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Advanced Access

The Family practice experience

Taming of the Queue VI
March 26, 2009

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Objectives:

- Principles of advanced access in primary care
- An approach to consistent quality clinical care in family practice
- Knowing your customers (panel) (Anatomy of a Family practice)

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What is the problem?

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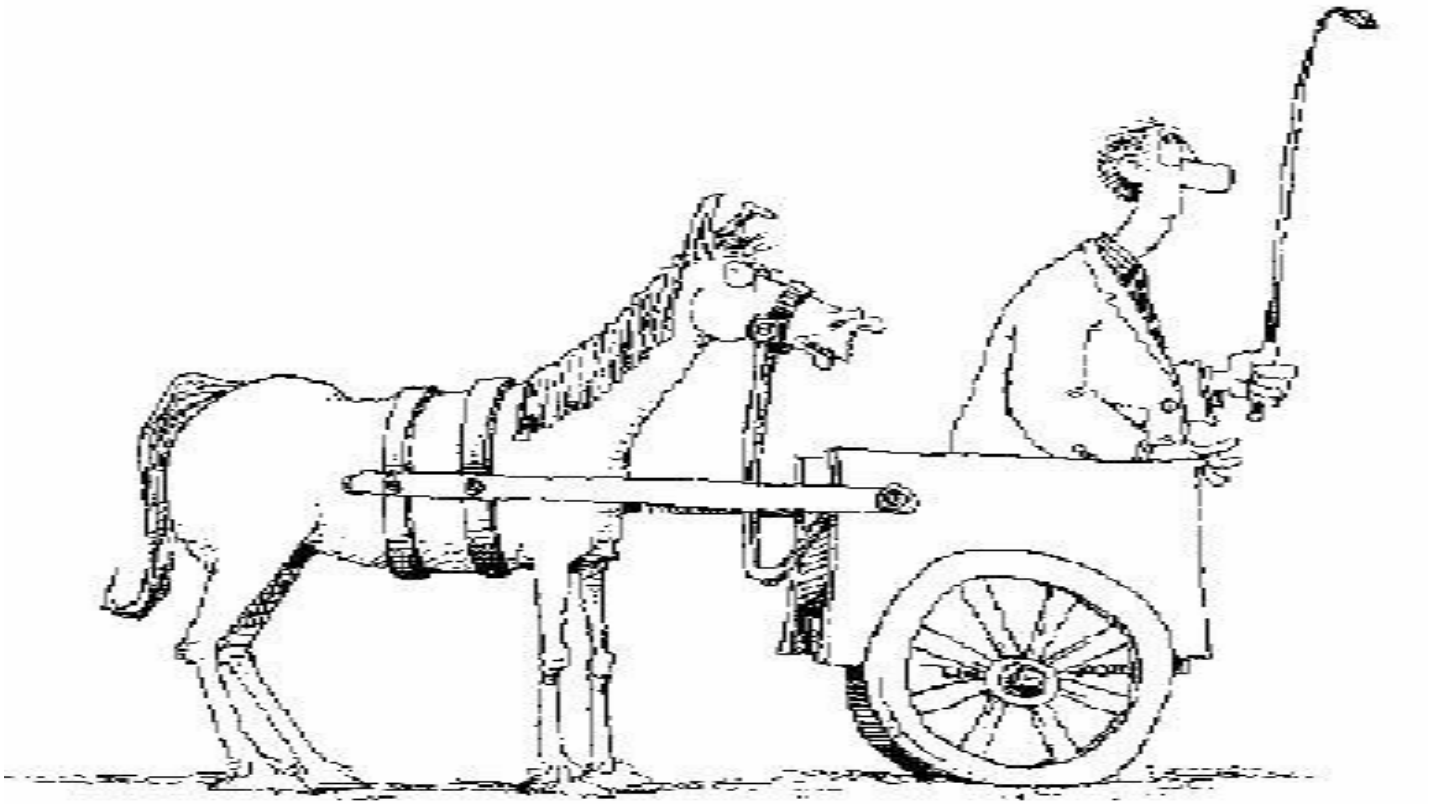
Common approach to reform



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Principles of advanced access and clinical practice redesign

- Toyota and Airlines principles
- Matching demand and supply
- Eliminate delays or waits
- Provider continuity
- Elimination of the “warehouse” (backlog)
- Doing “ today’s work today”
- Optimal work space set up

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Principles of advanced access and clinical practice redesign

- Analyzing and measuring for improvement (not judgment) as a continuous process (culture shift)
- Creating consistent quality in clinical care
- Streamlining the process

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Why same day access?

