the day, but I also feel like ie helps with my efficiency."
  - **Dotphrases, templaces, and favorites:** She has a lot of dot-phrases and templates as well as favorited medication titrations and orders which help her efficiency.
  - **Dax-Copilot? No, thanks:** She did not like Dax-Copilot and felt it made her less efficient. She found inconsistencies in how social history was recorded and felt it left out some of the things that might otherwise have helped her remember who a patient is.
  - **Medical students:** She admits med students slow her down.

- **Neurologist Dr. Rachelle Herring:**

  - **Dotphrases, templates, and favorites:** All three help her efficiency.
  - **Dax-Copilot? Yes, please!:** She really likes Dax-Copilot because even if not perfect "it really helps me focus on the patient rather than typing, and we take such detailed histories in neurology that this really takes a mental burden off."
  - **Precharting?- Not really.**
  - **Redirection:** Sometimes she has to redirect patients and offer a follow-up visit: "We really only have time to focus on seizures today," she says, "but let's schedule follow-up in a couple of months to talk more in depth about headaches." She continues, "In the meantime here is a handout on basic healthy habits for headache prevention." She stands when necessary and inches toward the door when out of time.
  - **Med students:** She says they do slow her down.

Dr. Herring and Her Dax Copilot (Virtual Midieval) Scribe

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How are our busy pediatric specialists doing it?

NEPHROLOGY: Insights from Dr. Patel

- **Seasonality:** **"**Generally, we do not have a seasonality "surge," but we do see an uptick in volume on the inpatient side (more consults) and increased volumes outpatient due to seasonal exacerbations of disease (e.g. illness/allergies triggering relapse of nephrotic syndrome, AKI)." We do not have a specific policy or change in templates at this time. Nephrology absorbs the higher volume with increased phone calls and sometimes overbooking for visits.
- **Surprise Increases in Demand:** He explains they are currently experiencing the rearrangements involved with a physician leaving—increasing number of call days, splitting patients (both dialysis and outpatient), increasing available clinic time such as by adjusting schedules to add spots and redividing outreach clinic coverage.
- **Higher and Higher Volumes:** With the departure of a physician, the individual clinicians have access to increased clinic space, which helps to accommodate more patients, in combination with adjusting time slots on the schedule.

The Effort of Filling Last-minute Cancellation Spots: Dr. Patel Asks if the Effort Is Worth It?

- **Last-minute cancellations:** **"Last minute fills are a struggle,"** he says. Each requires the call of the patient, the family's availability to come last-minute, insurance clearance, and the manpower to make these arrangements. It brings up the question, **"Is the juice worth the squeeze?"** They would like to prevent cancellations and no shows, but are still considering how best to do that, and they have wondered about dismissing frequent culprits but then hesitate to punish the pediatric patient.

- **Dr. Patel's Tips for Efficiency and general habits:**
  - **Preview:** He does preview charts the day of the visits and makes notes on a game plan, which can of course be adjusted during the visit.
  - **Keeping an eye on time:** He enters the patient room without a computer and sits down to talk with families. "I cannot claim to be super efficient, as many times my visits will run over to answer all questions," he says, "but them I am often not terribly late as I can make up time with subsequent visits."
  - **Uses favorites and standing lab orders.**
  - **Mmodal dication and templates.**
  - **Medical students:** "They generally function as observers, and there is teaching time," says Dr. Patel, "so they generally add time to the day."

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How are our busy pediatric specialists doing it?

ORTHOPEDICS: Insights from Dr. Kennedy

Dr. Jason Kennedy

- **Seasonality:** "We have bimodal peaks in April t"o June and then late August to October for trauma," Dr. Jason Kennedy says, "Elective procedures go way up in the summer.
- **Surprise Increases in Demand:** "We try **to plan ahead for seasonal volume**," he says, "and we have advocated to the system for **proper staffing** for our size of practice."
  - **Scheduling--**Good relationships with the UCCs and a system allowing them to schedule overnight injuries in ortho clinic the next day. This works very well at Walsh Ranch.
  - **Staffing**—"Athletic trainers work as physician extenders and faciliate communication and patient flow with the schools, he says. "We currently have plenty of MDs and APPs to cover the fluctuations in volume," he reports. "In the past, we just worked more [in those busy times], but now there are times of the year (slower times) when it feels like there are too many APPs that can siphon some MD volume and compensation."
- **Higher and Higher Volumes:** **Athletic trainers and APPs** have been very helpful in helping the orthopedic surgeons in tending to high volumes of patients, and the orthopedics group has worked hard to have **smooth on-boarding** and clear expectations of these team-members. For example, the spine group screens consults and prioritizes which patients (with which kinds of spinal curvatures) need to get in soon, which might not need as immediate follow-up (or follow-up at all), and how to monitor the curves moving forward. The group has tried to think ahead in terms of needs and retirement planning. "We have tried to grow organically, take good people when they come along, and build them up. "We have been fortunate to have leaders in place who have prioritized this," he says, "and we always try to stay ahead of it with succession planning."
- **Telehealth:** not used too much since most visits need physical exam and follow-up x-rays. However, sometimes telehealth comes in handy for post-op visits or for patients in West Texas requiring check-ins.

