Improving Access Breakout

Breakout A3

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Objectives

- Reflect on approaches to improve access
  - You will understand Access as a system with levers you can adjust
- Reconnect you to the Change Plan
  - You will better understand the change plan drivers
- Provide some examples of strategies to influence access
  - Tools and approaches others have used successfully
- Dialogue on Access
  - You will have an opportunity to ask questions and get connected to more information

Agenda

- What do we mean by “Access?”
- Why is it important?
- Levers to improve access
- Dialogue

The What and the Why

- Access to health services means "the timely use of personal health services to achieve the best health outcomes.“- Institute of Medicine

- The Why:
  - Access results in improved outcomes.
    - Starfield B, Macinko J. Contribution of primary care to health systems and health. Milbank Q. 2005;83:457-502.
    - Shi L. The impact of primary care: a focused review. Scientifica (Cairo). 2012;2012:22 p.
  - Access to Primary Care and Behavioral Health is a driver of utilization and cost.
    - Every primary care provider results in approximately $1.8M in hospital revenue.
    - Higher levels of physician-level continuity were strongly associated with lower total health care costs and hospitalizations, even among seriously ill patients, according to findings recently published in Annals of Family Medicine. Bazemore 2018 GWU.

Seeing the Impact of Access

Patient
Goes to MD
When
They are Sick

Patent Can't
Get Access

ER

40-60% Unnecessary

Delay in
Treatment

Self-
Treatment
$3B+

Hospital

40% Ambulatory
Sensitive Conditions

Payer

30% unnecessary
Referrals

Specialists

Strategies to Manage Medical
Loss Ratio:
Disease Management
Case Management
Complex Care Management
Nurse Advice Line
Wellness
Patient Incentives

Key concepts to keep in mind

- *Access to care involves a set of processes intertwined to form a system.*
- *"Every system is perfectly designed to achieve the results it achieves."* *Don Berwick and Paul Batalden- IHI*
- *Our systems have evolved based on an organization/provider centric focus and how we have traditionally been paid in health care. All the rules are changing.*
  - *Are we managing our system of Access?*
  - *Are we continuously improving our system of Access?*

