ONE TEAM
United on Access

UVA Health

One Team | United on Access: Frequently Asked Questions (FAQs)

Project Principles

- **Patients are first in everything we do*** – improve the experience for our patients when scheduling an appointment and when in our clinics for their appointment
- **Care team members are supported in their work and in their career** – streamlined processes using enhanced Epic functionality is a satisfier; offering career progression opportunities for all team members promotes retention
- **Physicians/APPs are partners in the work** – these efforts are most effective when our physicians/APPs are engaged in the development of decision trees, diagnosis matrices, visit types and templates specific to their specialty
- **One access model, tailored for specialties** – this model has been designed with best-in-class principles from other public, academic health systems using common tools across each specialty that are applied to meet the needs of that specialty
- **Clinics will optimize resources –** when clinics are open, they will have patients and care teams present to ensure we are matching our crucial staffing and space resources with the needs of the patients

General

Q: What are providers being asked to do?
A: We are asking providers to partner with us in improving the appointment scheduling process. This will include developing decision trees, diagnosis matrices and standard visit types that feed into four-hour template sessions. Using four-hour sessions will enable us to better optimize the use of our clinic space with the support of our clinic staff. It will be the responsibility of the clinic operations and access teams, working collaboratively with you, to ensure appointment slots are full, pre-visit planning occurs, medical records are collected, and no-shows are reduced.

Q: As a physician/APP, what changes will I experience as a result of this project?
A: As a provider, the change you will experience the most is in your scheduling templates. We will work closely with you to ensure the templates designed will work for your specialty and are consistent with UVA Health template standards. At go-live, we will not move or change the patients that are already on your schedule. Specialties that have patients scheduled out multiple months will have a gradual process of seeing patients that are scheduled through our new processes.

Q: How will we know the changes we are making are working? What are the plans to track, measure and change things, if needed?
A: During go-live, we will communicate each day with your clinic team to resolve any urgent issues. We will also use data to monitor outcomes and measure the adoption of workflows. After go-live, we will have check-in meetings that will include physician leaders to review metrics, resolve issues and receive feedback on the new processes. We will close the loop on any findings, learnings and solutions during these meetings and develop communications that can be cascaded to the entire clinic team.

Q: Will the approach be different for Primary Care?
A: Primary Care will still have a Decision Tree, but they won't have a diagnosis matrix in the same way that our specialties do. Since our Primary Care providers see so many different conditions, we will drive scheduling by the patient's reason for visit (e.g., new, physical, procedure, injection, etc.) rather than by their diagnosis. We will also use other factors, such as patient age, to drive accurate scheduling.

Q: What is Huron's involvement for the duration of the project? I have heard Huron is not going to be engaged for the work that's being done in the later waves.
A: We are planning for Huron to be engaged throughout each wave of the project implementation. The level of Huron's participation may change in future waves as some UVA Health resources are freed up from other priorities across the organization (e.g., project management, Epic builds, training). It is important to understand that this is UVA Health's project, not Huron's. The new access model that we are implementing as part of One

*UVA Health Guiding Principles

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Team | United on Access is based on best practice principles from other academic health systems designed for our environment.

Session Standards

Q: Why are sessions four hours?

A: Four-hour sessions are an existing standard at UVA. This expectation is supported by UVA Health and School of Medicine leadership and is a common construct across our peer academic health systems. Moving forward with this standard will allow us to fully optimize our support staff (clinical and non-clinical) and to fully utilize our clinic space, while offering patients more options for appointments. We realize this is a significant change in some clinics and we are committed to supporting you through this change in the following ways:

- Support staffing will align with provider templates/schedule
- Continue focus on recruiting and retaining staff, while also devising creative staffing solutions (e.g., Earn While You Learn Program)
- Remove some administrative duties from clinics (e.g., records collection, medication prior authorizations, referral requests) to allow patient-facing staff to focus on direct patient care
- Ensure support services (e.g., lab, imaging, etc.) are open until 5pm
- Create workflows and policies to have consistency across the health system

Q: Is there any flexibility with the four-hour sessions starting/ending times?