Ortho finds a way to get the kids with fractures seen promptly

- **Last minute cancellations:** **"We do not have much of a cancellation list but rather just jam folks in (into the schedule)." Many ortho patients have fractures which need to be seen in a timely way and may also require timely surgical intervention, so "fractures take precedence."** The ortho department operates at such high volumes that, even with some no-shows, their days are busy. They do sometimes "chase down post-ops and people is casts" who miss their appointments in order to be sure they are getting the care they need.

Dr. Kennedy's Tips for Efficiency and General Habits:

- Things are busy, and "I am always behind." He sees just under 300 patients in clinic per month, with 2.5 clinic days per week (30 per full day).
- **Sits** down with patients.

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- **ORTHOPEDICS (cont):**
  - **Relies on effective teamwork: "**We foster a culture that no job is above or below anyone," he says, "so rad techs, MAs, RNs, and MDs all to a lot of things on any given day to keep things moving forward." On days he is working in tandem with APPs and athletic trainers, they help a lot with history- collection and with post-operative and non-operative education.
  - **Mmodal**: through the microphone if on time. Otherwise uses Mmodel Fluency Mobile and pasts the notes into the charts.
  - **Med students**: Rewarding but do slow him down.
  - **Pre-charting**: Sometimes quickly, but usually too busy to be able to do that.

How are our busy pediatric specialists doing it?

PAIN SERVICE: Insights from Dr. Ghandi

- **Seasonality**: a slight decrease in pain clinic volumes is noted in April and May, as kids do not want to miss STAAR tests and end-of-year school events, and in the very beginning of summer, when they seems to enjoy the rest of summer. However, just as the pain clinic slows, "the inpatient service booms with trauma, injuries and elective procedures." The pain service will see all spinal fusion patients prior to surgery and follows them in clinic afterwards. Similarly, "trauma patients follow-up in clinic and usually fill any open slots we have." She reports that their service does utilize the Fast Pass system.
- **Surprise Increases in demand:** When members of the team have been out, the group "did experience longer wait times for appointments and had to 'create' extra slots for patient appointments." Creation resulting from some thinking outside the box—seeing patients on non-clinic days or coordinating with another department for which they had an appointment. They also utilitzed the Fast Pass sytem.

Dr. Corbin of Neuro and Dr. Gandhi of Pain Service Recommend Fast Pass

- **Last-minute cancellations and No-shows:** Dr. Gandhi explains that Fast Pass scheduling functionality has helped significantly to fill slots opened due to late cancelletions. As for no-shows, a system they instituted wherein their social worker calls new patients to confirm appointments has reduced no-shows substantially (a >90% decrease!). Telehealth appointments have helped in both areas, serving as an option to fill last minute open spots and providing convenience to potentially prevent no-shows.
- **Higher and Higher Volumes:** the pain group has hired another physician, spaced out follow-up visits, and created hold slots for emergency work ins which then can be released to Fast Pass if no one is scheduled for those slots within a week. Also there are different kinds of appointment slots, some longer than others. If a longer spot is not filled within a week, it can be "broken down" to shorter visits and if not filled within a week can go to Fast Pass.
- **Dr. Gandhi's Individual Tips for Efficiency:**
  - She uses templates and has favorite orders and tests
  - She always sits with patients and types but makes eye-contact while typing
  - She does not like Dax Copilot because her own detailed way she likes to chart
  - If going over time, she does suggest a telehealth or follow-up visit with her OR with her staff. She feels the pain team is very cohesive and well- versed in the same teaching and motivational interviewing, so she feels very comfortable advising patients to speak to other staff members for further details/clarification.
  - She does prechart and likes to take the history and physical for her own patients
  - She does feel medical students slow her down and feels she needs a breather between patients to rest or to chart

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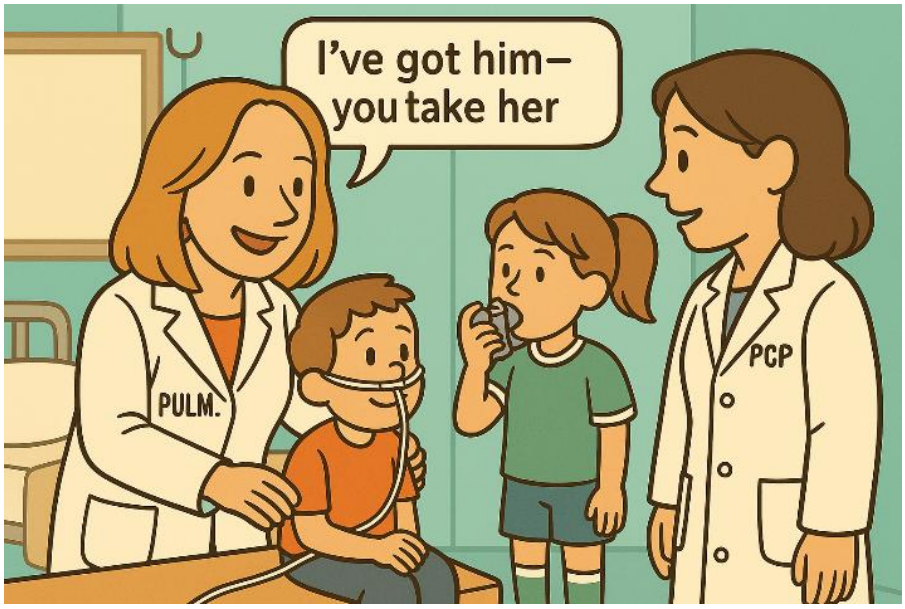
How are our busy pediatric specialists doing it?

