Online Scheduling: A Practice Management Boost

By Elizabeth Woodcock, MBA, FACMPE, CPC

Staffing has always been a challenge for medical practices, so practice management solutions that can convert manual work to automated are always welcome. Building an online scheduling platform for patients to self-serve may offer this opportunity but only if it is executed effectively. Consider these tactics to create a successful framework for your practice's online scheduling offering.

Prioritize real-time access. Your scheduling system is dynamic; at any moment in time, an appointment slot can fill – or open. Based on data from more than 100 health systems, nearly 40% of slots that are booked don't end up with the originally scheduled patient in them. That's no surprise, given the pace of our lives today. The fluidity of our schedule, therefore, necessitates that all booking operations must fire on a real-time basis. If a patient schedules an appointment by speaking with a staff member, that slot must be released from the inventory immediately. Your online scheduling system must function similarly; if it must be later worked by a person, it won't be as successful.

Watch the cancellations. Research has shown that cancellations rise with online scheduling. It's no wonder given consumers' 24/7 access to the scheduling platform. Consider that online scheduling is open for business 168 hours each week, compared to the roughly 45 business hours that your practice's phones are normally open. Cancellations must be immediately recognized in your system so that they can be converted to open slots. Consider integrating your online scheduling system with an automated waitlist, so that slot conversions can occur without friction. Although cancellations may rise with online scheduling, it's worth noting that research has proven that no-shows are lower.

Create a confirmation process. Appointment reminders improve patients' attendance, thereby reducing no-shows. Send out reminders for all appointment bookings, including self-scheduling. Because online scheduling often includes near-term appointments (e.g., the next day), consider confirming the appointment via a secure texting program as soon as the booking is complete. Then, move the confirmations into your "normal" workflow for appointment reminders, which is often three to five days out, and then the day before and/or morning of an appointment.

Untether the function. Many online scheduling solutions reside within the patient portal. Therefore, the option is limited to not only existing patients, but exclusively to those patients who have adopted the portal. Portal messages have risen substantially since the pandemic, adding to provider burnout. If your online scheduling system is tethered to your portal (e.g., "is this patient appropriate to schedule?"), you may be perpetuating the burnout problem. Furthermore, offering the solution outside of your portal opens the door to new patients – and may give you flexibility to extend the solution in a different language (if available from the vendor), as most portals are available only in the English language. Best practice is to have the function available to patients both inside *and* outside of the portal.

Open the offering. Consider which appointment slots you will offer via online scheduling: all new patients? Established patients for new problems or just existing ones? Etc. The more branches of the decision tree you create, however, the more "mistakes" will be made. You may have an idea of who constitutes the "right" patient for your practice, however, identifying the "right" patient may lead you on an elusive journey. Constructing a 53-point questionnaire for a patient who simply doesn't feel well will only frustrate the patient (yes, I have actually seen a 53-question self-scheduling system!) – and ultimately,

make your system unusable. Consider opening your offering widely, and then establish a brief triage or screening process to scrub the schedule two or three days out, if needed. Although you may have a few online-scheduling snafus, most consumers aren't trolling for random doctors' appointments needlessly. If you're really concerned about opening the inflow, limit your self-scheduling to controlled "offers." For example, send reservations with links to your self-scheduling system to established patients due for their follow-up visits, annual appointments, screening tests, and so forth. Be sure to work with your practice's attorney on messaging about emergency situations.

Market it. Review the opportunity to notify patients of the online scheduling solution. Train providers and staff to encourage patients to use it, add the function to your on-hold phone messaging, and make it prominent on your website to attract new patients.

Although online scheduling may offer some challenges for practices to deploy, it's increasingly becoming a necessity in the market. Convenience is the name of the game, and consumers are demanding it from the health care industry. Like many consumer-based offerings, once it becomes readily available in the market, we begin to assume that it exists. We check-in online for our flight, we use Venmo to pay our babysitter, we go online to buy a household product to be delivered to our doorstep, and we pump our own gas. Self-service is woven into our lives as consumers. Online scheduling no longer offers a competitive advantage; the solution is on the verge of becoming an expectation for medical practices. It's an opportune time to create or refine the blueprint for success for your practice.