A: The vast majority of sessions will be from 8am – 12pm and 1pm – 5pm. This allows for the most efficient use of staff and space. In unique situations, requests outside of these hours will be considered if the clinic is able to staff the request. The following is also important information to understand:

- Time spent at Grand Rounds will count toward a four-hour session.
- Virtual/telemedicine visits can be performed during and outside of the clinic hours

Q: I can see the same number of patients in three hours that I can in four – do I still need to meet the four-hour session standard? Why not just ensure I meet a wRVU target instead, regardless of the amount of time I am in clinic?

A: These changes are not about how many patients you can see in a set amount of time. The changes are about optimizing the patient experience by ensuring they have a complete visit and spend less time waiting to be seen, and optimizing the use of our space and provider/staff resources. Additionally, these changes may allow you to finish more of your documentation during clinic hours and decrease your Epic time away from work.

Q: The other support services (e.g., lab, imaging) in my clinic close before 5pm – if I extend my own session until 5pm how will the health system support me to make sure my patients still have access to those services after their visit?

A: We are committed to keeping needed support services open to meet the needs of the patients you serve.

Q: What are the criteria for a four-hour session? If I block a slot for catch-up time, will that impact reporting?

A: A session needs to have continuous uninterrupted time that is available for patient appointments. Any breaks in that schedule for catch-up time, unavailable slots, etc. would make the session non-compliant with the standard.

Q: I have standing meetings such as grand rounds, tumor board, or the all-surgeon meeting that prevent me from having a 4-hour session on those days – will this negatively impact me?

A: While we are unable to account for all standing meetings in every department, we *will* account for Grand Rounds in every department. For example, if a department's grand rounds end at 8:30 a.m. and the provider's template begins at 8:30 a.m. and goes to 12 p.m., the provider will receive credit for a 4-hour session.

Q: I have sessions at our clinic locations outside of Charlottesville and I currently don't have a four-hour session to account for travel time – how will this impact me?

A: Clinics within an hour of UVA Health University Medical Center will need to adhere to the 4-hour standard. Clinics that are beyond an hour are at the discretion of the department/service line, however, we encourage leaders to ensure that the time it takes to go to and from these clinics is worthwhile.

Examples of clinics within 1-hour: Augusta, Orange, Stoney Creek, Zion Crossroads
Examples of clinics beyond 1-hour: Culpeper, Haymarket, Lynchburg, Roanoke

Q: I have inpatient rounding or other clinical responsibilities that prevent me from having a four-hour session – how will this impact me?
A: These conflicts will be considered on a case-by-case basis with divisional, departmental, and organizational leadership, but directionally we want to find solutions that adhere to the four-hour session standard.

Q: I am not able to have a four-hour session because I have childcare issues, will this be an exception?
A: We understand that taking care of our loved ones is a top priority. We ask that you work to make arrangements that will allow you to meet both obligations in taking care of your loved ones and being able to work a four-hour session. We ask that you work with your clinic leadership (manager, medical director, access leader) to find a solution. Extenuating circumstances should be taken to your division/departmental and ACMO leaders for consideration.

Q: I sometimes come to clinic to see a few patients on days that I am not regularly scheduled, will I still be able to do that?
A: Yes, we absolutely want to support and encourage our providers that do these unplanned sessions to see our patients. Any session under 90 minutes will not be included in the four-hour session reporting. These will primarily be used for meeting urgent patient needs on a day you do not have a scheduled session.

Template Changes

Q: As a physician/APP, what input do I have on the design of my template?
A: While there are UVA Health Template Standards for consistency and specialty, individual providers will have the ability to tailor their template to match their clinical parameters (e.g., IV to FV ratio, urgent appointments, shared visits with support staff).

