

# Optimal Office Practice Support: A Systemic Approach to Improving Efficiency and Support in Medical Offices

By Darla S Holland, MD; Darlene C Squires, M Sc, OD

## Introduction

In the early 1990s, the Kaiser Permanente (KP) Orange County Medical Service Area (MSA) sought to become a leader in delivery of accessible, high-quality health care. Facing major cost challenges and shrinking market share, the Orange County MSA implemented two major changes: 1) decentralizing both primary and specialty care into a dozen different medical office buildings scattered over a large geographical area; and 2) shifting the support staff personnel from registered nurses and licensed vocational nurses to medical assistants. As these two changes coincided with rapid growth of the Health Plan membership, physicians struggled daily to meet the needs of members. In response to the need to improve support and efficiency in the medical offices, the KP leadership in Orange County, California commissioned the Optimal Office Practice Support (OOPS) project. The design phase of the project extended from August 1996 through October 1997; implementation began in March 1998 and is ongoing.

## Goals of the OOPS Project

The goals of the OOPS project were simple yet comprehensive:

- Physicians would receive con-

sistent clinical support from competent staff;

- Each team would be supervised by a Team Leader trained to support the medical assistants and to manage the flow of patients and physician messages;
- Examination rooms and special procedure rooms would be consistently stocked with equipment and supplies needed by physicians in daily practice;
- Physicians and other providers of care (such as nurse practitioners and physician assis-

tants) would be grouped into care teams visible to members and matched to those members' needs (eg, Vietnamese-speaking clinicians would be grouped at locations visited by Vietnamese-speaking members);

- Agreements and other tools would be developed to help clinicians to share the work (eg, answering messages from patients, reporting test results, and prescribing medication refills); and
- Receptionists would be recognized as vital members of the

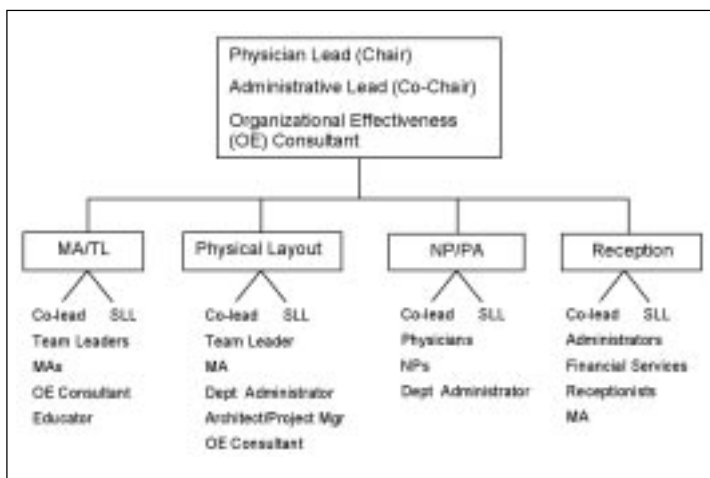


Figure 1. Structure of the Optimal Office Practice Support (OOPS) project designed and implemented in the KP Southern California Region. MA = medical assistant; TL = team leader; NP = nurse practitioner; PA = physician assistant; SLL = service line leader.



**Darla S Holland, MD**, (left) is a primary care physician in Yorba Linda, CA and the physician advisor for the Practice Enhancement for Physicians Program. She is also a surveyor for the Institute of Medical Quality in California. E-mail: darla.s.holland@kp.org.  
**Darlene C Squires, M Sc, OD**, (right) has been an Organization Effectiveness consultant in KP Southern California for 11 years. E-mail: darlene.c.squires@kp.org.

care team who begin the patient's care experience—ie, at initial contact at the office visit.

### **Process Used by the OOPS Project**

A change effort of this magnitude required—and received—guidance from a multidisciplinary committee, the steering committee, chaired by a physician recognized as a leader by other physicians; by an administrative co-chair at the assistant medical group administrator level; and by an organizational effectiveness consultant whose function was to assist the group in managing change (Figure 1).

Because of the magnitude of the change effort and the natural divisions in the work to be carried out, four multidisciplinary teams were created to address specific aspects of the project: the Clinical Assistant/Team Leader Team, the Physical Layout Team, the Nurse Practitioner/Physician Assistant Team, and the Reception Team (Figure 1). Each team included a representative from each stakeholder group that would be involved in the change effort. Following the partnership model of the steering committee, each team was led jointly by a physician and an administrator at the assistant medical group administrator level.

The Clinical Assistant/Team Leader Team addressed issues of nursing consistency and skills competency and supported team agreements and relationships.

