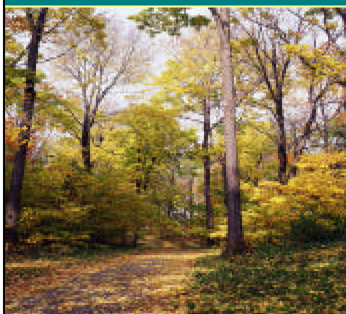
Issue 1

Fall/Winter 2005



HEALTHMETRICS PARTNERS, INC.

Family Planning Update

Operationally Speaking

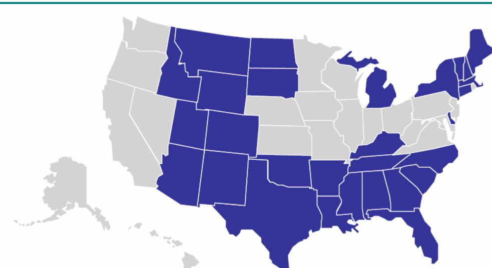
Welcome to HealthMETRICS' first issue of *Operationally Speaking: Family Planning Update*. Two issues per year will be published, with special issues when warranted.

This newsletter is designed to provide timely, useful and proven highlights, based on the Best Practice Family Planning Project findings.

To-date, HealthMETRICS has worked with 158 sites in 29 states to identify best practices for Family Planning services. Please contact us for additional information and/or should you wish to participate in a project.

Make sure you have our address!

HealthMETRICS Partners, Inc.
4 Preston Court, Suite 209
Bedford, MA 01730
781-687-9500; fax: 781-687-9700
www.healthmetricspartners.com



The Family Planning Best Practice Project continues to expand across the country. States in blue represent areas that have participated in the Project.

Drivers of Cost

The Family Planning Best Practice Project has identified wide variation across the country in the cost of providing an episode of care. Unit costs, after adjusting for geographic salary differences, varied from $42 to $205.

There are specific components of the Family Planning service that drive costs, and should be the focus for operational improvements. They are:

- Staff time to provide the visit,
- Non-direct patient care time,
- Staff mix, and
- Single visit vs. split visit appointments

Family Planning Project Highlights

Significant variations were found to exist in the following outcomes:

- Unit costs — $41.64 to $205.45 per episode of care (adjusted for geographic salary differences); average $91.69
- Time per visit — 22 to 164 minutes; average 61 minutes
- Patients seen per provider hour — 0.26 to 9.20; average 1.81
- No-show rates — 7% to 65%; average 37%
- Staff used to perform history, education, and exam varied widely
- Patient education scores — 50% to 100% regarding clear understanding of critical issues; average 90%
- Staff satisfaction — 3.83 to 6.60 on a scale of 1-7, corresponding to "somewhat dissatisfied" and "very satisfied"; average 5.28
- Patient satisfaction — 5.40 to 6.88 on a scale of 1-7, corresponding to "somewhat satisfied" to "completely satisfied"; average 6.50

Each issue of *Operationally Speaking: Family Planning Update* will address one of these drivers in detail and explain how variation affects the cost of providing Family Planning services.

Staff Time as a Cost Driver

This issue will address staff time, specifically those aspects that increase the amount of time spent with patients, which, in turn, increase the cost of a visit and decrease productivity.

The different processes used to educate patients account for one reason for the wide variation in staff time (22 to 164 min per visit). Some sites duplicate the education patients receive by having both the clinician conducting the exam and the staff member conducting the intake or exit interview discuss general method information, sexual safety concerns, and general health information. This duplication of effort doubles the amount of time, and therefore costs, necessary to educate a patient, without improving clinical or educational outcomes.

Despite the widespread belief that high-quality outcomes depend on the amount of time that staff spends with patients, data consistently shows no positive correlation between the length and quality of a visit. Visit duration is independent of clinical outcomes, staff morale, and patient satisfaction.

Additionally, the extent of patient education can vary across clinics. At some clinics, staff try to address *all* patient education needs at one appointment, resulting in much longer visit times than those sites where staff provide focused education on patient-specific issues.

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Staff Time...(continued)

Topics which fall outside the core information needed to place a patient on birth control can be important to cover with different subsets of patients. However, the relevance of these topics should be determined for each patient, and should not be routine. This will save costs and improve or maintain educational effectiveness.