1. Things don't get worse and teens won't get pregnant…
2. Reduced hospitalization and ER visit rates
3. Happier patients, happier team
4. A smaller "list" of complaints
5. No need for triage!
6. Measured by 3rd next available appointment

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Why same provider?

- Less duplication
- Less time required for a visit
- People prefer to see “their own doctor / provider”
- Fewer tests needed
- Reduced hospitalization and ER visit rates
- Less cost to the system….

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The myth about waiting time:

- Waiting times are always a result of demand/supply mismatch
- Demand and supply is balanced if the waiting time is static
- A backlog of waiting patients is due to limited resources
- A steady backlog can be cleaned up and eliminated (process improvement)
- A waitlist secures future income
- There is enough work out there. Really!

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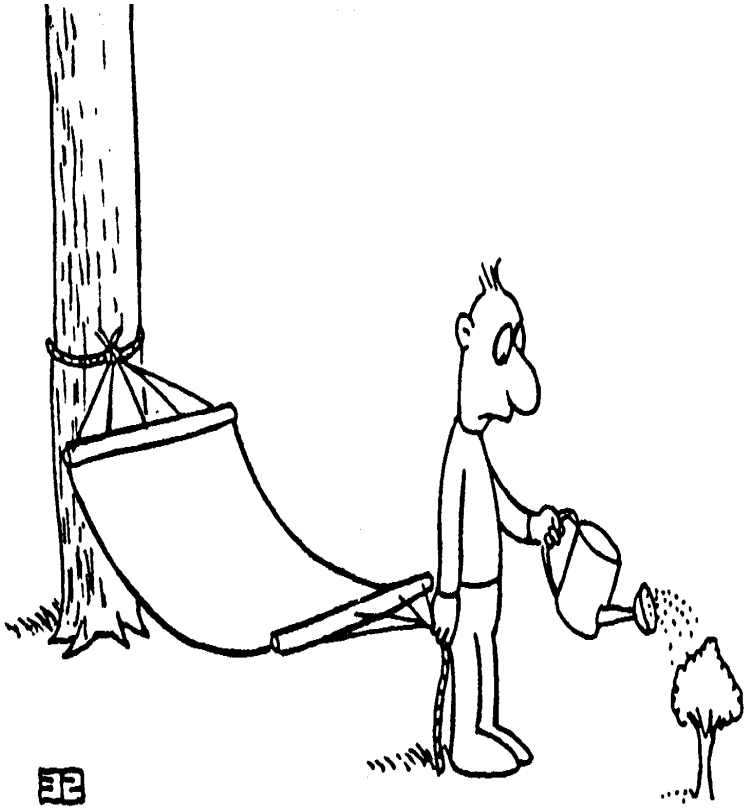
So, What is the objective?

- Sleeping better …knowing that everyone is well looked after
- Defining and distributing work load
- Maintaining sanity
- Economic viability (bottom line)



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Assumptions for Family practice

- The family doctor and his/her team are the " quarterback" for access into the healthcare system (Medical home concept)
- A strong relationship with the family doctor and his/her team is of high value for patients
- A well functioning team does not undermine the doctor-patient relationship
- There is a lot of work that is better done by health care professionals other then doctors

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Why is it important to know the patient panel?

- Define workload for MD and the team (demand)
- Define need for resources (supply)
- Define the work needed to meet objectives for CDM and preventative care for all patients
- Assign responsibilities
- Opportunity to report on deliverables

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So, how are we doing things now?