PULMONARY: Dr. Karen Schultz

Dr. Karen Schultz

- **Seasonality:** Inpatient volume doubles in the winter viral season (fall through spring). It is not possible to increase outpatients because of this inpatient volume demand. Of note, pulmonary does not see outpatient "sick visits" in the winter in clinic—they rely on PCPs to manage day in-day out respiratory illness in shared patients not requiring hospitalization
- **Increases in demand:** they work and plan ahead with regard to physicians retiring from the group, and they have found Cook to be supportive of adding pulmonogists when needed
- **Last minute cancellations**: There is no system in place such as a waitlist, but a family calling with a need for an appointment will be told of last minute openings and can luck into an early appointment.



In winter, Pulm Service sees oodles of sick wheezing inpatients and relies on PCPs to see sick outpatients

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RHEUMATOLOGY: Dr. Maria Perez

Dr. Maria Perez

- **Seasonality:** there is no seasonality to their specialty
- **Surprise Increases in Demand**: Rheum group schedules new patients as per their schedule, but **they try to be flexible in their accommodation of urgent requests. In those cases, it is advised that the referring doctor contact the the rheumatologist on call to help triage the urgency and determine timing.**
- **Last minute cancellations:** they utilize a **waitlist** in EPIC should there be a suddenly open new patient visit.
- **Strategies for individual efficiency:**
  - **Dax CoPilot:** Some of the rheum docs like Dax CoPilot.
  - **Medical students:** They slow the docs down rather than increase efficiency of clinic, but in general the rheumatology specialists still really like teaching and having the students.
  - **Pre-charting:** Dr. Perez makes pre-charting a part of her daily routine.

A Call from a Referring Doctor Helps Dr. Perez Know When to Work In an Urgent Request

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How are our busy pediatric specialists doing it?

Dr.. Jeff Pugach

UROLOGY: Insights from Dr. Pugach

- **Seasonality**: Dr. Pugach feels the seasonality "smooths out" when wait times are shorter, and things feel steady continuously. He has noted that with higher and higher deductibles people have started wanting their surgery in January, in order to stack their chances of meeting their deductible sometime in the year. Previously, they were almost always meeting deductibles toward the end of the year and therefore wanted surgery in November or December.
- **Surprise Increases in Demand:** As all in our network are well aware, the Urology department—and all of us—mourned the unexpected death of Dr. Blake Palmer three years ago. Aside from the emotional impact on all, the urology department also had to act quickly to absorb Dr. Palmer's patients and continue moving forward while short-staffed. Dr. Pugach reports that their urology wait times for appointments got to 3 months, which was significantly longer than they had been. How did they make it through? **"Everyone stepped up,"** he says.
  - **APPs:** The group "leaned heavily on our APPs, who expanded what they were seeing—they provided our greatest buffer." The group currently has 5 APPs, 4 in the office and 1 in the hospital. They are very helpful in seeing those patients with non-surgical urologic issues.
  - **Double-booking appointments:** The urologists tend have 15 minute clinic visits and began to allow for some double-booking of appointments, although Dr. Pugach himself tries hard not to double book. He feels double-booking can sometimes leave everyone involved a little dissatisfied."
  - **Buffer time:** The urology group did a timed study some years ago to assess their efficiency and found that leaving some "buffer" slots in the day for potential catch-up or additional visits was helpful. There is some buffer time at the end of morning patients so that he can get caught up before the second half of the day. "Everyday you hit some kind of hiccup where you get a little behind, but then by the end of the half day there is catch-up time." In addition, his first patient is usually at 0830, but if needed he sometimes adds patients at 0800 or 0815.
  - **Telemedicine:** Telehealth visits helped when volumes were up, and they especially came in handy in trying to review imaging and study results with families. He could show patients and families the studies on the screen just as well as in the office and could offer suggestions for next steps. Dr. Pugach likes the flexibility and functionality of telehealth visits and has at least 2 of these visits per half day. He finds that these visits can be added to a day's schedule quite easily, since logistics can be easier for families. He sometimes even adds a telemedicine appointment at the end of an OR day.
  - **Portal messaging:** The urology team, including nurses, got into the habit of managing more patients' needs over the portal which previously might have been a visit. Mostly these visits take less time to manage than a 15 minute clinic appointment. If a child has imaging studies with abenign diagnosis, like mild hydronephrosis, messaging can come in handy to relay the news and set up a repeat ultrasound in a year.
- **Higher and Higher Volumes:** The urologists have been successful in getting their wait times for a new appointment down to about 3-4 weeks. Dr. Pugach and his group have an eye for efficiency and continue to tweak.
- **Last-minute cancellations:** Dr. Pugach says these issues are handled effectively per the Urology office staff. "I am happily ignorant of what they are doing to manage these," he says, "but I'll say I usually don't start my day with holes in the schedule." He says show rates in his department are 85-90%.
- **Hiring challenges:** Yes the urologists have faced hiring challenges since losing Blake and with the transition of Dr. Jonathan Kaye covering Prosper. They have added a urologist downtown and have another starting soon. Succession planning is something he knows they will have to discuss soon, as some of the docs may be looking to retire, and planning ahead will be important.