The Physical Layout Team devised guidelines for creating a professional appearance for all parts of office buildings visited by members (eg, waiting rooms, check-in stations, examination rooms, and procedure rooms). This team also developed strategies that would help physicians to decide what supplies would be stocked in examination

and procedure rooms and that would enable the staff to stock these supplies easily.

The Nurse Practitioner/Physician Assistant Team created tools to help Health Plan members to better understand the team care concept and to identify their care team. The team also devised both a set of templates and a process for creating work agreements for the teams. The process was designed to clarify the answers to such questions as who prescribes medication refills or handles patient messages when a clinician is away from the office.

The Reception Team worked to standardize appearance of the reception area and the forms used there and developed strategies to meet variable demand at check-in while avoiding long waits in lines.

The project was conducted in two phases: a design phase and an implementation phase. Although the membership of the design teams was different than membership of the implementation teams, some key members served during both phases, mainly to help ensure continuity. During the implementation phase, each team visited each medical office building sequentially to work with a building-based implementation team. Depending on the team product being implemented, the OOPS team conducting the implementation remained involved from start to finish at each building. The mean duration of this process was three months.

Early in the implementation process, teams discovered that the extensive amount of work required for implementing change at each location could not be done without using an explicit "roadmap" of tasks to be accomplished. Each team therefore developed "toolkits" containing templates and timelines for all tasks to be accomplished. This

degree of detailed instruction as well as periodic follow-up were necessary to ensure completion of the work.

### **Products Created by the Teams**

#### **Medical Assistant/Team Leader Team**

This team compiled a list of all skills necessary for each staff member of every clinical department. The team also established a process for training and monitoring staff competency in those skills. The team also established guidelines for ensuring that for every clinician, a primary medical assistant would be designated and that this support would be provided with an established level of consistency (ie, at least 80% of the time). The team created the "Provider Preference Guide," a tool for physicians, nurse practitioners, and physician assistants to clearly state their preferences for work-related items and procedures (eg, glove size, preparing patients presenting with certain problems, or whether the clinicians' mail would be opened for them.) Templates for agreements between medical assistants and their team leader were devised, and the role of each team leader was clarified. Suggested target ratios were established for the number of clinicians supported by each team leader, although we have found that these target ratios must be adjusted as processes of delivering care become progressively complex.

#### **Physical Layout Team**

This team created templates for planning specialty-based examination and procedure rooms. Each template consisted of a map taped inside the cabinet to list supplies located in the examination or procedure room. Supplies were orga-

nized in a series of blue plastic bins labeled with the item contained. Each bin was also labeled with a “par” value, a designation intended to assist the restocking process: Items used in high volume would be assigned a high par value, indicated that the items should be stocked in greater quantities.

The team also developed guidelines for ensuring a more professional appearance of examination rooms and nursing stations. For example, items taped to examination room walls were not permitted; instead, items were to be attached to bulletin boards or framed. The appearance of patient check-in stations also was addressed: All personal items were to be kept from members’ view by being located under a mat on the desktop. Items remaining in view were to have an uncluttered appearance.

#### **Nurse Practitioner/Physician Assistant Team**

This team facilitated development of care teams consisting of physicians, nurse practitioners, and physician assistants. The team also developed visibility tools (eg,

photographs) to be posted in examination rooms of all care team members supporting a given physician. This practice allowed the nurse practitioner or physician assistant assigned to work with a physician to be introduced to the patient at the time of a visit. In addition, agreements were made between physicians and their “practice partners” (nurse practitioner or physician assistant) about how to share the care of patients with chronic conditions (eg, diabetes). For example, the physician and his or her practice partner could each see the patient separately at alternate visits.

Another product created by the team was a template for formulating agreements about “who will cover for whom” with regard to obtaining and conveying test results, handling messages to and from patients, and prescribing medication refills when team members are away from the office. In addition, tools were created for clearly communicating these agreements.

#### **Reception Team**

This team examined the forms available and functions being per-

formed in reception areas. The team streamlined the number of forms that receptionists were required to handle and identified communication strategies for use with the “back office” team. The “lead receptionist” position was created so that the group would have a point person for communication about new tasks and systems as well as issues of importance to the team. This team also originated the concept of a “morning report” for each building: For this daily morning event, the staff “huddle” for a few minutes to communicate and plan the day’s work.