- The doc does it all…….
- Never run out of work (Warehouse guarantees work)
- Hire no help because (Billings – overhead = income)
- The GP has become a well trained clerk

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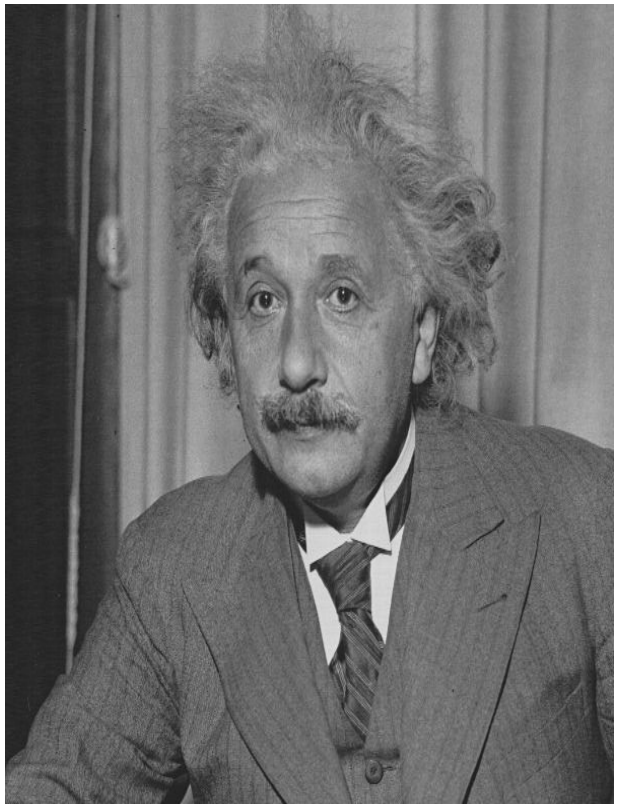
Changing Our Thinking

"*Insanity is doing things the way we've always done them, and expecting different results.*"



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The old approach to Family Practice

- Patient initiates most encounters
- Nothing happens without office visits (in Fee for service)
- Omission of follow up and screening is seen as the "patient's problem"
- "You should have come in earlier….."

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Future expectations:

- Evidence based
- Diligence and performance
- EMR with patient access and follow up functionality
- Consistent screening and CDM
- Office visits, email, phone, group visits
- Doctors do “doctor’s work” only
- Support by a well functioning team
- Optimize capacity through improved efficiencies
- Patient self management

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So, what did we do in our office?

- Participate in Primary Care Improvement project (AIM)
- Started measurements (for improvement)
- Tackled backlog of patients
- Set Aims for clinical improvements
- Weekly Team meetings
- Designed a process for improvement.

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Measuring for Improvement

- Supply and Demand
- Cycle Time
- Delay = Third Next Available Appointment (TNA)
- No-show rate
- Provider continuity rate
- Mantra:

  “See your own, don’t make them wait”

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Practical Changes

- Uniform exam room set-up
- Flow mapping of clinic tasks
- Addition of a CDM nurse
- Decrease return visit rates
- Weekly team meetings and daily “huddles”

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How many patients can a practice handle ?

- Simple math:
- Total number of patients x return visits / year = # of available appointments per year
- Example:

  1500 patients x 5(return visit rate) = 7500 appointments / year

  = 34 patients / day (11 months worked)

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The old fashioned "check up"

- 25 years ago an easy task…
- Today = PHE +Screening+CDM+list of everything that hurts+psychosocial issues and time for bonding…..
- Many GPs limit number of check ups per day.
- 5000 patients, allow 4 "check ups" per day = 880 check ups (11 months) = a check up every 5.7 years

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The periodic health exam

- Scheduled as per evidence based activities
- Team members and IT schedules can do a lot
- Learn from the dentists……
- Can become a “regular” shorter appointment for Family Physician

