2011 Military Health System Conference

Best Practices in Access to Care

How the most successful clinics are improving both access and continuity

The Quadruple Aim: Working Together, Achieving Success
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# Best Practices in Access to Care. How the most successful clinics are improving both access and continuity

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Access to Care Success

- Overview of advanced access scheduling
- Consider new approaches to templates and template management
- Discuss the importance of business rules and appointing
- Review options for advanced communication and demand management
“Every system is perfectly designed to get the results it produces”

W. Edwards Deming

Healthcare is no different -- if patients have a several week wait to get an appointment -- it is because we have designed the system that way!
Green Team: Patient Testimonial

- Why should you care about this talk?
Traditional Model of Healthcare

- Doctor shows up to work with full schedule
- Anyone else needing to be seen:
  - Doctor begged to add them on
  - Patient told to call back tomorrow
  - “Go to the ER” or “I’ll take a message”
- Vain attempts to fix:
  - Vast array of restrictive and complex appointment types
Advanced Access Scheduling

- Redesigns scheduling systems
- Do today’s work today
- System focuses on the doctor patient relationship and stresses:
  - Continuity with personal provider
  - Capacity to care for the anticipated demand
- Also referred to as “open access” or “same day scheduling”
Demand is fairly predictable

- Somewhere between 0.5% – 0.6% of enrollees will call for urgent visits
  - 45 to 55 of 10,000 enrollees
  - Rate will vary depending on day of week
- Many open access practices have found:
  - 50% of patients are seen same day
  - 20% seen the next day; rest within 3 days
- My experience is that 60% of appointments should be within 24 hours (urgent or desired)
Consider a Med Home Port team

- 4 providers on the team
- 4440 patients
- Anticipated demand for same day care at 0.5% would require 22 urgent visits
- If 4 providers are all in clinic that day and each has 16 appointments = 64 available
- Thus, to cover urgent care needs 33% of appointments needed when day starts
But what about non urgent?

- If we assume that 1% of patients may want care (urgent plus routine) same day…
  - 44 will want to come in
  - $\frac{44}{64} = 70\%$ of appointments available

- Open access literature supports 65-75% same day

- Remaining 25-35% for good backlog:
  - Follow ups needing specific date in future
  - Patients who don’t want appointment today
Open Access Scheduling

- Don’t do last month’s work today!
- Eliminates the distinction between urgent and routine care
- Do all of today’s work today!
- By committing to doing today’s work today, maximum capacity is created for tomorrow
- Demand is not insatiable
- Once backlog is removed, practices are surprised their capacity often meets demand
Five necessary changes

- Commit to model of practice
  - Traditional to open access

- Reduce the backlog (6 to 8 weeks)
  - Pick a date on calendar

- Use fewer appointment types
  - Simplify to 2-3 types only, same length

- Develop contingency plans
  - For deployments, leave, holidays, etc.

- Reduce demand for unnecessary visits
  - Richer visits, provider practice patterns
NH Pensacola: A Case Study

- Implemented two appointment types in primary care (Peds, IM, FM, Branch Clinics)
- ACUT for same day care
- EST for good backlog (future)
- PROC used for procedure clinics
- Developed standardized templates
- Templates:
  - 16 available slots
  - Contingency slots if needed
  - Time built in for team based care
## Standardized Continuity Template

### Morning

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<td>EST</td>
</tr>
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</tr>
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</table>
Setting business rules

- Protect the patient provider relationship
- Only pre-schedule when necessary
- Providers care exclusively for their patients
- Don’t force overflow to colleagues
- Exceptions:
  - Absences and extreme demands
- Use patient reminder systems
- Team operates at top of license
- Asynchronous messaging
Managing Provider Absences

- **Deployments**
  - Be creative in how you use OCO backfills

- **Provider leave**
  - Rules can help avoid backlog build
  - One practice that uses a 5 day window
    - Block schedule for the week they are on leave
    - Three days prior to return open half appointments for first day back
    - Two days prior to return open half slots on second day back
    - One day before return open remaining slots
Green Team: Staff Testimonial