Continue-->

UROLOGY (cont):

- **Individual Habits and Strategies for Efficiency**
  - **Keeps an eye on the time:** he looks at arrival time vs scheduled time and therefore knows which people are on time or a little early/late. He prioritizes things accordingly.
  - **Template:** he has 15 minute slots and tries not to double book (see above). "Being realistic about how much time you really need is important," he says. He does sometimes block complex patients for double slots if needed.
  - **Reviews FLAGS from his nurse and FILTERS in chart review:** He does not prechart and instead has a helpful nurse teammate and an efficient system for reviewing charts in real-time, just before entering the room. His nurse helps to prep his charts by flagging important results or parts of history for him. He also makes use of filters in the Chart Review—one button for him, another for urolgy, and another for urology and renal—in order to scan the chart quickly for recent visits. When reviewing his own patient visits, he quickly scans his Dear PCP note (see below).
  - **He brings his laptop into the room and sits down with patients.**
  - **Charts as he goes:** he tries very hard to chart as goes but sometimes may need to return to a note later. Adds a few bits of history to the note during visit. Then in the hallway he makes use of dictation (not Dax Copilot, at least not yet). He makes sure that whatever parts of the chart are needed for his teammates to do their work are done—for example orders are in (which team may have to help schedule) and billing info is complete for front staff. "You are a cog in the wheel," he says, "and you need to make it so the others on your team can do their job." If he starts running behind, he may have some dictating to do at the end of the day, but he has all of his notes done before he leaves because "trying to recreate things the next day is a blur," he says.

Dr. Pugach's Dear PCP Letters at the start of his Notes Both Inform and Remind All about Next Steps

- **DEAR PCP notes:** The initial page of each of his visit notes—part of his visit template-- is a letter to the referring PCP, which he dictates immediately after exiting the patient room. This letter has a concise story about the patient, including how they presented, recommendations for management, and plans for follow-up and imaging/lab studies. This is a system he loves because it is a win-win situation—a personal, and informative message to the referring physician and a memory trigger for himself. "In part this letter is informing you (as PCP)," he says, "and in part it is leaving the breadcrumbs for me." He likes having the letter at the top of his notes so that it is easily accessibly with no scrolling needed.
- **Dictation:** He uses dictation, as much as possible in the hallway just after seeing a patient, thought sometimes this gets partially pushed to later. He **tries not to be perfectionistic about the dictation**. "What comes out is often not exactly how you might wish you phrased it, and making corrections to dictations can keep people up charting, he says. "But I don't do that," he adds, as—barring any glaring errors, "sometimes you just have to live with what it is."

The subject viewed through different lenses.

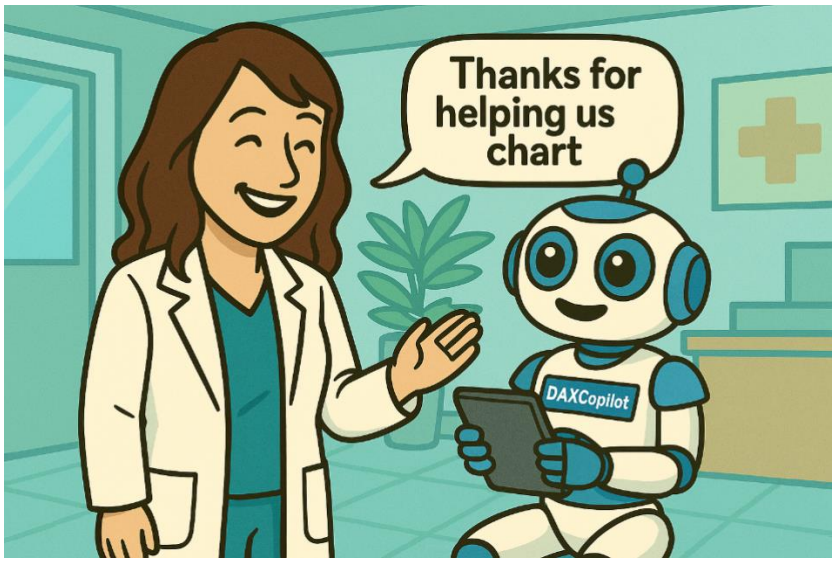
Words from our Chief Medical Information Officer: Dr. Ashley Antipolo, Pediatrician

It's hard to keep up with caring for patients, daily work, *and* making sure you are "optimized" when it comes to your EHR documentation and personalization. Not only that, change isn't easy, is it? And "ruts" of inefficient workflows are difficult to get out of.

If I could share one thing with you today it would be to let you know that we are investing in tools at Cook that are aimed at reducing the cognitive burden of our work as pediatricians, making the complex work we don a bit easier. One significant effort on that front is our recent deployment of an ambient listening technology, DAX Copilot, which allows you to focus on the interaction with your patient and use that conversation to generate a drafted note for your encounter. We had a very successful pilot with DAX last year and I'm thrilled to share that we will be deploying our enterprise-wide license for DAX Copilot this May. So, keep an eye out for more information coming soon on how to get started with DAX. This is truly the first of many exciting efforts dedicated to having the technology work for you, not the other way around.