Access Change Plan in the WPCC Portal

Levers- Change Concepts You Can Use to Influence Access

Empanelment

Balance Supply

Manage Demand

Optimize Work Flow

Optimize Care Team

Explore Start on Alternative Time
Visit Types
Types

Leverage

Technology

Ensure

Continuity

Advanced

Access

Reduce

Appointment

Schedule

Levers- Change Concepts You Can Use to Influence Access

Educate patients

Standardize Rooms

Do Today's Work Today

Contingency Planning

Co-locate Staff

Home Leverage Visits Payer Resources

Engage Patients in Redesign

Walk Through with the eyes of a patient

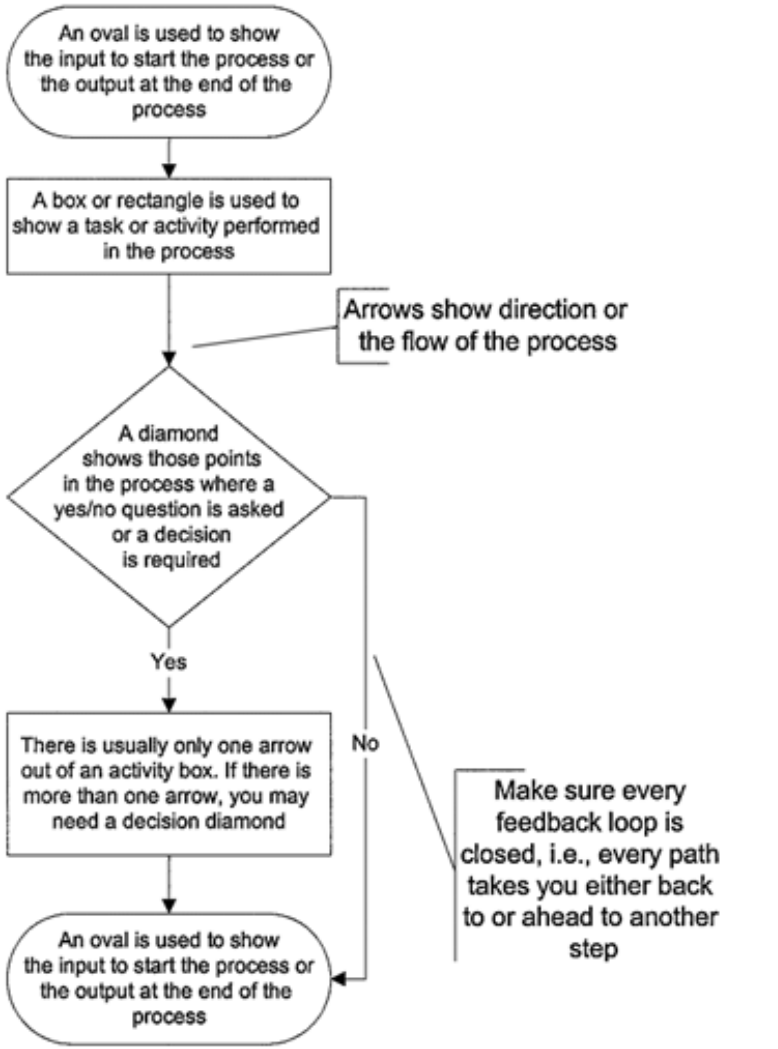
e-Prescribing

Optimize Ancillary Services

Tools to help you adapt improve access

- Process Mapping
- Swim Lane Diagram
- Five Rights Framework
- Clinical Microsystems Workbook

