Luther/Midelfort Mayo Health System is part of the Mayo Foundation and is a Wisconsin regional system of three hospitals, 11 outpatient facilities, 160 physicians, and 2,000 staff.

Poor patient access to clinical offices has been a chronic problem. Despite high levels of frustration and a sense that improvement must be possible, most clinicians and office leaders either did not know what to change or were hesitant to make changes. The difficulty in implementing a change was seen as more burdensome than maintaining the status quo.

Senior leaders at Luther/Midelfort joined the IHI ID-COP initiative because they believed that such a redesign would not only benefit patients and the system as a whole, but would also help clinicians and office staff. Most clinicians were hesitant, if not outright resistant.

Early work focused on office access and efficiency. Collective wisdom suggested that better clinical care and financial outcomes would be achieved if we could help physicians and staff improve their efficiency and productivity. We were convinced that such changes would thrill clinicians and staff by addressing the chronic “out-of-control” feeling and helping them get out of the office on time each day.

Doctor’s lounge conversation generated heated discussion. While the changes promised significant benefits in several months, it was clear that it would take real work to get there. Most were not interested. However, two physicians were interested in trying some of the changes. Both were from practices with difficult access and scheduling problems and had reached a “burnout” stage. One even stated, “the change cannot be any worse than what I have now.”

While the goal was to change the way the whole organization practices ambulatory care, we knew that the place to start was by focusing on a few sites. If success and advocacy by clinicians could be gained on a limited basis, and if the improvements were clearly advantageous, the spread of innovation would occur much more easily. Instead of trying to convince “resistant” clinicians, we wanted to create changes that were so attractive that they would volunteer to participate.

The early attractor was offering something different from a situation that seemed hopeless. With a minimum of planning and focusing on a few rules that physicians, receptionists, and patients could follow, changes in access and effi-
CONTINUED...

Imbedded in those practices—the advantages have been so powerful that sliding back into the old system is not possible. Both offices now keep about 60 percent of their appointment slots unbooked, releasing them only on that day. The plan is to increase this percentage even further so that every patient who requests a same-day appointment can get it. Neither would go back to the old system, in spite of some difficulties with the new model.

Word has spread about these two successes. The “resistors” are still saying that this will never work for them, but the demand from offices wanting to implement the changes now surpasses our ability to provide assistance. The attractors are so strong that the departments who want to try the new process are “wildcatting” (just doing it on their own). We need to slow the rate of acceptance of these new concepts so the support staff’s ability to handle the change is not outstripped. It is a nice problem to have.

ROGER RESAR, MD, is an internist and pulmonologist at

Acknowledgements

The authors wish to express thanks to each of the organizations in IHI’s IdealizedDesign of Clinical Office Practices initiative for their wonderful efforts in creating attractors for change. IdealizedDesign and IdealizedDesign of Clinical Office Practices are trademarks of the Institute for Healthcare Improvement.

References