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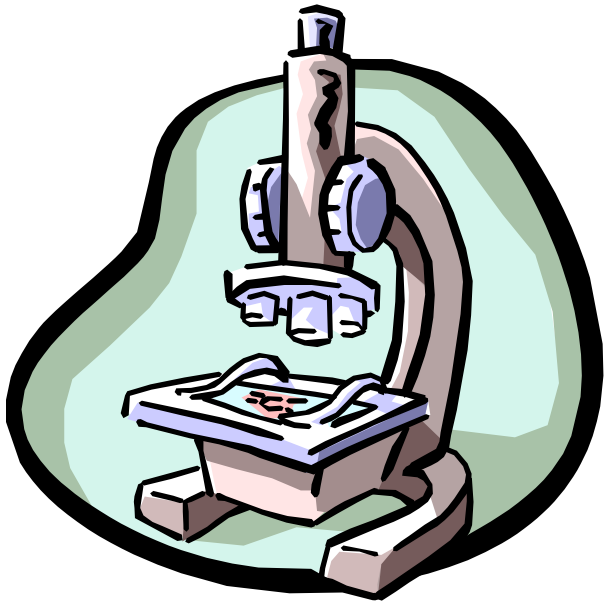
Anatomy Of An Urban Family Practice



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- Current Panel is 1388 Dec.31/2009
- Return Visit Rate is now 2.8 / patient / year
- was 4.5 two years prior
- Need 3886 appointments per year
- Needed 6246 appointments in 2007

- Max pack appointments, reduce unnecessary recall, longer Rx intervals, team follow up

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Gender and Age

- 56% males
- 44% females
- 31% age 60 +
- (51% age over 50)
- 37% age 40 – 59
- 15% age 20 – 39
- 17% age under 20

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Patients with chronic conditions

- 29% hypertension
- 9 % diabetes (31% female, 69% male)
- 15% type 1, 63% type 2, 22% IFG
- 68% HBA1C <7.0
- 17% HBA1C 7.1 – 8.0
- 16% HBA1C >8.0
- 23 % dyslipidimia 36% female, 64% male

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Patient panel analysis 2007

- 73% of panel visited office in 2007
- 91% of those had a check up in 2007
- 52% of female over 40 had mammogram in 2007
- 35% of panel over 50 had FOB done