Tips for Monitoring your Online Scheduling Solution

Consider these reports for your practice's online scheduling platform:

- Establish a process to identify and monitor where patients fall off the system (that is, when they are making an online appointment), and then discontinue the process. Work with your vendor to provide a weekly report for you.
- Create a report of the timing of self-scheduled appointments, when are patients using the system? This may help detractors if they see that patients are booking appointments at all hours of the day, particularly outside of business hours.
- Add a disposition section to your online scheduling system to monitor cancellations; if a patient cancels, prompt them to select a reason from a pre-set menu to explain their choice. Monitor these reasons for cancellations to determine opportunities, e.g., many patients canceling their appointment due to insurance acceptance may prompt you to review your lack of participation with that health plan.
- Report on the volume of appointments booked online and monitor efficacy: how many appointments were booked online and did those patients arrive in the booked slots? If not, why not? Measure slots that go unfilled (which may occur if they are cancelled at the last minute) and no-shows. Compare these outcomes to staff-generated bookings.
- Measure cancellations – and the portion of canceled slots that are subsequently

filled. This "cancellation conversion rate" should be 100% or as close as possible.

- Monitor the portion of your total appointment bookings that occur online, as compared to your schedulers and other staff (e.g., surgery schedulers who may book post-ops and staff at check-out who may book follow-up appointments).
- Track new patients who book online and keep their appointment. Report on their demographics (e.g., age, gender, and geographical location). These insights may guide your marketing efforts.

Risk Matters: Maximizing the Benefits and Recognizing the Risks of AI in Healthcare
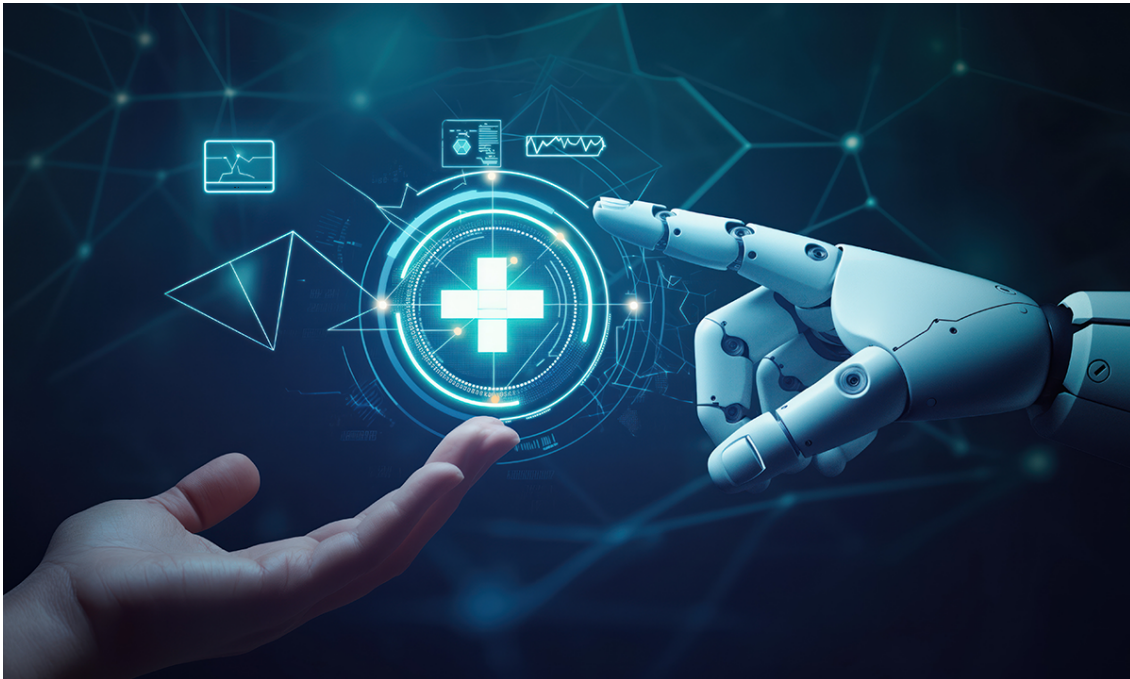
By Justin Joy, JD, CIPP

Various applications utilizing some form[1] of artificial intelligence ("AI") have been in place in healthcare for decades. The utility and utilization of AI have increased dramatically as the technology continues to develop and improve. A 2019 Harvard Business Review study estimated that AI applications for back-office activity save the industry $18 billion annually, noting that "activities that have nothing to do with patient care consume over half (51%) of a nurse's workload and nearly a fifth (16%) of physician activities." [2] With the dramatic improvement and availability of AI applications over the past half decade, such cost-saving estimates are likely more generous today.