As your CMIO and a fellow pediatrician, I know firsthand how technology has been a two-sided coin, at times, a blessing, others, a curse. I am dedicated to tackling these challenges and am here to help and support you and your practice, as are our amazing team of trainers and informaticists. If you or have any questions, please don't hesitate to reach out.

Note: There are comments about physicians' use of technology throughout this document. Most use smartphrases, templates, and favorites. There are a few who mention really liking DAX Copilot (see pediatrician Dr. Shori's page or Neurology's section with Dr. Herring's comments).



Dr. Antipolo Encourages Us to Try out the Technology

The Subject Viewed through Different Lenses:

Physician Wellness: Dr. Kirk Pinto and Dr. Sara Garza

Most specialties in medicine proceed at their own seasonal pace. Allergies bloom in the spring, and flu surges in the winter. This requires physicians to throttle their efforts to match the pace of their work.

It is a tenet of business that the way to become more productive is to "attack" rate-limiting steps. In medicine, that rate-limiting step is care. This involves balancing the care of your patient population, office staff, individual patients, your professional reputation, and, equally important, care for yourself.

When circumstances require more effort, doctors want to respond, and they should. But we need to be mindful of the malign effects these efforts can have on every aspect of our personal and professional lives. Hard work does not inevitably lead to burnout; overextension and emotional exhaustion often do.

We have signed up for challenging and strenuous work. The calculus about how much work we can do and for how long has to consider our reasonable needs in providing that care; otherwise, we are of no good to anyone. Realities of life often impact our ability to flex, and it is essential to recognize and take stock of these factors. A fulsome assessment of how best to fulfill your duties to your patients, your practice, your family, and yourself will help ensure your availability for many seasons to come.

Dr. Garza and Dr. Pinto Remind Us to Take Care of Ourselves, Too

The subject viewed through different lenses.

Words from Dr. Anu Partap,

Caring and Seeking Understanding

The challenge of service in today's social and health care environment:

Many of us go into health care because of a calling to serve and yet we find ourselves in an environment of health care that can feel like it's built to keep us from the sacred role of service, wearing us down, the mountain of barriers and pressures ever-growing. What if the way we feel is also how families are feeling? Families come with curiosities, worries or fears and to some degree, we do, too. We might begin our days thinking, "Did I miss something on my last patient…Will I collect enough revenue this week...Will I see my kids before their bedtime?" And at the same moment, somewhere our patient-family may be thinking "Is my baby okay?...Will they cancel me because I'm running late?... Can I afford the tests they order? How much will they hurt?" The shared tie that binds us is our commitment to be in service to a child. When it feels we are miles apart despite our shared goal, there are often invisible pressures at play, and for families, it can shape a family's ability to show up, follow-through, or connect. The more we allow families to share those pressures, the more aligned our service will feel. The more we know, the more we can ask for what we need and for what families need to protect our patients and our sacred moment of service. Systems changes take time, but we are lucky - families come to a person - you – and your presence in the sacred moments of service is fully yours. For some families, connection sometimes begins with the right amount of vulnerability – allowing families to see we are human, committed to serve and protecting them from pressures outside of our control. Being vulnerable is scary and yet trust and connection is at the center of service. Allowing space for unspoken barriers and pressures to be spoken – for families and us alike – can be transformational. We might need to take the first step - just a bit of vulnerability from us can help families feel safe to do the same during those sacred moments of service. Which was the calling that brought us to the moment. And Our Promise.

Dr. Partap Reminds Us that--High Volume or Not, Fast or Slow-- We Do This Work Because We Care

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The subject viewed through different lenses.

Resources from our Director of Medical Education: Dr. Hannah Smitherman

Dr. Smitherman hopes that Cook clinicians will enjoy teaching students and trainees and that they will find ways to teach that are not a significant drain on their time or efficiency. She also wants to remind people that the students themselves should be taking a very active role in their own learning—they should be watching and listening carefully, formulating questions, and taking notes on questions and topics they will look up later. You do not have to spoon feed them everything to provide them a good learning experience.

That said, there are resources that can help streamline your approach to medical students and may help you be an efficient and even a better teacher.

COMSEP (Council On Medical Student Education in Pediatrics) is a fundamental source of information for many clerkships. They have developed some faculty development tools that are quite good, and in fact, put together a "**Preceptor Startup Package**.' These are 5 short (7-11 minutes) slide and video presentations that were developed by the military for their preceptors at their teaching facilities:

- **One minute Preceptor**
- **Clinical Teaching Simplified**
- **Teaching Tools**
- **Direct Observation**
- **The Rhythm of RIME**
- **Giving Feedback**

They can be found here: https://www.comsep.org/faculty-development-videos/

U a very good video for medical students on **introduction to the pediatric exam,** which would be a good introduction for students:

https://uthvideo.uth.tmc.edu/Panopto/Pages/Viewer.aspx?id=1eeb71ad-dfcc-4a61-b518-94e1a6565113

COMSEP has recently revised their recommendations for pediatric clerkship, and it is interesting to see what other pediatric educators have come up with for pediatric clerkship curriculum:

https://gallery.mailchimp.com/d2249282f08ed957954d0b3b6/files/501849fa-1ad1-451d-ab3c-4fdfe6bdcdf8/COMSEP_Curriculum_Toollkit_2019_.pdf

The subject viewed through different lenses.