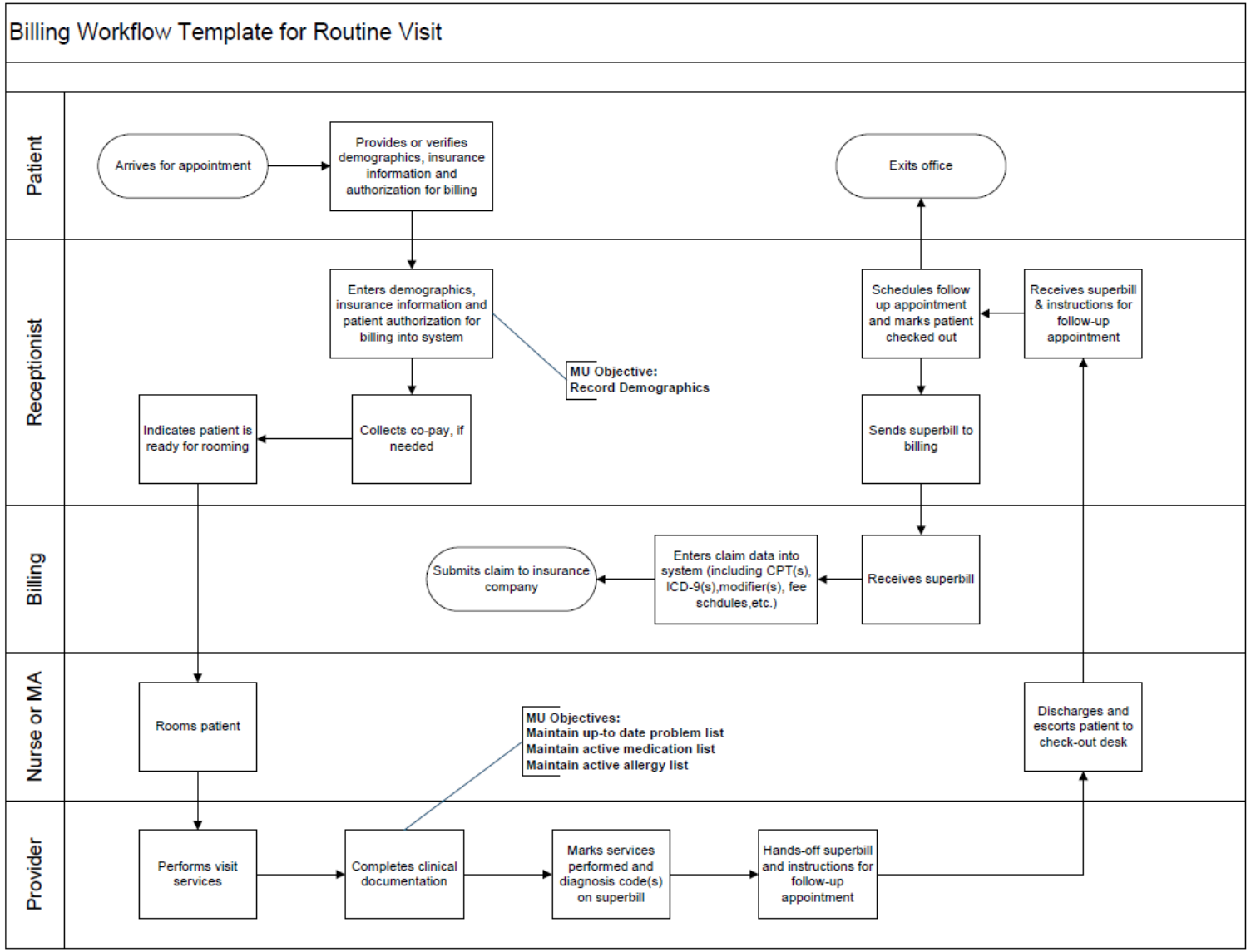
Process Mapping



Chris Ahoy, Associate Vice President
Facilities Planning & Management
Iowa State University

From *Facilities News*, September 1999

Swim Lane Process map



Aim: To maintain a comprehensive and accurate registry of our patients with Diabetes in order to perform appropriate and timely care.

Diabetes Registry Measures:	Average A1c % of patients have A1cs < 7%	% of patients with two A1cs in the last 12 months	% of patients with last BP < 130/80 % of patients with last LDL < 100	% of patients are current smokers	% of patients have an annual foot exam % of patients have an annual eye exam	% of patients with an annual self-management goal documented

	Actions					
Operations	Print off Diabetes registry and workflow the first Tuesday of every month.					
Front Desk	Review registry for last visit, blood pressure, eye exam, foot exam, lipids, and A1c.					
	Visit	**Blood Pressure**	**Eye Exam**	**Foot Exam**	**Lipids**	**A1c**
	If more than six months, make appointment. Otherwise, review Blood Pressure, Lipids and A1c for follow-up guidelines.	If blood pressure <130/80 use other risk factors to determine follow up needs. If BP Systolic is >130 or BP Dyastolic is >80 follow up at least every month.	Add patients without eye exam in the last 12 months to wait list for eye clinic. Contact patient when slot opens with date of clinic.	If no foot exam in the last 12 months, schedule an appoitment.	If LDL <100 use other risk factors to determine follow up needs. If LDL >100 but <130 follow up should be at least every three months. If LDL >130 follow up should be at least once a month.	If Hgb A1c > 9, follow up every month. If Hgb A1c >7 but <9 follow up should be at least every 3 months. If HgbA1c <7 follow up should be every three to six months
Case Manager	Review registry for risk stratification, tobacco, and self-management goal. **Note:** For patients who do not have information populated in the flowsheet, CM will open NextGen and determine if patient is actually a diabetes patient. Alert clinical team to patients on huddle report.					
	Tobacco	**Self-Management**	**Group Visits**			
	If current smoker, review for tobacco cessation counseling. Advise patient to quit at next contact.	Monitor patients on registry for annual goal. Responsible for connecting with patient to set goal when in for a visit.	Determine which patients/providers do groups. Coordinate DM group visits for pod by doing the following: • Determine provider availability • Denise's schedule availability • Coordinate with NTM on support staff availability • BHP schedule availability Call pts and schedule for DM GV as needed.			
Provider	Review the flowsheet every visit and enter any new data. Review registry for any patients for which there are concerns and patients who are MOGE. Provide information to CM.					
MA	Review the flowsheet every visit and enter any new data. Responsible for patients on registry who are in for visit today.					
Nurse	Reviews copy of registry given by CM to ensure all follow-up has been completed and is accurate.					