#### **Assessment of OOPS Project Progress**

Throughout the project period, the Steering Committee continually re-evaluated whether or not the issues being discussed were indeed the right issues and whether the changes being attempted were actually happening. Understanding that many things are required to support medical practices and that efforts at change may sometimes become secondary to the struggles of day-to-day operations, the Steering Committee used an audit process to maintain focus. Instead of merely asking, “Do you have agreements between providers about coverage?” each team audited certain key elements of their products. For example, an audit might instruct, “Show me the agreements that your team has made” or “Show me your exam room templates for the pediatricians in your building.” This audit was conducted at the conclusion of the implementation team’s efforts for a building. These audits were necessary to ensure consistent implementation across the medical service area. For the same reason, a semiannual audit process was developed to help teams to maintain focus on an ongoing basis.

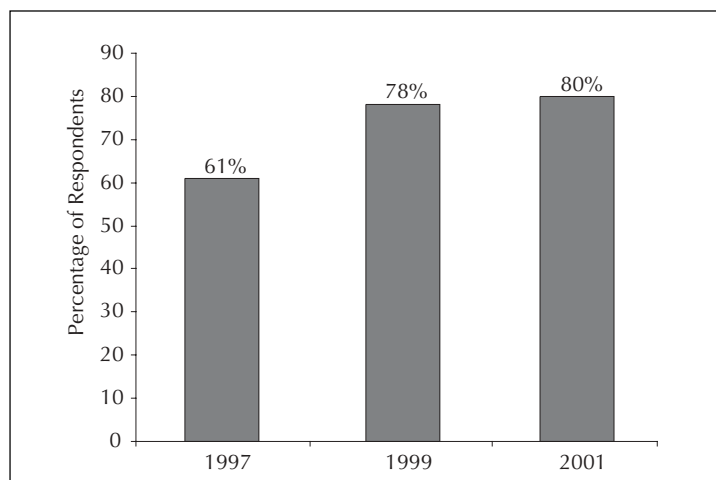


Figure 2. Graph shows results of question 11 on 2001 Physician Assessment of Support Service survey distributed to KP physicians in Orange County, California.

A survey also was developed for each group of care team members (physicians, nurse practitioners and physician assistants, team leader, medical assistants, receptionists, and department administrators) in each building. This survey was designed to examine all aspects of the team's products and to locate opportunities for further improvement.

### Results of Project Assessment

The results of this effort were measured in many ways. An OOPS audit and survey were done annually; the data from these instruments were used primarily to determine whether the planned work was actually done; whether the constituents of each building perceived these results as helpful; and whether need for improvement remained. Physicians' perceptions were measured by using relevant questions from the Physician Assessment of Support Services (PASS) study done semiannually by KP in Orange County (Figures 2,3).

The overall staff satisfaction was measured by the People Pulse study, which examines more than OOPS-related issues. In this employee survey, Orange County ranked first in Southern California for 20 of 28 indicators. Health Plan members' perceptions were inferred from the Meteor study and from the Ambulatory Satisfaction Questionnaire (ASQ) (Figure 4), two tools used in Orange County to measure satisfaction.

### Learning From the Project

A project of this size, scope, and length of time produced some key learnings:

- Visible support from senior leaders is essential. This support was embodied by the

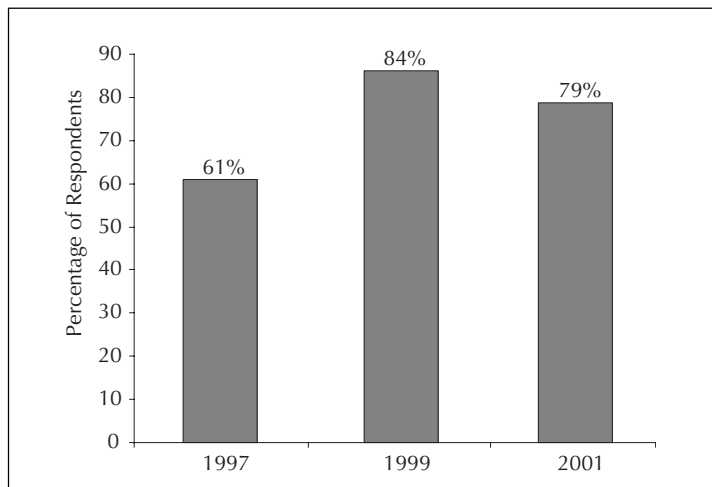


Figure 3. Graph shows results of question 13 on 2001 Physician Assessment of Support Service survey distributed to KP physicians in Orange County, California.