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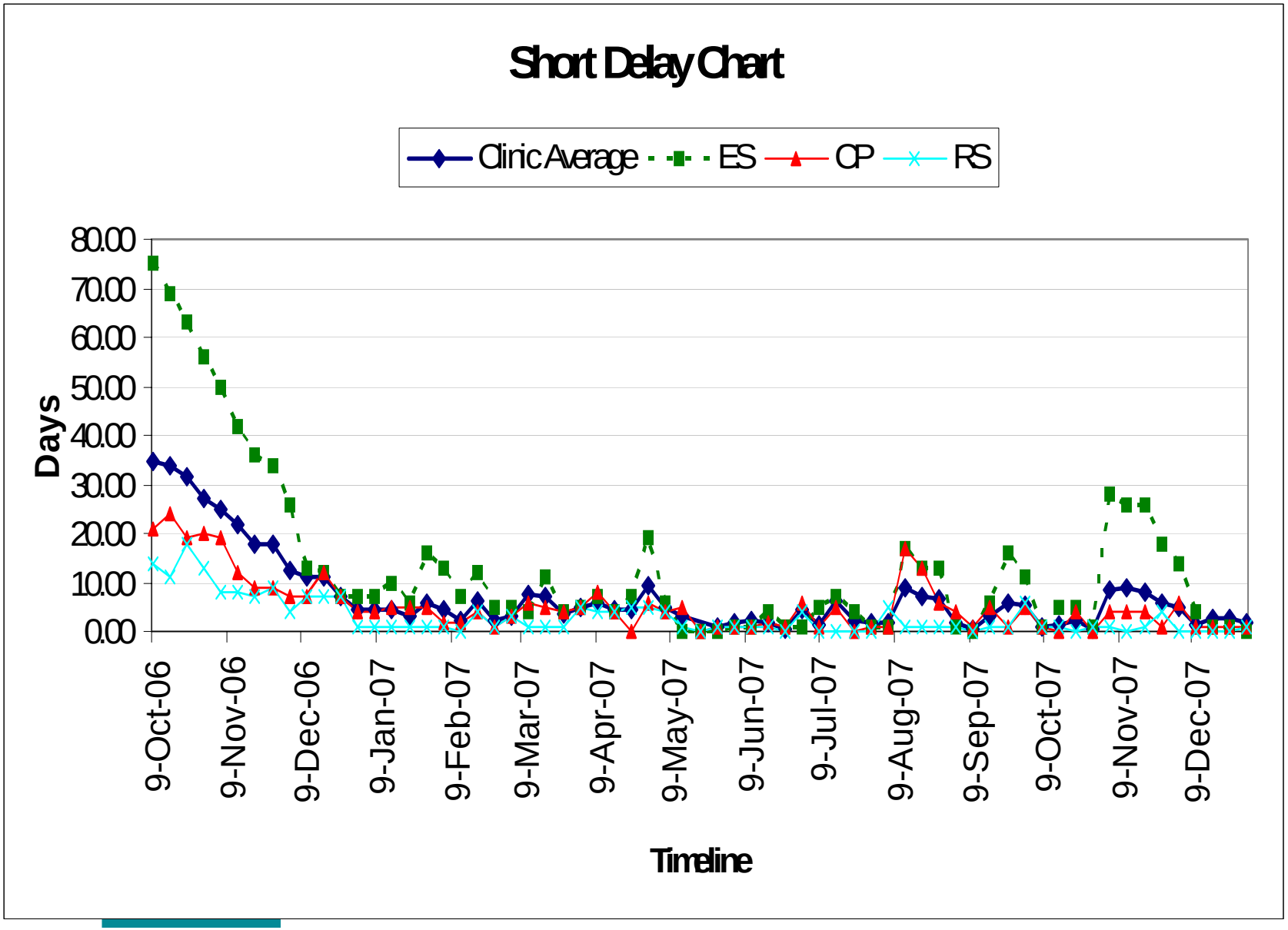