Source: Clinica Campesina, Lafayette Colorado

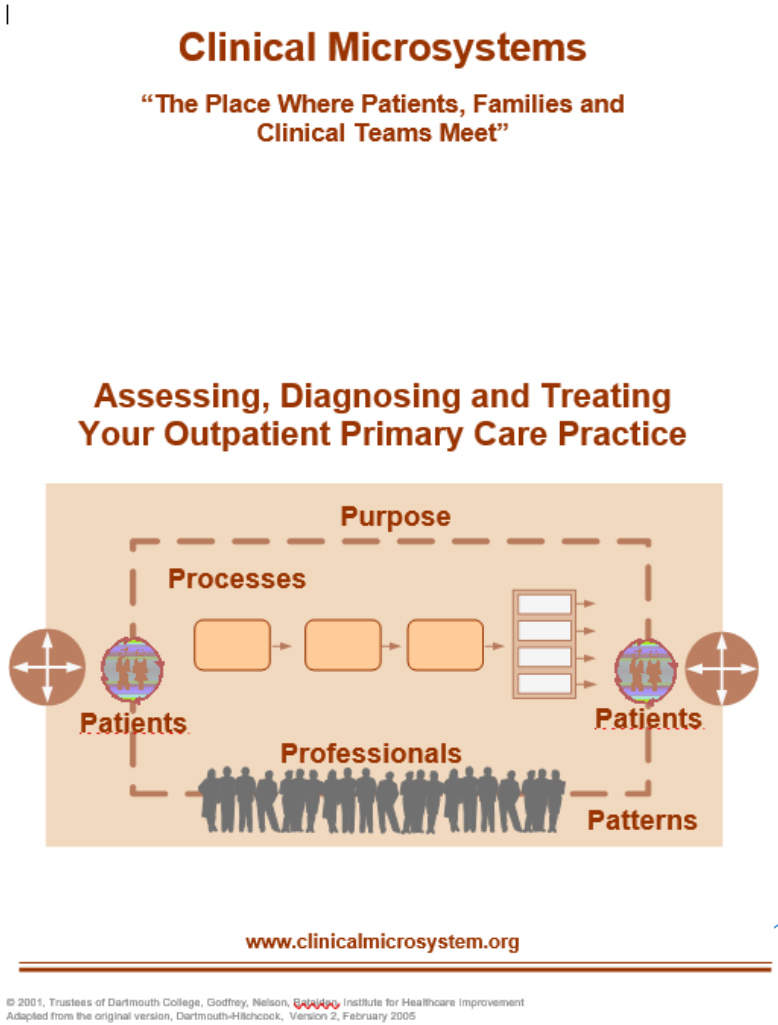
Flow Optimization-Five Rights Framework

Five Rights Framework Tool

Workflow Step	Purpose/Decision	Right Information	Right Person	Right Time	Right Medium	Right Format
Before the Visit						
In the Huddle						
Patient Check-in						
Pt. In Waiting Room						
Rooming the Patient						
Provider in Exam Room						
After the Exam Room						
After the visit						
Outside the visit						

Dartmouth “Green Book”

- Clinical Microsystems workbook
- In the WPCC portal.



Sample Tools from the Workbook

Processes

- Beginning to have all staff understand the processes of care and services in the practice is a key to developing a common understanding and focus for improvement. Start with the high level process of a patient entering your practice by using the Patient Cycle Time tool. You can assign someone to track all visits for a week to get a sample, or the cycle time tool can be initiated for all visits in a one week period with many people contributing to the collection and completion of this worksheet.
- Typically, other processes will be uncovered to measure and you can create time tracking worksheets like this template to measure other cycle times.

Primary Care Practice Patient Cycle Time

Day: _____ Date: _____

Scheduled Appointment Time _____ Provider you are Seeing Today _____

Time	
	1. Time you checked in.
	2. Time you sat in the waiting room.
	3. Time staff came to get you.
	4. Time staff member left you in exam room.
	5. Time provider came in room.
	6. Time provider left the room.
	7. Time you left the exam room.
	8. Time you arrived at check out.
	9. Time you left practice.

Comments:

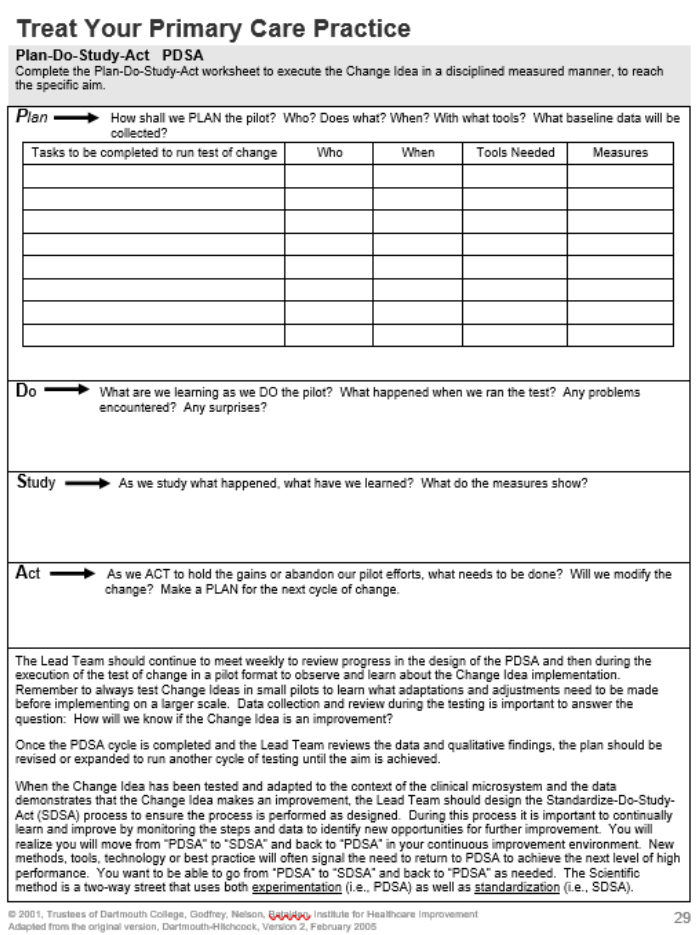
Patterns

- Patterns are present in our daily work and we may or may not be aware of them. Patterns can offer hints and clues to our work that inform us of possible improvement ideas. The Unplanned Activity Tracking Card is a tool you can ask staff to carry to track patterns of interruptions, waits and delays in the process of providing smooth and uninterrupted patient care. Start with any group in the staff. Give each staff member a card to carry during a shift, to mark each time an interruption occurs when direct patient care is delayed or interrupted. The tracking cards should then be tallied by each person and within each group to review possible process and system redesign opportunities. Noticing patterns of unplanned activities can alert staff to possible improvements.
- This collection tool can be adapted for any role in the Primary Care Practice to discover interruptions in work flow. Circles in the example indicate processes to further evaluate for possible improvements.

Primary Care Practice Unplanned Activity Tracking Card

Unplanned Activity Tracking		Unplanned Activity Tracking	
Name:		Name:	
Date: _____ Time: _____		Date: _____ Time: _____	
Place a tally mark for each occurrence of an unplanned activity	**Total**	**Place a tally mark for each occurrence of an unplanned activity**	**Total**
Interruptions		Interruptions	
• Phone		• Phone 𝍸 𝍸 𝍸	15
• Secretary		• Secretary	
• RN		• RN 𝍸 𝍸	10
• Provider		• Provider	
Hospital Admissions		Hospital Admissions 𝍸 𝍸 II	12
Patient Phone Calls		Patient Phone Calls	
Pages		Pages 𝍸 𝍸 𝍸 𝍸	20
Missing Equipment		Missing Equipment	
Missing Supplies		Missing Supplies 𝍸	5
Missing Chart: Same Day Patient		Missing Chart: Same Day Patient	
Missing Chart: Patient		Missing Chart: Patient 𝍸 𝍸	10
Missing Test Results		Missing Test Results	
Other		Other	○
			○

Sample Tools from the Workbook



Treat Your Primary Care Practice

Plan-Do-Study-Act PDSA

Complete the Plan-Do-Study-Act worksheet to execute the Change Idea in a disciplined measured manner, to reach the specific aim.

Plan → How shall we PLAN the pilot? Who? Does what? When? With what tools? What baseline data will be collected?

Tasks to be completed to run test of change	Who	When	Tools Needed	Measures

Do → What are we learning as we DO the pilot? What happened when we ran the test? Any problems encountered? Any surprises?