Q: How can I make changes to my template or the conditions I see after go-live?
A: There will be a standard and streamlined process in Epic to submit these requests. Providers will be able to submit requests themselves or communicate requests to their clinic leadership team to process. While your specialty is engaged in the project, a streamlined outline of the change request process will be shared.

Q: How do I get a deviation from the template standards?
A: When extenuating circumstances occur, these requests will be brought to the division/departmental leadership for consideration in partnership with the assigned ACMO.

Q: How will fellows and learners be impacted by the template standards?
A: We will work with each specialty individually on the appropriate conditions and visit durations for our fellows and other learners. We will remain in alignment with GME criteria.

Q: Will telehealth sessions be included in this project?
A: Yes, we will want to streamline the process for scheduling telehealth visits and design templates to support these virtual visits.

Q: How will APPs be impacted by the template standards?
A: APPs will be expected to have their own template on days they practice independently, as well as have four-hour sessions. We will work with leadership in each specialty to determine the appropriate visit durations and conditions for which APPs can see patients. APPs are inherently mentees at the outset of their hire and the adjustment of templates to enhance their transition into a new role/diagnostic group will be considered. Clinic

resources will also need to be planned with the clinic leadership (manager, medical director, access leader). Additionally, we are coordinating with the broader APP project that is underway at UVA Health.

Q: What is my escalation pathway as a provider in a clinic?
A: Begin with the medical director in your clinic. There is an expectation the medical director will work with the other clinic leaders (manager and access leader) to resolve issues. If there are issues that need to be escalated beyond the clinic leadership (manager, medical director, access leader), they can be escalated to the division chief, department chair and ACMO. If necessary, others will also be included.

Referrals

Q: My clinic is currently referral based and we make outbound calls to schedule patients – will this project have any impact on that process?
A: Our goal is to leverage technology to automate processes and give our patients the information and tools they need to contact us. As part of this project, we will leverage text messaging and optimized functionality in MyChart to automatically notify patients when we receive their referral, provide them with our phone numbers, and encourage them to contact us at their convenience. We will assess our staffing to make sure teams are structured to accept these increased incoming call volumes (while understanding that the outbound call volume will decrease).

Q: How will the decision tree and cross-location scheduling impact my referrals and overall distribution of patients?
A: We will continue to honor direct referrals, unless the patient requests to be offered additional options with other providers that also specialize in their condition/diagnosis. For general requests for care, we will offer patients the next available appointment at all locations that offer that service and have a provider qualified to provide care for their condition/diagnosis. We can work with each department or division on template design strategies to meet the specific needs or nuances of their group.

Go-Live Readiness & Training

Q: How will my team experience these changes at go-live?
A: Our Access, nursing and HIM teams will start the new processes for scheduling, nurse triage, and medical records collection on the go-live date for all future appointments scheduled on that day and moving forward. The amount of time it will take for providers to see/feel the changes is dependent on how far out that provider is scheduling patients.

Q: How will my team and staff be trained and supported to adjust to these new workflow changes?
A: We have a training program for schedulers, nurses, and other clinic staff. Additionally, at go-live, the project team will have team members in your clinics to support the care team, answer questions, and identify and help resolve any issues associated with the changes. Any issues or questions that physicians or staff have can be reported to clinic leadership (manager, medical director, access leader) so they can be shared with and collaboratively addressed by the project team and clinic leadership.

Q: Will there be training for me to better understand how templates work?
A: Yes, we will provide template training as part of each wave implementation and provide training resources on the project intranet site. This is a learning from Wave 1 – that common language and understanding regarding templates helps during the template design phase.

Scheduling

Q: Will my School of Medicine administrative assistant continue to schedule for me?
A: No, not after your specialty wave implementation. Moving forward, all scheduling for ambulatory clinics will be managed by members of our Access team. If there are SOM admins who would like to maintain scheduling duties, we will be happy to accommodate their transition to a full-time Access role. Ultimately, this project will help define the distinct academic versus patient-centric duties.