Tips from our Experience Team:

Cara Bozarth, Dr. Amit Singh, and Megan Chavez

Communicate to Connect – how to be effective in a short time

Acknowledgment builds trust

- Families feel seen, heard and acknowledged = connection
  - *"I am so sorry you've had to wait so long!"*

Legitimization validates emotions

- *"I know when I have to wait for my family member at their appointments, it can really be stressful!"*

Partnership to move the visit forward

*"Now that I am here with you, how can we work **together** today?*

Agenda setting makes the visit more efficient

- Ask directly, *"With the time we have today, what is most the important thing you want to discuss?"*

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Blameless Apology

Lead with empathy

- *We really apologize for the inconvenience.*
- *That sounds frustrating.*
- *I'm sorry you did not get the results you were hoping for.*

Add what helps

- *I know this must be difficult.*
- *I want to help.*
- *What can I do?*

Avoid excuses

- *We're short-staffed.*
- *Dr. X is always late.*
- *That's how late we always run.*

Manage up instead:

- *Dr X is a very thorough doctor. Let me check to see how much longer it might be for her to see you*
- *Our team is committed to taking excellent care of all patients who need care today*

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Confidential

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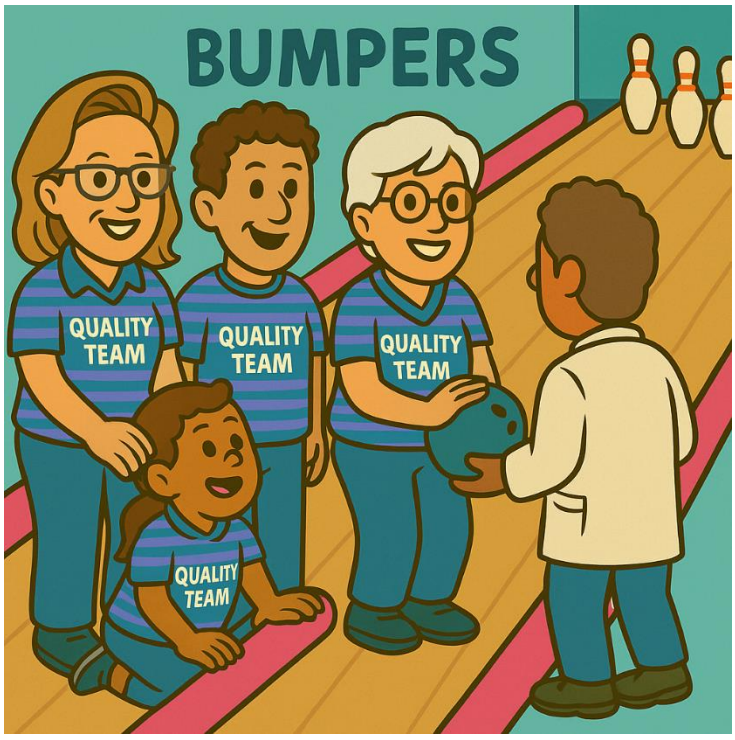
The subject viewed through different lenses.

Words from our Quality Team Physician Leaders:

Dr. Joann Sanders, Dr. Matt Carroll, Dr. Alice Phillips,

Dr. Ben Olsson, and Dr. Anne Kirk

The physician leaders of the quality department at Cook Children's recognize that our teams work hard. We also recognize the amazing skill and dedication our physicians and APPs bring to the table to provide patients with the highest quality of care. Through our ongoing work focused on education, development of new clinical pathways, quality improvement initiatives, and yes, sometimes review of care, we strive to consider all factors within the healthcare process. With deep dive analysis of workflows and care plans, we aim to help our teams work smarter and not harder. Through collaborative efforts between quality and all of our busy teams, our ultimate goal is to support everyone in their efforts to provide the high quality our patient's deserve.



Quality Team Creates Systems (in this metaphor, bumpers) to Help Us Succeed in Providing High Quality Medical Care

A: Assessment

Meeting the care needs of high and rising volumes of patients presents challenges and requires planning and mindfulness in addition to flexibility. It is not so much about RUSHING -- it is more about building structures, systems, and habits to help efficiency. Thanks to so many who shared their insights and their habits for this report, as well as their doubts and questions about how to improve efficiency.

We as clinicians have the ultimate say on how many patients per day we can and will see, and we are part of a group (an office/department and Cook's) that will have to arrive at solutions together about how to meet high and ever increasing demand. Moreover, efficiency isn't everything—it is just one piece of the puzzle. Also vital to our life's work is our compassion for our patients, the goal of providing high quality care with an evidence basis, an eye to our own wellbeing (clinician wellness), a look to the patient+family+physician experience, and a consideration of the cycle of teaching and learning that yields new doctors.