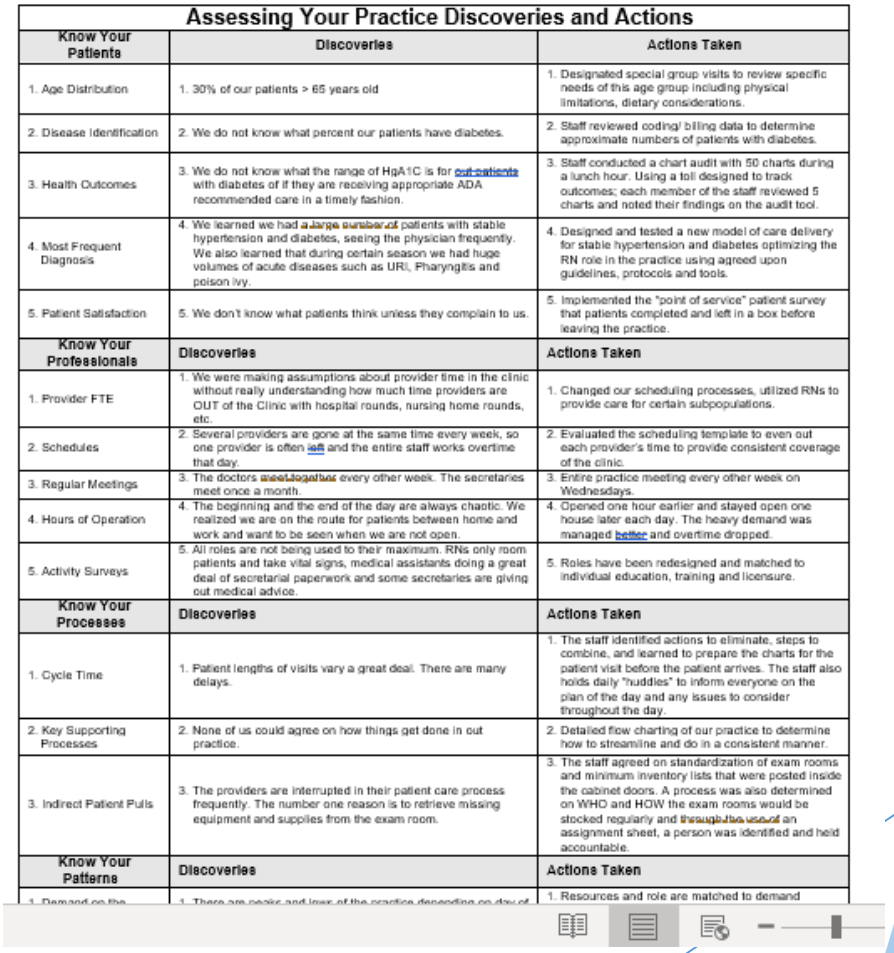
Study → As we study what happened, what have we learned? What do the measures show?

Act → As we ACT to hold the gains or abandon our pilot efforts, what needs to be done? Will we modify the change? Make a PLAN for the next cycle of change.

The Lead Team should continue to meet weekly to review progress in the design of the PDSA and then during the execution of the test of change in a pilot format to observe and learn about the Change Idea implementation. Remember to always test Change Ideas in small pilots to learn what adaptations and adjustments need to be made before implementing on a larger scale. Data collection and review during the testing is important to answer the question: How will we know if the Change Idea is an improvement?

Once the PDSA cycle is completed and the Lead Team reviews the data and qualitative findings, the plan should be revised or expanded to run another cycle of testing until the aim is achieved.

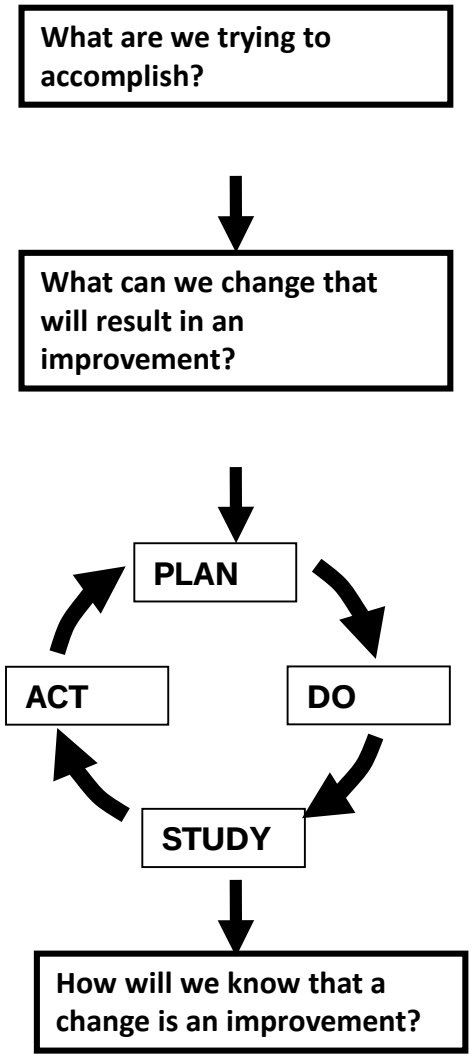
When the Change Idea has been tested and adapted to the context of the clinical microsystem and the data demonstrates that the Change Idea makes an improvement, the Lead Team should design the Standardize-Do-Study-Act (SDSA) process to ensure the process is performed as designed. During this process it is important to continually learn and improve by monitoring the steps and data to identify new opportunities for further improvement. You will realize you will move from "PDSA" to "SDSA" and back to "PDSA" in your continuous improvement environment. New methods, tools, technology or best practice will often signal the need to return to PDSA to achieve the next level of high performance. You want to be able to go from "PDSA" to "SDSA" and back to "PDSA" as needed. The Scientific method is a two-way street that uses both experimentation (i.e., PDSA) as well as standardization (i.e., SDSA).