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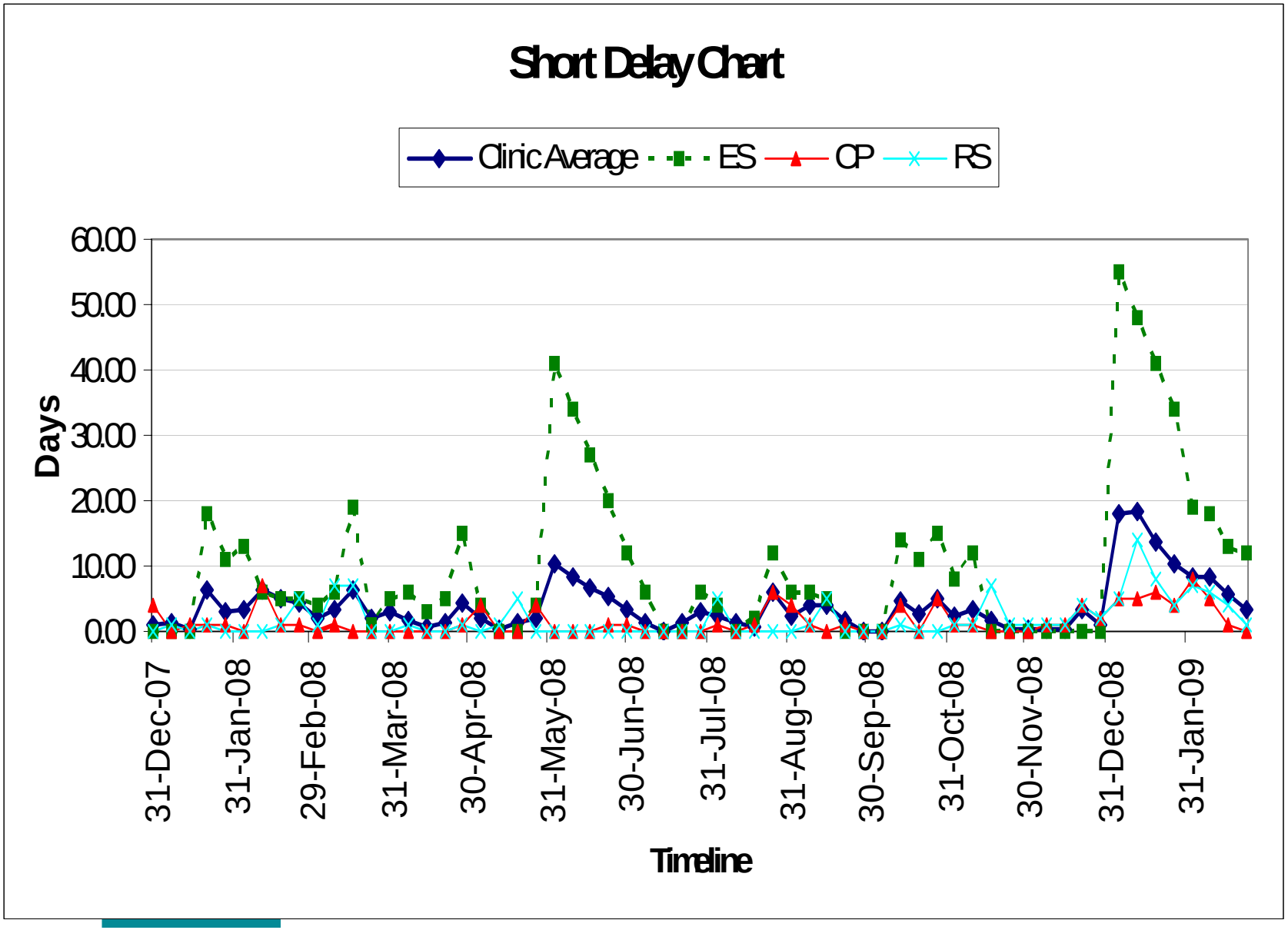