R: Recommendations: A compilation

(See the individual PCP and specialty pages for a bit more fun)

- **Individual Tips for Efficiency and Seeing High Patient Volumes**

Set an Intention for Greater Efficiency

- The highest-volume pediatricians and specialists have put a lot of thought into their efficiency and prioritize it, constantly reviewing systems and bottle-necks to make processes smoother
- They also make clear to their team that timeliness and efficiency is important, so that it is part of the group mindset. (PCPs Dr. Jones, Dr. Smith, Dr. Moye/Cardiology)
- They strive to be **concise** (PCP Dr. Smith, Dr. Katz)
- Be ready to hustle (PCP Dr. Ateek)

Mindful Scheduling

- Decide on a reasonable office visit time for your template – one that pushes your pace but not overly so
- Design a template to provide a framework for efficiency that suits you. Some clinicians like to stagger visit types for a known structure which optimize pace (Dr. Day), while others prefer block scheduling of certain visit-types (Dr. Hamilton).
- In viral season, PCPs will likely need to flip their template to make more room for sick visits. In a yellow capacity zone (surge or short-staffed/coverage situation), clinicians may need to allow double-booking or add visits to the front or back ends of their day.
- Consider designating specific time slots for patients with complex concerns (like mental health issues or complex care) at the end of the day or end of a half-day, so that running long will have the least effect on the timeliness of seeing other patients.
- Consider booking telehealth if patients live far or have scheduling issues otherwise, or if there is a surge with a need to help more people with fewer staff.

Prepping Pays Off

- Preparing or pre-charting—even just 30 minutes in the morning—helps you walk in knowing at least part of your plan. Many of us do this: Dr. Dzurik and Dr. Moye/Cardiology, Dr. Hsieh/Endo, Dr. Patel/Nephrology)
- Some clinicians review the next days' charts the night before or the next week's-worth of charts the weekend before (see PCPs Dr. Hamilton, Dr. Jones, Dr. Shori).

Imbed Reminders in Your Notes

- Even without prepping or precharting, there are other habits which help clinicians to be prepared as they walk in the door:
  - A memory trigger in the prior note (for ideas see Dr. Schutte/cardiology and Dr. Pugach/Urology, PCP Dr. Hamilton)
  - A clinical team which flags the chart before hand (see Dr. Pugach/Urology)

Respect the Clock

- Use room timers, checklists, or staff nudges to stay on track (see PCPs Dr. Shori and Dr. Hamilton).
- Consider making a template with built-in mile-markers for your pace (see PCP Dr. Day).
- Start physical exams while caregivers are still talking—just say, "Keep going while I take a quick listen." (most physicians I interviewed said to do this)

Clarify Goals for the Patient Visit at the Start

- Identify goals for the visit which, once done, can help you bring an end to the visit (Dr. Anani/GI, Dr. Roy/Endo)
- If there seems to be more to discuss, you can propose and set the goals for another visit

Lean on Your Team

- Make sure you have **ENOUGH team members** and that you are delegating enough (PCP Dr. Katz, Dr. Kennedy/Ortho)
- Train staff (and even medical students, in the case of HPI) to gather histories, run tests, and prep rooms like a pit crew
- Your team can help you in flagging your charts (Dr. Pugach/Urology)
- **Standing orders** (like for RSV/flu tests) save time by entering the room with some answers already in hand (UCC Director Dr. Starnes, PCPs Dr. Day, Dr. Goff).

Identify and Mitigate Bottlenecks

- Look out for the parts of a patient visit which add to time (ie echocardiograms and echo-reading for cardiology, perhaps questionnaires for PCPs). Minimize these bottlenecks by prioritizing their completion and working other steps in and around them (see Dr. Moye/Cardiology).

- Consider doing fewer labs, if they do not affect your management (PCP Dr. Goff)

Use Your Tech Tools

- Templates, dotphrases, and smart orders make charting faster (many of us, see Dr. Goff).
- **Use reminders:** consider having a section at the start or the end of each visit note directing/reminding you or other clinicians about next steps in the plan, such as when to follow-up, prospective labs and imaging (Dr. Schutte/cardiology and Dr. Pugach/Urology).
- **Dax CoPilot**, ambient listener and virtual scribe, is ever changing, and it can help (Dr. Chisholm/ENT, PCP Dr. Shori, CMIO Dr. Antipolo)
- Use **portal messaging** wisely—but don't let it eat your time or add too much to your unpaid work. It's ok to say, "Come in and let's talk."
- Use **Care Coordination Note** in caring for complex patients (NHC Dr. Ateek)
- **Don't be a perfectionist about your charting** (PCP Dr. Day)

Coffee Talk Primary Care Series: Nixing Perfectionism in Charting - The Freedom of 'Good Enough'A panel of Cook Children's physicians joined by psychologist Alicia Hooper discusses technical and mental strategies to close our charts efficiently. **Please click here to watch.**

Educate Efficiently and Effectively

- Sketch the diagnosis and have the families take a picture, while you snap one for the chart (Dr. Dzurik/Cardiology and Dr. Anani/GI).
- Be aware of Cook's educational handouts and resources and use them
- Have smart phrases for your own patient education. Train patient families to refer to online handouts/portal attachments.
- Consider skipping the printed handouts unless your process allows for the printing in an efficient way (ie you have it in-hand when you walk into the room, or you have a system for notifying your staff to bring a handout).
- Make use of your team—other members of the team may be able to review home management as you move on to see your next patients (Dr. Kennedy/Ortho).
- Make use of social media and portal blasts for big educational bang for your buck.