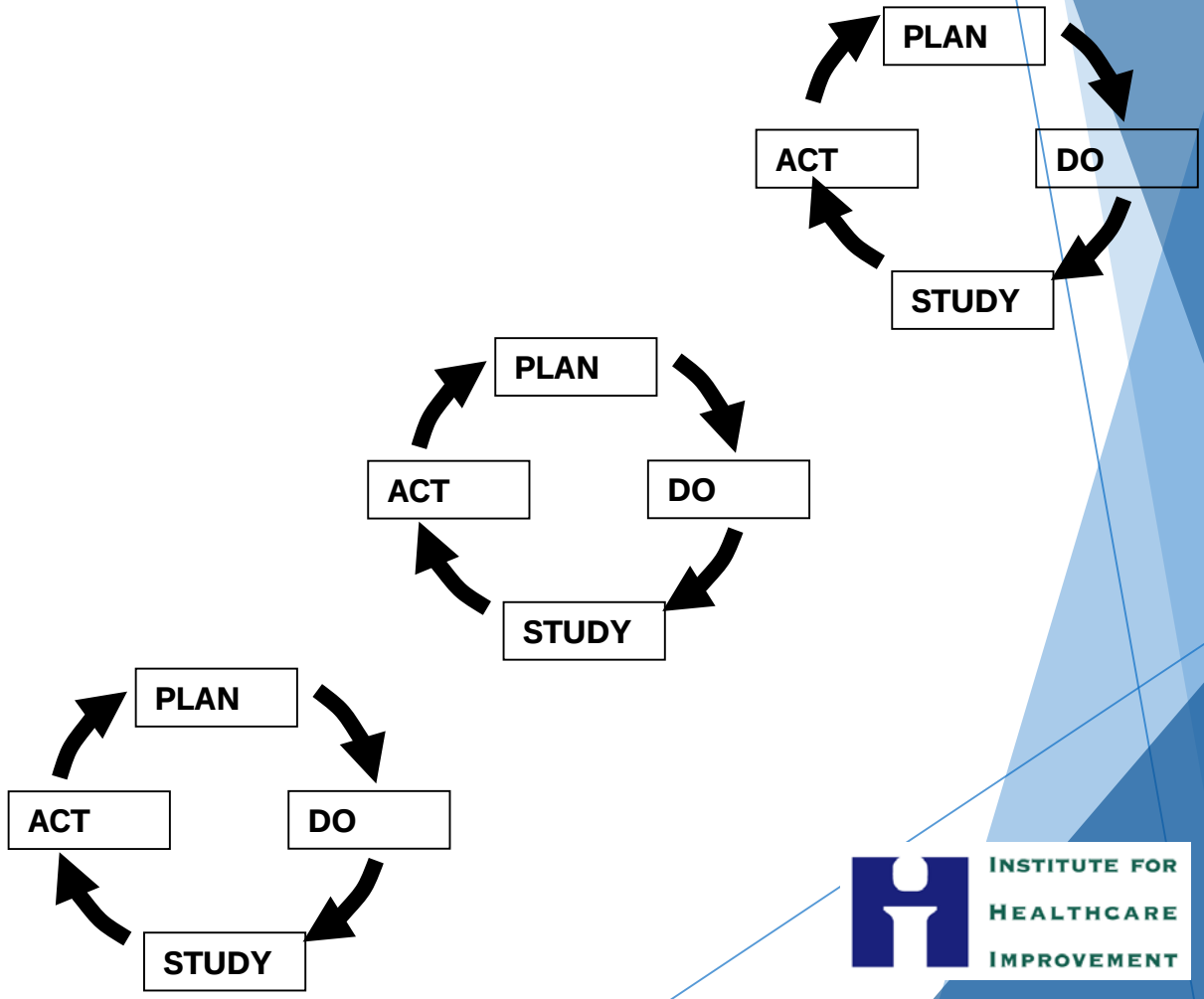


Assessing Your Practice Discoveries and Actions

Know Your Patients	Discoveries	Actions Taken
1. Age Distribution	1. 30% of our patients > 65 years old	1. Designated special group visits to review specific needs of this age group including physical limitations, dietary considerations.
2. Disease Identification	2. We do not know what percent our patients have diabetes.	2. Staff reviewed coding/ billing data to determine approximate numbers of patients with diabetes.
3. Health Outcomes	3. We do not know what the range of HgA1C is for out-patients with diabetes of if they are receiving appropriate ADA recommended care in a timely fashion.	3. Staff conducted a chart audit with 50 charts during a lunch hour. Using a tool designed to track outcomes; each member of the staff reviewed 5 charts and noted their findings on the audit tool.
4. Most Frequent Diagnosis	4. We learned we had a large number of patients with stable hypertension and diabetes, seeing the physician frequently. We also learned that during certain season we had huge volumes of acute diseases such as URI, Pharyngitis and poison ivy.	4. Designed and tested a new model of care delivery for stable hypertension and diabetes optimizing the RN role in the practice using agreed upon guidelines, protocols and tools.
5. Patient Satisfaction	5. We don't know what patients think unless they complain to us.	5. Implemented the "point of service" patient survey that patients completed and left in a box before leaving the practice.
Know Your Professionals	**Discoveries**	**Actions Taken**
1. Provider FTE	1. We were making assumptions about provider time in the clinic without really understanding how much time providers are OUT of the Clinic with hospital rounds, nursing home rounds, etc.	1. Changed our scheduling processes, utilized RNs to provide care for certain subpopulations.
2. Schedules	2. Several providers are gone at the same time every week, so one provider is often left and the entire staff works overtime that day.	2. Evaluated the scheduling template to even out each provider's time to provide consistent coverage of the clinic.
3. Regular Meetings	3. The doctors meet together every other week. The secretaries meet once a month.	3. Entire practice meeting every other week on Wednesdays.
4. Hours of Operation	4. The beginning and the end of the day are always chaotic. We realized we are on the route for patients between home and work and want to be seen when we are not open.	4. Opened one hour earlier and stayed open one house later each day. The heavy demand was managed better and overtime dropped.