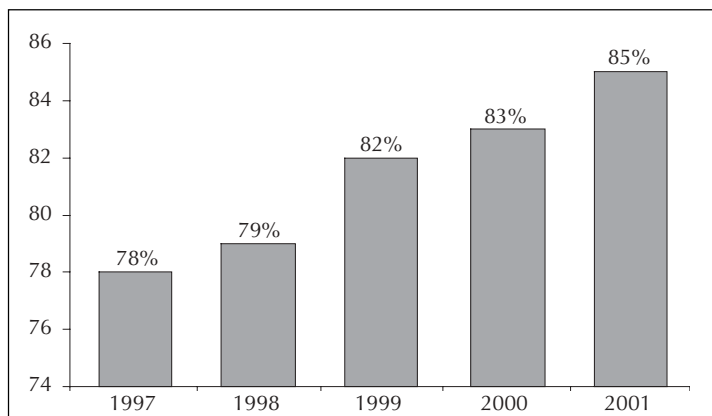


Figure 4. Graph of results of Ambulatory Satisfaction Questionnaire (ASQ) shows percentage of patient-respondents reporting "very high satisfaction" with their medical visit.

OOPS project being part of the strategic plan, by carefully allocating key people's time, and by intervening with regard to key issues to help project teams move forward.

- Physician leadership and involvement is critical. Physicians selected to lead teams were highly regarded by their peers. In addition, physicians served as team co-chairs and were involved in every aspect of implementing the project.
- Allow enough time to success-

fully anchor the changes. Resist attempts to set overly optimistic or unrealistic timelines.

- Make work easier for target groups. Create processed checklists and toolkits.
- Adapt, adjust, and revise as needed. Ask questions as they arise; listen to complaints and feedback; and change, adapt and revise operations as needed. Use learnings gleaned from each site to implement and adapt products according to the unique needs of each

**The magnitude of change contemplated by the OOPS project required enormous planning, resources, and commitment on the part of everyone ...**

department and location.

- Communicate, communicate, communicate! Keep changes on everyone's "radar screen." Share design data and reasons for each change. Focus positively on the need for change and on the ways this change will improve the workplace for everyone.
- Actively manage all aspects of the process. Regularly update the leadership and obtain help from all available sources.
- Observe and integrate the success of others. Showcase and use best practices and novel ideas regardless of their origin.
- Create accountability within operations. Ensure that accountability is part of everyone's role and is clearly stated to be a performance expectation.
- Celebrate success. Reward progress and celebrate small milestones. Because the process is long, maintaining the team's enthusiasm is essential. Create an overall award to be given annually for the highest-achieving locations.

## Conclusions

The magnitude of change contemplated by the OOPS project required enormous planning, resources, and commitment on the part of everyone who worked at KP in Orange County. As often occurs when staff implement efforts to change daily operations, projects begun with much energy are later found to require tools for maintaining processes of change as well as for refocusing efforts. These mechanisms are needed to ensure that all change takes root in the organization and accommodate the continuous, rapid evolution of health care delivery systems—in particular, the electronic medical record. Thus, the need to reassess continuously the basic assumptions and workflow analyses used to design office support systems forms the basis for the OOPS project, whose work is continuing. ❖

## Acknowledgments

We would like to acknowledge the following individuals for their contributions to this project: Edward Ellison, MD, Orange County Area Associate Medical

Director (2002 through present) Kenneth Bell, MD, Orange County Area Associate Medical Director through 2001; Judy White, MBA, Medical Group Administrator, Orange County Medical Center; Gerald McCall, Senior Vice President and Service Area Manager, Kaiser Foundation Hospital, Anaheim (January 1988 through November 1998); Janice L Head, RN, FACHE, Senior Vice President and Service Area Manager, Kaiser Foundation Hospital, Anaheim (November 1998 through May 2002); Julie Miller-Phipps, MSHA, Senior Vice President and Service Area Manager, Kaiser Foundation Hospital, Anaheim; Diem H Do, MBA, Optimal Office Practice Systems (OOPS) Project Manager (2000 through present); Sharon Hobson, RN, OOPS Project Manager (inception through 2000); Monica Mehren, MD, OOPS Physician Chair (inception through 1998); Peggy Grau, MD, and Judith Malouf, RN, MSA, Medical Assistants/Team Leaders; Sam Constantini, MD, and Priscilla Daniel, RN, Nurse Practitioner/Physician Assistant Team Leaders; David Cordes, MD, and Jeff Hunter, Physical Layout Team Leaders; Brenda Steffensen, MD, and Arlene Lundy, Reception Team Leaders; Debra Freedman, MA, Organizational Research; Maggie H Pierce, RN, and Tam Minh Chung, MD, Leaders Educare Team. Virginia Fitz provided administrative and graphics support; and Juan Domingo, Department of Medical Editing, provided graphics assistance.

## Enabling Others to Act

A leader who *Enables Others to Act* is someone who includes others in the planning; treats others with respect; supports decisions of others; fosters cooperative relationships; provides freedom and choice and/or lets others lead.

*The Leadership Challenge, J Kouzes and B Posner, Jossey-Bass.*