Q: Certain subsets of the patient population in my specialty are too complex to be scheduled by a pre-designed algorithm, how will this be handled?
A: While we will work with your assigned physician/APP representatives and physician leaders to minimize these situations, our Ambulatory Nursing Administrator will work with your clinic to streamline and create consistent processes for how the scheduling team connects with nurses and clinical staff. We will create a system to leverage the existing nursing staff to support this need. If a division or department validates the need to create a specific navigator role (or if one currently exists) we will develop workflows that incorporate and leverage this person.

Q: Will all specialized scheduling knowledge be removed and replaced by a general 1-800-UVA scheduling number?
A: No, schedulers will continue to be assigned to and learn specific specialties as part of their work. They will be trained and have the ability to schedule for all locations within their assigned specialty.

Q: How can I submit feedback if a patient was scheduled incorrectly onto my template?
A: Your feedback as we implement these new workflows will be critical. We will have a button in Epic where providers (and their care team) can quickly notify the scheduling team of the issue, and our scheduling leadership team will be able to investigate how the patient was scheduled and close the loop with the outcome.

Staffing

Q: Will my Access staff be moved out of my clinic to a central location with this work?
A: No, we do not have plans to remove staff from the clinic. Outside of normal staff additions and departures, your current access staff who support your clinic and know your book of business will remain in place. In some rare exceptions staff may need to be based in a space other than the clinic. Additionally, if it is appropriate, we will offer telework options for our access staff.

Q: How will this project support the well-being of our providers and staff? We already feel overworked and underpaid and we feel like you are asking us to do more.
A: Taking care of our team members is our top priority. One of this project's goals is to allow our providers to focus on the work they have been trained to do and spend less time on administrative tasks. One way we can reduce burnout is to reduce the administrative workload of clinic care teams (e.g., prior authorizations for medications and medical records collection). Additionally, the new workflows we have designed are more efficient than past scheduling workflows and will allow team members to work more effectively. We aim to ensure that our providers have all the tools and resources they need to do their jobs. We understand that there are questions around physician compensation. Physician compensation is being addressed outside of this project.

Q: How can we do this work without more staff? What if staffing does not improve?
A: The work we are focused on is streamlining scheduling processes and removing some work from the care team in the clinic. We understand the current staffing challenges and this work will reduce some of the inefficiencies that exist today and will better support the staff that we do have. We are also creating a development ladder within our access team to allow them to grow and to encourage retention and professional growth. Partnering with HR, we are also bolstering our recruitment efforts and continually assessing the market to ensure we are wage competitive. Additionally, we have created an Earn While You Learn Program for certified medical assistants (CMAs) and have dozens of new CMAs starting in our clinics. Float pools for nurses and access team members have also been created. If provider templates are consistent, we can flex up and flex down to improve staffing ratios by way of the float pools. Finally, we will continue to evaluate our staffing throughout implementation and work together to resolve the issues identified.

Q: I do not have enough clinic space or support staff to see more patients. I am already leaving the clinic after hours. How do you expect me to see more patients?
A: Most clinics at UVA Health do have adequate space available (with a few known exceptions). This project is not setting any "number of patients seen" expectation. We are focused on creating a process that seamlessly

allows an access team member to schedule a patient into a well-designed template. The template and your use of it will ultimately determine how many patients you see in a session.

Q: I don't have enough OR time to meet my current needs. If I see more patients in the clinic that will likely result in more patients needing surgery. Will there be more OR capacity to meet those increased needs?
A: We are working to grow capacity in all areas of UVA Health. While this current project is focused on access to ambulatory care, we have other leaders working to enhance areas such as the OR, lab, and radiology services. As we grow our ambulatory footprint and volumes, the organization is committed to also growing the other services.