- Team Based Care
### Tools to manage capacity / demand

<table>
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<tr>
<th>PROVIDER</th>
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<th>TODAY</th>
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<th>TUESDAY</th>
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<td>0</td>
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<td>10</td>
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**Notes:**
- ACUT: Actual Cases Utilized Today
- EST: Estimated Cases
- OTHER: Other Cases
- BOOKED: Booked Cases
- OPEN: Open Cases
- WAIT: Wait Cases
- KEPT: Kept Cases
Tools to manage capacity / demand

### TOTAL LAST WEEK

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### Pediatrics Team

- **4 providers**
- **Equal 2.0 c-FTE**
- **2,000 patients**
- **Open for enrollment!**

### LAST FULL MONTH (November 2010)

<table>
<thead>
<tr>
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Suggested Principle Metrics

- 3rd next available – Routine Care (< 7 days)
- 3rd next available – Acute Care (< 1 day)
- Team continuity (pending 4th level MEPRS)
- PCM by name continuity
- Patient satisfaction with access

3rd next available can be looked at two ways:
- Lead time to appointment
- % time goal is met
3rd Next Available Metrics

- Includes the following Third Level MEPRS Codes
  - Family Practice Clinic (BGA)
  - Flight Medicine Clinic (BJA)
  - Internal Medicine Clinic (BAA)
  - Pediatric Clinic (BDA)
  - Primary Care Clinics (BHA)
  - Primary Med Care Not Elsewhere Classified (BHZ)
  - TRICARE Clinic (BHH)
  - Underseas Medicine Clinic (BKA)
3rd Next Available Metrics

- Fourth level MEPRS Code Exclusions
  - Codes 0, 1, 2, 5, 6, 7 are excluded
    - APVs, Observation, Troop Readiness Clinics
  - Air Force facilities exclude BGAZ
    - Coumadin clinics, etc.

- Two metrics:
  - Routine Care (ROU and EST appt types)
  - Acute Care (ACUT and OPAC appt types)
  - Measures third next available in the system

- Much better measure of ATC than old metrics
PCM Continuity Metric

- Same MEPRS inclusions and exclusions
- Direct care enrollees assigned PCM at site
- Enrollee visits at that site
- Appointment statuses:
  - Pending, Kept, Walk-in, Sick Call and LWOBS
- Appointment types:
  - ACUT, OPAC, WELL, EST, ROU and PCM
- Non provider visits excluded
Family Medicine Green Team

- Pilot Medical Home
- Opened Nov 2009
- Integrated team of military and civilian faculty, military residents and civilian FNP or PA
- 4.8 c-FTE on the team
- 2 military faculty deployed; 1 OCO backfill
- Enrollment: 4,108 and open
- 8 other teams opened Nov 2010 based on pilot experience
Third Next Available – Routine Care

Data from MHS Insight 12/30/2010

Air Force | Army | Navy | Green Team | Blue Team | Gold Team

Time to Third Next Available (Days)

Lower better!
Third Next Available – Acute Care

Data from MHS Insight 12/30/2010
Third Next Available – Acute Care

Data from MHS Insight 12/30/2010

- Air Force
- Army
- Navy
- Green Team
- Blue Team
- Gold Team

Time to Third Next Available (Days)

Lower better!
## PCM Continuity One Year Ago

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<th>Nov 09</th>
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<tr>
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<tr>
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<tr>
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Updated PCM Continuity Metric

- Air Force
- Army
- Navy
- Green Team
- Blue Team
- Gold Team

- 2010 Goal
- 2012 Goal
- 2014 Goal

% Time Saw PCM Nov 09
% Time Saw PCM MTD
Ease of Scheduling

% Navy Patient Satisfaction with Ease of Scheduling

- Target: 90%
- Threshold 80%

- NH Pensacola
- NH Jacksonville
- NH Camp Lejeune
- NH Camp Pendleton
- NH Bremerton
Meets Need for Appointment

% Navy Patient Satisfaction with Phone Service

Target: 90%

Threshold 80%
Questions?