Recent improvements in, and increased adoption of, generative artificial intelligence ("Gen AI") have reinvigorated imaginations on how AI can be leveraged to improve healthcare on

a wide scale. For example, prior to Gen AI, voice-to-text technology could automatically and instantly transcribe notes dictated by a provider. With the introduction of Gen AI, those voice recordings from a patient visit can be taken from unstructured text and adapted into a structured office visit note with conversational language.[3]

While categorically dividing AI healthcare applications into two likely-overbroad categories of clinical and administrative may be helpful for discussion and comprehension purposes, clinicians utilizing any AI application must be aware of the risk no matter how the technology is used. The risks of employing AI in any clinical application, such as assisting with diagnoses, should be evident on the surface. The challenge-which is well beyond the scope of this article-is to mitigate that risk in a meaningful way while not significantly diminishing the recognized efficiencies and other benefits of utilizing the technology for clinical purposes.

While not as obvious, the risks for administrative tasks should not be underestimated. Particularly with the increasing use of Gen AI, the benefit of the technology in quickly providing customized material unique to each patient, such as after-visit summaries specifically addressing points discussed during the visit, must be weighed against the possibility of error in that output upon which a patient may rely. Similarly, with the increased availability of AI technology for improving remote monitoring,[4] unchecked reliance on the technology could potentially lead to adverse results. Privacy and security concerns must also be addressed. For example, ambient clinical intelligence is a technology that "listens to" a conversation between a provider and patient and then automatically creates a clinical note based on the encounter. Those using the technology must understand if and whether any audio recording is maintained, and the security of the information collected during the visit utilized to generate the note.

Risk management resources continue to develop with the continued commercial proliferation and adoption of AI systems and applications. The National Institute of Standards and Technology (NIST) released the first version of the AI Risk Management Framework in January 2023 with the goal "to improve the ability to incorporate trustworthiness considerations into the design, development, use, and evaluation of AI products, services, and systems."[5] For organizations seeking adoption of a management system standard to structure how they address "the unique challenges AI poses, such as ethical considerations, transparency, and continuous learning," the International Organization for Standardization released ISO/IEC 42001:2023 in December 2023 to provide "a structured way to manage risks and opportunities associated with AI, [while] balancing innovation with governance."[6] While comprehensive and innovative, recognized organizational standards and frameworks consider the entire AI development lifecycle. A considerably more straightforward and focused approach can be followed for a medical practice seeking to find a starting place to address its AI risk.

Medical practices must first understand and identify where AI is used anywhere within the organization, including software or systems provided by outside vendors. Next, groups should identify any output created by AI or, relatedly, any data derived from AI processing.

Given that AI may be embedded into applications and not always apparent at the surface, IT staff or others familiar with the practice's software and systems should be involved in this identification process. Once AI applications and systems have been identified, the risk posed by the output or AI data should be assessed, with any application assisting in rendering medical diagnosis or judgments generally weighted as a potentially higher risk than AI processes geared toward administrative tasks. The assessment process should challenge how AI outputs are validated and how automation bias is mitigated. In other words, just because the process seems correct nine times in a row, that alone does not justify a presumption, without some check or control, that it will be correct the tenth time. Similarly, quality checks comparable to human-generated output should be utilized for administrative tasks. For example, just like human-transcribed dictation should be proofread for errors, text generated by an AI application should be subject to the same review process.

While AI in healthcare offers tremendous potential for improving patient care and operational efficiency, healthcare organizations must recognize and proactively manage the associated risks.

[1]. For an overview of certain types of AI-machine learning, natural language processing, rule- based expert systems, physical robots, and robotic process automation-relevant to healthcare applications, see Thomas Davenport and Ravi Kalakota, "The potential for artificial intelligence in healthcare," Future Healthcare Journal, Vol. 6, No. 2:94-98 (2019). Of course, as the technology continues to develop, new variations and combinations of AI are introduced.

[2]. Brian Kalis, Matt Collier, and Richard Fu, "10 Promising AI Applications in Health Care," Harvard Business Review (May 10, 2018).

[3]. Shashank Bhasker, Damien Bruce, Jessica Lamb, and George Stein, "Tackling healthcare's biggest burdens with generative AI," McKinsey & Company (July 10, 2023), available at ***********.mckinsey.com/industries/healthcare/our-insights/tackling-healthcares-biggest- burdens-with-generative-ai.

[4]. Shannon Flynn, "10 top artificial intelligence (AI) applications in healthcare," VentureBeat (Sept. 30, 2022), available at ********venturebeat.com/ai/10-top-artificial-intelligence-ai- applications-in-healthcare/.

[5]. ***********.nist.gov/itl/ai-risk-management-framework

[6]. *********** .iso.org/standard/81230.html

Medical Malpractice Litigation: The Long and Winding Road

By Matthew Bauer, JD

The Beatles wrote a song entitled "The Long and Winding Road." While it is doubtful the Beatles were talking about medical malpractice litigation, defendant health care providers are certainly justified in feeling as if their medical malpractice cases are long and winding roads, especially given the fact that over the course of its nearly fifty-year history SVMIC has defended multiple cases that were pending for more than a decade before finally concluding with a jury trial. Fortunately, there have been many cases defended by SVMIC that were dismissed in a relatively short period of time at various points during the litigation and for various reasons, as demonstrated by the two closed claims discussed below.