5. Activity Surveys	5. All roles are not being used to their maximum. RNs only room patients and take vital signs, medical assistants doing a great deal of secretarial paperwork and some secretaries are giving out medical advice.	5. Roles have been redesigned and matched to individual education, training and licensure.
Know Your Processes	**Discoveries**	**Actions Taken**
1. Cycle Time	1. Patient lengths of visits vary a great deal. There are many delays.	1. The staff identified actions to eliminate, steps to combine, and learned to prepare the charts for the patient visit before the patient arrives. The staff also holds daily "huddles" to inform everyone on the plan of the day and any issues to consider throughout the day.
2. Key Supporting Processes	2. None of us could agree on how things get done in out practice.	2. Detailed flow charting of our practice to determine how to streamline and do in a consistent manner.
3. Indirect Patient Pulls	3. The providers are interrupted in their patient care process frequently. The number one reason is to retrieve missing equipment and supplies from the exam room.	3. The staff agreed on standardization of exam rooms and minimum inventory lists that were posted inside the cabinet doors. A process was also determined on WHO and HOW the exam rooms would be stocked regularly and through the use of an assignment sheet, a person was identified and held accountable.
Know Your Patterns	**Discoveries**	**Actions Taken**
1. Demand on the	1. There are peaks and lows of the practice depending on day of	1. Resources and role are matched to demand

Rapid Cycle Change





INSTITUTE FOR HEALTHCARE IMPROVEMENT

Opportunities for Deeper Learning

- Population Health LAN Webcasts
- Potential Access Affinity Group
- Office Hours
- The WPCC Portal will have increasing resources on Access

Dialogue

Examples of Alternative Visit Types

- Group Visits
- DIGMA (Drop In Group Medical Appointment)
- Pharmacist visit
- Nurse visit
- Community Health Worker/Promotors
- Peer advisors
- Social Workers visit
- At home visit
- EMS visit
- Telehealth

Group Visit Example

100 Diabetes Patients- Traditional

- Protocol 4 visits a year
- 400 visits needed
- $100 reimbursement
- 10% No shows
- 360 Net due to no-shows
- $36,000 in revenue
- -$4,000 lost revenue plus ancillary services

100 Diabetes Patients- Group Visit

- Protocol of 10 patients in a group visit.
- Need 40 Group Visits/Year
- 360 new slots opened
- $36,000 revenue from cohort
- $36,000 new revenue - $3,600 for now shows- $32,400
- Net $68,400