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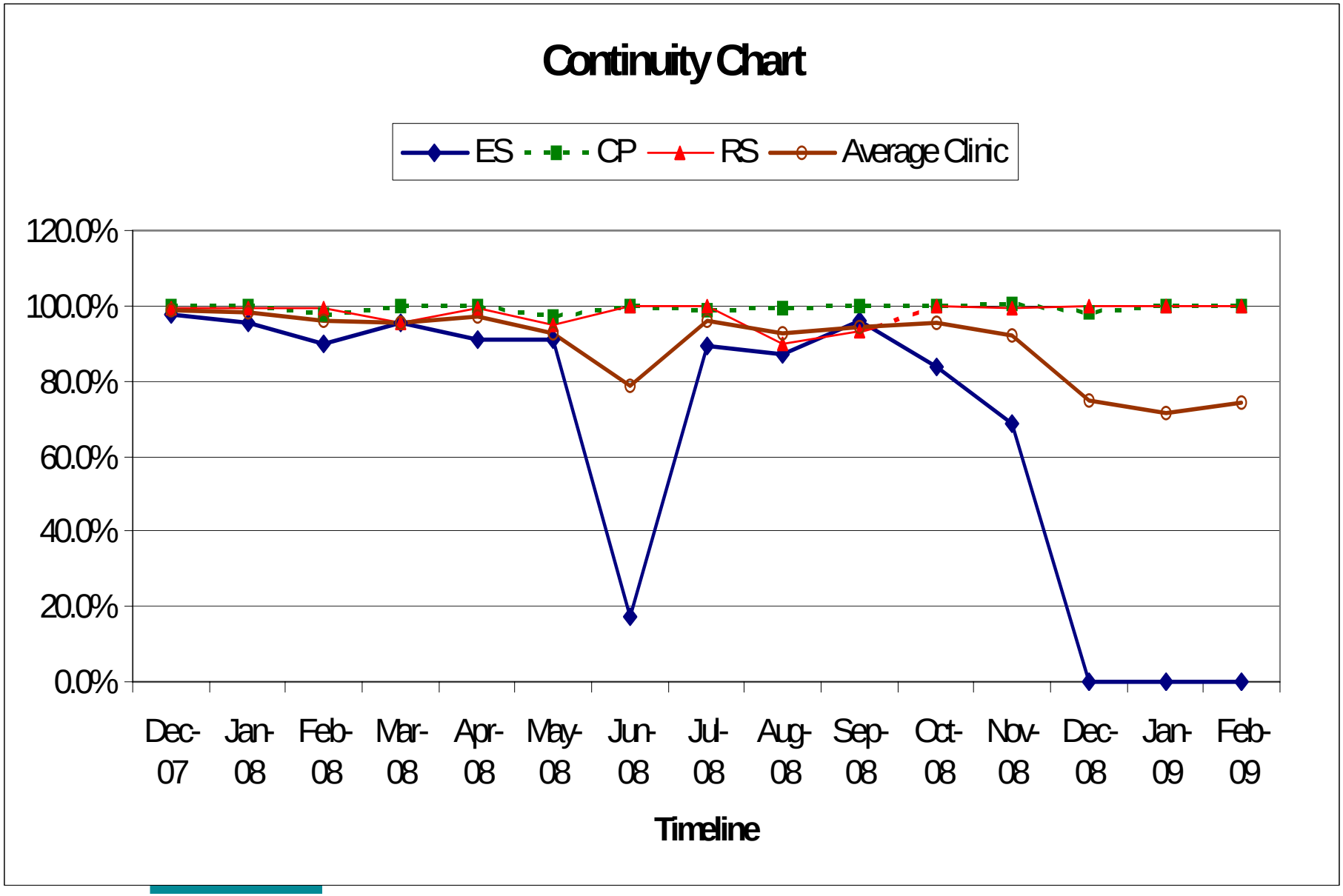

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No Show Average

January 01, 2007 to December 31, 2007

	Total No Show	Total Patients	No Show Rate
CP	317	4,249	7.5%
ES	204	4,048	5.0%
JR	56	1,716	3.3%
RS	343	5,179	6.6%
Clinic Average			6.1%

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No Show Average

January 01, 2008 to December 31, 2008

	Total No Show	Total Patients	No Show Rate
CP	141	3,737	3.8%
ES	96	2,818	3.4%
JR	36	1,374	2.6%
RS	211	4,254	5.0%
Clinic Average			4.0%

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Cycle time (Pt. Roomed-checkout)

Results for the period January 01, 2008 to December 31, 2008

Appointment Type: Long

Provider	Time in Minutes
CP	27.7
ES	28.2
JR	27.8
RS	20.6
Average for Long Appointment types	26.3

Appointment Type: Short

Provider	Physician	Time in Mins
CP		23.5
ES		25.5
JR		19.4
RS		16.1
Average for Short Appointment types		21.1

Summary Dr. Schuster's Clinic) 21.9

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Challenges :

- Engaging staff and other physician colleagues in improvement process
- Explanations to patients (no waits does not mean you got a“lousy doctor”)
- Limited professional FTEs to support MD
- Need modified clinic design (infrastructure)

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How AIM is taught

- Currently – “collaborative” model
- 12 – 14 month process
- Six 2-day learning sessions
- Monthly reports and teleconference
- Weekly or biweekly team meetings

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Alberta Experience

This improvement initiative first started in Chinook in November, 2005 – has since spread throughout the province.

6 Collaboratives are Complete
4 Collaboratives are in Progress

These 10 collaboratives represent approximately 495 family physicians and 205 specialists in 124 clinics/programs.

3 more collaboratives are scheduled for spring/fall 2009; with 2 more in winter 2009.

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Quantity vs. Quality of care in Family practice

- "Every Canadian should have a Family doctor"

- "Every Canadian should have a Family doctor who has the capacity to provide consistent excellent care"