

## How do you increase capacity when you're already at 100%?

Process maps are traditionally associated with manufacturing. It's a pictorial depiction of the steps in the assembly line. But process maps can be very valuable outside the manufacturing environment too. By laying out the steps in any operation, we can identify duplication and wasted steps. Look for steps that have inputs but no outputs for example. But the simple process map can be made much more powerful with the addition of a few enhancements. Adding the cost and time for each step, along with the value it adds to the final outcome turns it into the so-called Value Stream Map. Now you can look for non-value adding steps and consider how they can be eliminated. With a little creativity, the Value Stream Map can be applied almost anywhere. Consider the following example:

A healthcare team was counselling patients on managing diabetes. Although the team was already handling more patients than other similar clinics in the field, they were capacity limited. Wait times were increasing. Appointment calendars were full, and the healthcare practitioners were seeing patients back to back all day every day. They were feeling stressed.

Considerations of patient confidentiality meant that each patient had to be seen individually by a healthcare provider in a closed office. Appointments were time limited, and the feeling was that there was no room to move in that direction. A high rate of no-shows exacerbated the problem.

Some appointments were purely informational, and involved no disclosure of personal information or patient medical data. An attempt had been made to manage these through classroom sessions after a first assessment by the provider, with limited success.

As a first step, we mapped the process, using a variation on the Value Stream concept. Instead of using dollar value cost, we looked at the confidentiality requirement as a "cost". The classroom sessions had a high potential since the confidentiality requirement was low. However, it was inappropriate for some patients, necessitating an initial consultation with the practitioner to determine suitability first. The process map showed that the family doctor was already in a position to make this assessment, so they were asked to indicate this when making the referral. After an education program with the family doctors this became the norm and the initial consultation was avoided for most patients. Patients could now attend the next classroom session without an appointment, sometimes as early as the same day. Follow-up continued to be on an individual basis and there was no compromise in confidentiality.

Capacity of the team was increased 15% and wait times dropped from 8 weeks to 2. Over time, classes grew from an average of 20 to as many as 90 participants. Each additional patient in a classroom setting represented an hour of provider time freed up. The effect of no-shows was drastically reduced as it had little impact on the class overall. In addition, classes were scheduled at different times, including evenings, allowing for more convenience for patients and flexible work hours for providers. The classroom sessions were still unsuitable for some patients but these could be identified earlier in the process and continued to receive care through the traditional approach.

So what made this project successful when earlier attempts were not? A more detailed understanding of the process flow and the critical factors. By separating issues of confidentiality from those of scheduling the team was able to address both effectively.