Variation in how the medical history is taken is another explanation for variation in staff time across Family Planning clinics. Some sites provide the patient with a self-assessment history form, which is briefly reviewed by the clinician prior to the exam. Some sites perform an extensive interview to obtain the medical history with the patient. Other sites take even more time by combining the two; the patient completes the self-assessment history form, which is then reviewed in detail by the provider during intake. Still, other sites have two staff independently review the medical history with the patient during the course of one visit.

Through strategic analyses, HealthMETRICS has proven that organizations can optimize the quality of care by taking the following actions:

- Eliminate unnecessary duplication of education.
- Provide focused education that is patient-specific.
- Require patients to complete a self-assessment history form, which needs only to be briefly reviewed by the clinician prior to meeting with the patient.

Success Stories - Scotland, NC: Self Assessment History

North Carolina's Scotland County Health Department is a model example of a clinic that implemented recommendations to reduce staff time per visit through strong clinic leadership. The result was a dramatic decrease in unit costs and increased access to care, while maintaining excellent clinical quality outcomes.

Baseline data collection results at Scotland County found that staff were spending 112 minutes on each initial family planning visit. This long staff time per visit was largely caused by duplication of effort among staff. Part of this duplication occurred in taking the patient's history, contributing to an RN/LPN time of 54 minutes and a PA time of 28 minutes per visit. This led to higher unit costs as well as reduced access for patients.

At Scotland County, the RN or LPN interviewed the patient to obtain a comprehensive patient history. The clinician then reviewed the history prior to performing the exam. Data from over 150 family planning sites indicated that having multiple staff involved in the patient history process did not improve outcomes. Therefore, Scotland County adopted the Best Practice Process for taking patient histories.

The Best Practice requires patients to complete a self-assessment history form while in the waiting room after check-in. Only the clinician reviews the history prior to the exam. This process has the advantage of moving the patient quickly from the waiting room into the exam with only a brief stop with the RN or LPN. By using the Best Practice model at the Scotland County site, RN or LPN time required for taking the patient history could be eliminated.

To implement this recommendation, Scotland County developed a streamlined history form written at a 5th grade reading level. Patients were given the self-assessment history form at check-in, and staff were available to assist patients with questions or literacy issues. One year following completion of the report, this recommendation contributed to Scotland County's 63% reduction in staff time per visit and 62% cost savings. High patient and staff satisfaction, as well as excellent clinical outcomes were maintained.

A well-designed self-assessment history form is critical to successful implementation of this recommendation. The language of the form should be written at a 5th grade reading level, and forms in other languages should be provided depending on the site's patient population.

The State of North Carolina worked with the sites to create an effective and user-friendly form, encouraging successful implementation across participating sites. We commend Scotland County and North Carolina for their success!

Ask a Question!

This space is reserved for your questions about a process, finding, recommendation, implementation, or how to join a Best Practice Project.

Email your question along with your Name, Title, Organization, and Contact information to:
info@HealthMetricsPartners.com

Avoiding the Hidden Costs of Staff Burnout

Our work to-date refutes another misconception that staff burnout increases as organizations try to drive down costs. Study results show that staff satisfaction, like high quality outcomes, relates directly to the effectiveness of the clinical process.

The most expensive site in the project utilized a process that tripled the length of the visit compared with that of the Best Practice site. As a result, scores were significantly lower than the Best Practice on both staff satisfaction and clinical quality.

HealthMETRICS Presentations

November:

- Emory Advisory Board Conference, Covington, KY....... Nov 3rd
- Center of Excellence Director's Meeting, Washington, DC....... Nov 7th
- North Carolina Review of Results Meeting, Raleigh, NC....... Nov 17th

December:

- USDA Presentation to Regional WIC Directors, Washington, DC....... Dec 7th
- Georgia Family Planning Open Access Video Conference....... Dec 13th
- Annual Immunizations Meeting, Idaho....... Dec 15th

HealthMETRICS Partners, Inc. developed the Best Practice Strategy in 1996 to help healthcare providers systematically enhance cost-effectiveness, improve the quality of care provided, improve access to services, and reduce disparities in care.

HealthMETRICS' process is based on the systematic measurement of outcomes for clinical quality, patient satisfaction, staff satisfaction and unit cost, combined with benchmarking and an astute understanding of the ways in which processes influence outcomes.

The next *Family Planning Update* will be issued in Spring/Summer 2006.