In some medical malpractice lawsuits, the plaintiff's attorney simply sues all the health care providers identified in the patient's medical chart, or they sue a health care provider due to mistaken identity. In these situations, the defendant health care provider will likely be dismissed from the lawsuit after facts are developed during discovery that show the health care provider is an improperly named defendant, as demonstrated by our first

closed claim. The four-year-old male patient underwent a brain MRI under general anesthesia due to seizure-like activity. During the MRI, the minor patient decompensated, coded, and died after unsuccessful resuscitation efforts. The plaintiff filed a medical malpractice lawsuit against the anesthesiologist, CRNA Jane, CRNA John, the anesthesiology group, the MRI tech, the radiology group, and the hospital alleging the defendants breached the standard of care (SOC) by improperly administering anesthesia, by untimely responding to the minor patient's decompensation and code, and by improperly performing resuscitation efforts resulting in death.

In this lawsuit, CRNA John and the radiology group were improperly named defendants, which became clear as the facts developed during the litigation discovery process. First, CRNA John was listed on the hospital's MRI room assignment sheet, which appeared to be why the plaintiff's attorney named him as a defendant to the lawsuit. However, CRNA John did not administer anesthesia, monitor the minor patient, participate in the code and resuscitation efforts, or otherwise treat the minor patient. At his deposition, CRNA John testified he was not involved in the care and treatment of the minor patient. Additionally, CRNA John was able to explain that he was assigned to the MRI room after the minor patient coded because CRNA Jane had left the MRI room to participate in the resuscitation efforts. After these facts were developed during the discovery process, the plaintiff's attorney dismissed CRNA John because he never treated the minor patient, and he was therefore not a properly named defendant.

Second, the radiology group was named as a defendant to the lawsuit because the plaintiff alleged the radiology group was vicariously liable for the acts and/or omissions of its employee (the MRI tech) under the legal doctrine of *respondeat superior* ("let the master answer"). However, at her deposition, the MRI tech testified she was an employee of the hospital, not an employee of the radiology group. Additionally, the radiology group submitted an affidavit from a corporate officer confirming the MRI tech was not an employee of the radiology group. After these facts were developed during the litigation discovery process, the plaintiff's attorney dismissed the radiology group because the MRI tech was not its employee, and the radiology group was therefore not a properly named defendant.

Sometimes in medical malpractice lawsuits, the plaintiff's expert proof does not come in as expected during discovery, and the plaintiff does not have sufficient expert proof to maintain his/her medical malpractice claim against some or all of the defendant health care providers, as demonstrated by our next closed claim. The fifty-year-old female patient underwent CT-guided percutaneous needle aspiration of her thoracic paravertebral abscess. Radiologist Dr. Farmer read the patient's post-procedure imaging and did not note any retained foreign body. The patient subsequently presented to the ER with chest pain secondary to a migrated needle fragment shown on additional chest imaging, and the patient underwent thoracotomy to remove the retained foreign body. The plaintiff filed suit alleging Dr. Farmer breached the SOC by failing to recognize a retained foreign body (needle fragment) on the patient's post-procedure imaging causing chest pain and infection and necessitating thoracic surgery. During litigation, the plaintiff's attorney

disclosed one SOC expert (Dr. Smith) to testify against Dr. Farmer.

"In medical malpractice actions, Tennessee adheres to a locality rule for expert medical witnesses. Claimants are required by statute to prove by expert testimony the recognized standard of acceptable professional practice in the community where the defendant medical provider practices or a similar community." Shipley v. Williams, 350 S.W.3d 527, 532 (Tenn. 2011). During his deposition, the plaintiff's expert, Dr. Smith, failed to establish that he had knowledge of the SOC for the community in which Dr. Farmer practiced or for a similar community. Consequently, the defense attorney for Dr. Farmer filed a Motion to Exclude Dr. Smith's opinions because he was not qualified to offer standard of care opinions in the case secondary to the locality rule. Since the expert proof did not come in as expected, the plaintiff's attorney was forced to dismiss the lawsuit against Dr. Farmer.

While it is a terrible feeling to be sued for medical malpractice, SVMIC policyholders can rest assured that regardless of whether the course of their medical malpractice case is long and winding, or short and straightforward, SVMIC will be with them each step of the way ensuring their interests are protected.

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