Dartmouth Health

Mt. Ascutney Hospital and Health Center

August 5, 2022

Attn: Ms. Sarah Lindberg, Director
Green Mountain Care Board
89 Main Street, Third Floor, City Center
Montpelier, Vermont 05620

Re: Wait Times

Dear Ms. Lindberg,

This letter serves to respond to the wait time inquiry from the Green Mountain Care Board. The following charts address the primary requests relative to wait time at MAHHC:

3rd available appointment data (days)

Clinics	New Patient/Long Appointment	# Days	Follow Up/Short Appointment	# Days
Cardiology	10/18/2022	127	7/27/2022	44
Gastroenterology - NP	6/21/2022	8	6/20/2022	7
Gastroenterology - MD	7/7/2022	24	6/30/2022	17
General Surgery	7/7/2022	24	6/30/2022	17
Oncology	6/22/2022	9	6/15/2022	2
Ophthalmology	1/10/2023	211	6/28/2022	15
Optometry	7/7/2022	24	6/30/2022	17
Pain Medicine	10/10/2022	119	9/26/2022	105
Pediatrics	6/22/2022	9	6/24/2022	11
Podiatry	7/12/2022	29	7/8/2022	25
Primary Care	7/13/2022	30	6/15/2022	2
Psychiatry	8/2/2022	50	6/30/2022	17
Rheumatology	3/6/2023	266	1/3/2023	204
Urology	7/8/2022	25	7/6/2022	23
Neurology	7/14/2022	24	7/5/2022	15
Physiatry	6/24/2022	4	6/23/2022	3
	Average	**61**	**Average**	**33**
Radiology Modalities	**3rd Appt available**			
Routine X-ray	7/11/2022	3	N/A	N/A
Fluoroscopy	8/11/2022	14	N/A	N/A
CT	7/12/2022	4	N/A	N/A
Ultrasound	7/18/2022	10	N/A	N/A
Echocardiogram	8/30/2022	53	N/A	N/A
Bone Denosty	7/18/2022	10	N/A	N/A
Mammography Screening	7/13/2022	5	N/A	N/A
Mammography Diagnostic	7/19/2022	11	N/A	N/A
MRI	7/18/2022	10	N/A	N/A
	Average	**13**		

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Note that we provided data for all modalities in diagnostic imaging (radiology). If follow-up testing is required for diagnostic imaging, these would be considered urgent/emergent in most cases and would be scheduled and performed immediately in most cases.

Relative to the remaining questions:

- **How do you currently measure and benchmark wait times?**

  We do not routinely/systematically measure wait times.

- **What efforts is your organization making to improve wait times, particularly in areas where your organization records wait times longer than available benchmarks?**

  We are in a constant state of attempting to improve nearly all of these wait times. It should be noted that we are unable to improve these wait times without adding providers/increasing provider compliment, adding the required support staff, increasing operating costs and subsequently increasing our NPSR. Additionally, any increases to providers and staff in these areas would likely not be efficient. For example, in the areas where we "rent" a provider for a day a week from Dartmouth Health, it would be near impossible to contract for an additional 0.1 or 0.2 FTE of a provider, to hire an additional 0.1 or 0.2 FTE of a nurse or other support staffing. For a number of these specialties (Psychiatry, Ophthalmology, Rheumatology) we have been recruiting but have not been able to find or recruit additional providers and there is no surplus in the region for these specialties. Providers that we "rent" from DH are always subject to the needs of the tertiary/quaternary care center, which is generally appropriate.

- **What EHR system(s) does your organization use and how does that impact your ability to measure wait times?**

  Cerner Community Works is our EMR. It does not negatively impact our ability to measure wait times.

- **Please overview your clinic scheduling process, including centralized scheduling if applicable.**

  This varies by specialty, by clinic, and by provider. Overly complicated to describe but here are some of the guiding principles:
  - Clinics maintain limited schedule time daily for acute and urgent appointments.
  - Provider schedules include slots for preventative care, routine care, follow-up care, acute/same day, etc.
  - We have a provider dedicated every day for same day urgent needs. This reduces volumes in the ER and increases the efficiency of the clinic scheduling.
  - Patient who have urgent needs who cannot be scheduled with their provider of choice, are given the option of selecting another provider or location who can appropriately address their needs.

- Urgent/Emergent patients are prioritized to the extent possible. Referrals to the Emergency Room or to DH may happen as well based on our available providers, specialties, and patient need.
- Most clinics utilize support staff and mid-level providers to augment services and to improve access.
- Our primary care practices utilize CHT/BluePrint navigators and other staff to support the providers and to more effectively help patients receive what is needed as efficiently and quickly as possible.

We would be happy to discuss this in greater detail as needed, off-line.

• Please describe how referrals enter your system, and how staff triage, schedule and prevent the loss of those referrals.

Referrals are always received and managed based on the patient's condition and the availability of the service/provider needed. As with scheduling, there are varying protocols by specialty and this is far too complicated for this document. Internal referrals are tracked within our EMR and unresolved referrals/requests are managed daily at the department/clinic level. Incoming referrals, including self-referrals from patients, are addressed as they are received according to the protocols of the specialty. They are "converted" to electronic events for tracking within our EMR. Outstanding requests and referrals that have not been scheduled/resolved are managed within each clinic/department. Most of our scheduling turn-around is better than the region so we do not have significant leakage due to availability unless it is emergent.

Recommendations:

• What metrics (qualitative *and* quantitative) would you suggest using to track and report wait times? In your opinion, how should state regulators best account for and measure the intricacies (e.g., acuity, uniform reporting) of wait times?

This is a good start but staying consistent in the measurements over time will be important. To be honest, unless there is some give on NPSR growth and the expense structures to allow for the increase in operating expense to improve these measures, there is probably not a lot of value in the measurement. We do not typically have providers waiting for the next patient. As a small hospital, we are often one or two deep relative to provider staffing for a given specialty. A provider out on leave, reducing their hours, being pulled back to the DH system, or retiring creates a backlog very quickly.

Data

• Please submit a sample of recent anonymized patient feedback concerning wait times, if available. Please submit, if available, any aggregate reports based on patient satisfaction surveys regarding wait times produced by the hospital/health system.

As mentioned above, we do not systematically and consistently measure wait times as we have little or no opportunity to improve them. Clinic and ancillary managers review schedules on a daily basis and make adjustments as appropriate to incrementally improve scheduling efficiency. Accordingly, there are no ongoing data collected.

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Let us know if there are additional questions or concerns.

Sincerely,

David C. Sanville
C.F.O.