Know When to Say "Let's Follow Up"

- If the visit is running long, offer another appointment or quick portal follow-up. (Dr. Herring/Neurology,
- It's not brushing patients aside—it's pacing yourself to serve more families well.

Communicate Like a Pro

- Update your team about current or projected challenges, including epidemics or short-staffing, and work together to plan for how to tackle them (PCP Dr. Smith)
- Update families when running behind—transparency earns grace (at least sometimes) (NHC Dr. Ateek)
- Let patients know what to expect (and what you *can't* do today).

- ## Specialty Department Tips for Seeing High Patient Volumes

Team Expansion

- **APPs to the rescue**: Nearly every specialty (Endocrine, Urology, ENT, GI) mentioned how Advanced Practice Providers help absorb demand—especially for follow-ups or lower/medium acuity new patients.
- APPs allow physicians to focus on complex cases, procedures, or inpatient care.
- Continue to look at signs—like wait times for new patient visits—to know when to request and start the search for a new hire
- Communicate well about retirement plans—
    - See **PM Matters: Stepdown to Physician/Clinician Retirement** Practice Management Matters: What You Need to Know

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Smart Scheduling Tactics

- In a pinch, add appointment slots. Start earlier, stay later, utilize telehealth, consider add-on clinics. (Dr. Chisholm/ENT, Dr. Pugach/Urology)
- Buffer slots: Consider having catch-up slots in your template, and use them to chart, take a deep breath, or potentially see another patient if needed.
- Refining visit types: Endocrinology added a "new urgent" category for sooner consults and is limiting new patient slots as well as filtering certain new patients to APPs.
- Add telehealth visits if needed, for easier last-minute solutions.

Waitlist and Cancellations

- Use **Fast Pass** capabilities (Neurology, Pain): This allows patients to fill last-minute cancellations via portal technology.
- Manual outreach: proactively fill cancellation spots using lists of families seeking sooner appointments.

Workflow Redesign/Mitigating Bottlenecks

- **Pre-charting and standing orders**: Many subspecialists use pre-built templates and orders to move faster during the visit.
- **Staff roles**: Nurses often handle med reconciliation, interval histories, and flagging needed forms or recent imaging studies or lab results for review (e.g., in Cardiology, Neurology, Urology).

- **Redefining visit types for MDs vs APPs.** Endocrine department has been working hard to redefine the kinds of visits which their department will see (vs refer back to pediatrician or other services) and which can be seen by APPs. See also Urology and Orthopedics for similar delineations.
- **Mitigate bottlenecks** (Dr. Moye/Cardiology).

**** ***Tech & Tools***

- **Smartphrases and favorites:** Nearly universal among specialists to streamline documentation.
- **DAX Copilot:** Mixed reviews so far but NEW and likely has a learning cure—some (e.g., Dr. Herring in Neuro) love it for reducing cognitive load, while others prefer manual typing or MModal dictation.
- The **Care Coordination Note** is very helpful for managing complex patients

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**** ***Telehealth & Portal Use***

- Telemedicine is embraced selectively—for image reviews (Urology), med checks (Endo), or patient convenience (Pain). Those who have found a use for it very much enjoy the flexibility and have even been able to incorporate a review of imaging studies.
- Portal messaging sometimes replaces visits entirely—especially for benign follow-up like mild hydronephrosis (Urology). This has the downside of portal messaging not yet being reimbursed. However, if a department is overstretched and unable to get people into clinic in an expedited way, effective messaging per ancillary clinical staff may be quite good, as it can eliminate the need for a scheduled visits. Consider turning a portal messaging discussion into a telemedicine visit, which is reiumbursed, which can be quite quick, and which does not require the same number of team members.

**** ***Culture & Mindset***

- Set visit expectations early: "Today we'll focus on seizures; we'll discuss headaches more in depth next time."
- Train and trust your team: Everyone from nurses to front desk plays a part.
- Efficiency ≠ rushing: Sitting with families, eye contact, and communication still matter, even in high volume situations.

Hopefully this conversation about efficiency and high patient volumes—and how different people and groups within our organization are navigating the challenges-- will be ongoing. Discussion and sharing helps us all to be better.

Thanks to each and every one of you for the work you do toward the promise we share.

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THANK YOU

Document written/ compiled by me, Daphne Nizza Shaw, MD, current Chair of Practice Management Committee. AI was also used in the creation of this document, particularly in the making of the cartoons, which was done just for fun and with the sincere hope that they will be seen as playful and not offensive. Cook photos were used to help AI generate the cartoons.

I am incredibly grateful to Cook's talented and ever-patient videographer **Mr. Tom Reihm** for working so hard on this video-preview and all other PM Matters video previews. He is incredibly talented and patient and busy, and I very much appreciate his making time to help and adding his own art to our reports.

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Thanks so much to **Mr. Robert Goodwill**, CCPN Chief Operating Officer and Vice President of Primary and Specialty Care at CCHCS, for being in the video with me. This was a big ask, and he was a great team player. He is also a believer in efficiency and of seeing high patient volumes.

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