Lessons Learned

Q: What has been learned during Wave 1 that will be applied to the project plan moving forward?
A: We have learned a great deal during Wave 1 and appreciate the specialties that have helped make suggestions for us to do this work better. Key changes that will be made for future waves include:

- Communication
  - Physicians and APPs – this document itself is a result of a lesson learned. We need to provide more context for the project and continue to answer questions and concerns consistently so that we are all on the same page. We will continue to iterate and add to this document as new questions arise.
  - Team Members – starting in Wave 2, we are scheduling "all staff" kick-off meetings at the beginning of each wave so that we can provide all team members with an overview of the project and answer their questions.
- Templates
  - We will be creating additional educational materials on template terminology, use cases for advanced functionality, and more detailed FAQs on how these decisions impact workflows and what patients will end up on providers' schedules.
  - We will be moving the template work up earlier in the timeline for each wave so that we have more time to partner with our physician/APP leaders to agree on the design and changes for their faculty in alignment with template standards.
- Epic Demonstrations of Tools and Workflows
  - Now that we have built new workflows and tools (e.g., decision trees) we will be able to show these as part of our kick-off meetings. Showing this process early will help us all be on the same page and see the end goal and the benefits to our patients and team members.
- Current State Understanding
  - Our teams will spend additional time seeking to understand the current state of your operations and performance and validate that understanding with your stakeholders. This will help make sure we are all starting from the same place, build upon what is working well, and understand the ultimate change for your providers and staff.
- Best Practices
  - Sharing lessons learned and solutions across each of the specialties within Wave 1 could have been better. We are incorporating a process to facilitate this sharing for all future waves.
- Change Is Hard
  - Although we knew this coming into the project, it is worth emphasizing. The changes we are implementing – with your support and participation – are different than what UVA has ever done across the entire organization. Everyone involved is being asked to do something differently and is concerned that those changes may make things worse. This is normal for any person or organization to experience. We ask that we work together as partners during this effort and remember that we are all on the same team.
- Constant Improvement Is Needed
  - We will be the first to admit that everything has not gone perfectly for Wave 1 of this project; we are learning much that will make future waves better. We are grateful for the Wave 1 specialties

being pioneers and helping us identify and resolve the challenges we have discovered. We also ask for your feedback and participation in helping us learn even more when we get to your specialty wave implementation.

Unanswered Questions from Dec. 14, 2022 Physician Roundtable

Q: Dr. Nakada (guest speaker from the University of Wisconsin) noted increased nursing resources needed for triage during the transition- will UVA increase nursing staffing ratios to support this transition?
A: In the short term, we are implementing workflows to take administrative work off the plate of our nursing staff, including medical record collection and real-time pharmacy benefits. The Ambulatory Role Delineation Project is also working to ensure all staff have clear responsibilities and clinics have adequate staffing to support our care teams and patients.

Q: Is there a plan for system-wide integration of physician scheduling software (like Qgenda) with Epic?
A: There currently are no such plans in place by HIT. It is something that could be considered in the future.

Q: There are ambulatory departments that intentionally schedule patients with overlap in the clinic. What mechanisms and safeguards will be put in place to recognize the true encounter as part of both session length metrics and scheduling templates? This is essential to prevent a 30-minute new encounter at the end of day that will extend 60-90 minutes beyond availability of support staff and ancillary services and impact staff childcare needs.
A: We have many tools available to us in Epic that can achieve the clinical needs of our providers and support patient flow in the clinic. While designing templates, each provider can partner with our team on the design of their template, including initial and follow-up visit placement and structure.

Q: I certainly want to decrease no shows and optimize my schedule. But to be honest, no shows are what allow me to keep up with MyChart, documentation, email, etc. As clinics get more efficient, do you anticipate problems with delays in documentation, answering calls, etc.?
A: By optimizing the other functions in our clinics – such as nurse triage, records collection, and pre-visit planning – our providers will operate in more efficient clinics while not having to spend additional time on administrative duties. Additionally, visit types and durations within each specialty take into consideration documentation time.