Enhanced Access-
Third Next Available Appointments
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Notice of Disclosure:

Disclosure information: HRET, planners and the following speakers have disclosed they have no relevant financial interest or relationship with any manufacturer(s) or any commercial product(s) discussed in this educational activity. The following have provided disclosures: *Aline Holmes, DNP, MSN, RN; Nancy Winter, MSN, RN, Thomas R. Ortiz, MD, FAAFP, Tyla Housman, Kemi Alli, MD; and HRET Planners.*

Outline for Today

1. Key Understandings, Considerations and Principals

2. Why should would Re-Design our systems?

3. Where did Advanced Access come from?

4. Important Concepts in Advanced Access

5. Question and Answers

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Key Understandings, Considerations and Principals

Understanding Poor Access

Demand – Patients Want Appt.   Supply – Available Appt. slots

An access problem is a delay problem . . .

A delay problem is a system problem . . .

and delay is the relationship between Demand and Supply!

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Considerations before starting this work

Advance Access will not solve ALL system problems. It will eliminate or reduce delays to get an appointment into your system and eliminate or reduce waste and inefficiencies involved with this process.

IT IS AN ONGOING PROCESS OF IMPROVEMENT AND SUSTAINING THE WORK.

Considerations before starting this work

Advance Access Scheduling is NOT:

- Trying to add more patients to already crowded schedules

  * Except when working down the BACKLOG*

- Working harder/longer/faster

  Except when working down the BACKLOG

- Not doing or scheduling follow-up/return appointments

What is the Process/Strategy?

1. Form the Teams
   - *How many teams should you have?*
   - *Who should be on the teams?*
   - *How often should the teams meet?*

2. Define the AIM of the initiative

3. Measure/Map the processes
   - Delay (Third Next Available)
   - Backlog
   - Panel (Demand and Supply)
   - Continuity
   - Failure to Keep/No Show Rate

4. After the first 3 steps and only after that do we begin to **Implement Change**

* I recommend the rapid cycle tool of **PDSAs – Plan Do Study Act**.

What are the Key Change Principals?

1. Balance **Demand** and **Supply**

2. Monitor **Panel** Size

3. Reduce the **Backlog**

4. Reduce time to **Third Next Available** appointments

5. Develop **Continuity** plans

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Why Re-Design the system?

Why Re-Design Your System?

"EVERY SYSTEM IS PERFECTLY DESIGNED TO GET THE RESULTS THAT IT GETS"

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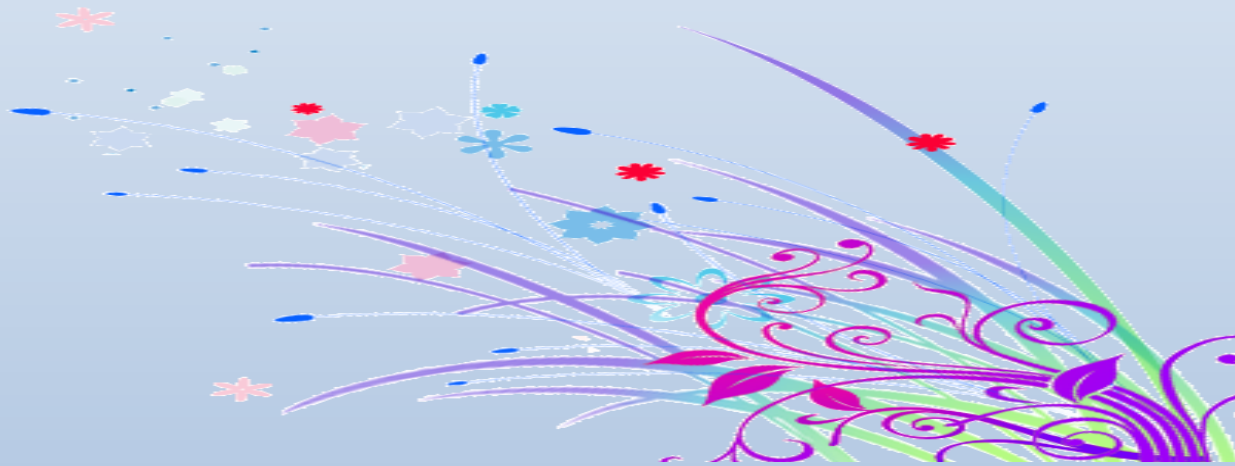
Why Advance Access?

Advance Access

Open Access By Denial

Traditional

Carve-Out

Traditional/Carve-Out/Open Access by Denial Model

1. Do your teams have the time to do all the work that needs to be done?

2. Are the teams spending time preparing charts for patients that No Show or spending time to follow up on No Shows? (*what is the cost?)*

3. Are your providers and support staff feeling overwhelmed?

4. Are we providing the best care for the patient?

Advance Access Model

Under this model patients calling to see their provider are given an appointment the same day (or *next day*).

- Patients always see their "**own**" provider

- Patients are given an appointment that fits *their* needs –**whether urgent or not**!

Where did Advance Access come from?

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Advance Access - Origins

Advance Access scheduling work was started over 30 years ago by Dr. Mark Murray from Kaiser Permanent. At that time the Kaiser system was riddled with:

- Long wait times to get an appointment

- High no show rates with in-efficient systems

- Dissatisfied patients

- Dissatisfied Staff

The system was broken and he was charged to "fix" it!

Advance Access - Origins

How do they know how to get it right ?

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Advance Access - Origins

How did other industries successfully do that?

Toyota, model of Lean Manufacturing

What is Lean Manufacturing?

This system is an approach to eliminating waste or non-value added activities in an effort to provide high-quality product or service to the customer at the lowest cost and in the shortest lead time possible.

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What are the Important Concepts when considering Advance Access?

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What are some important Concepts?

When implementing an **Advanced Access Schedule**:

- Demand and Supply (Capacity)

- Panel Size

- Patient Backlog

- Third Next Available (TNA)

- Continuity

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What is Demand and Supply?
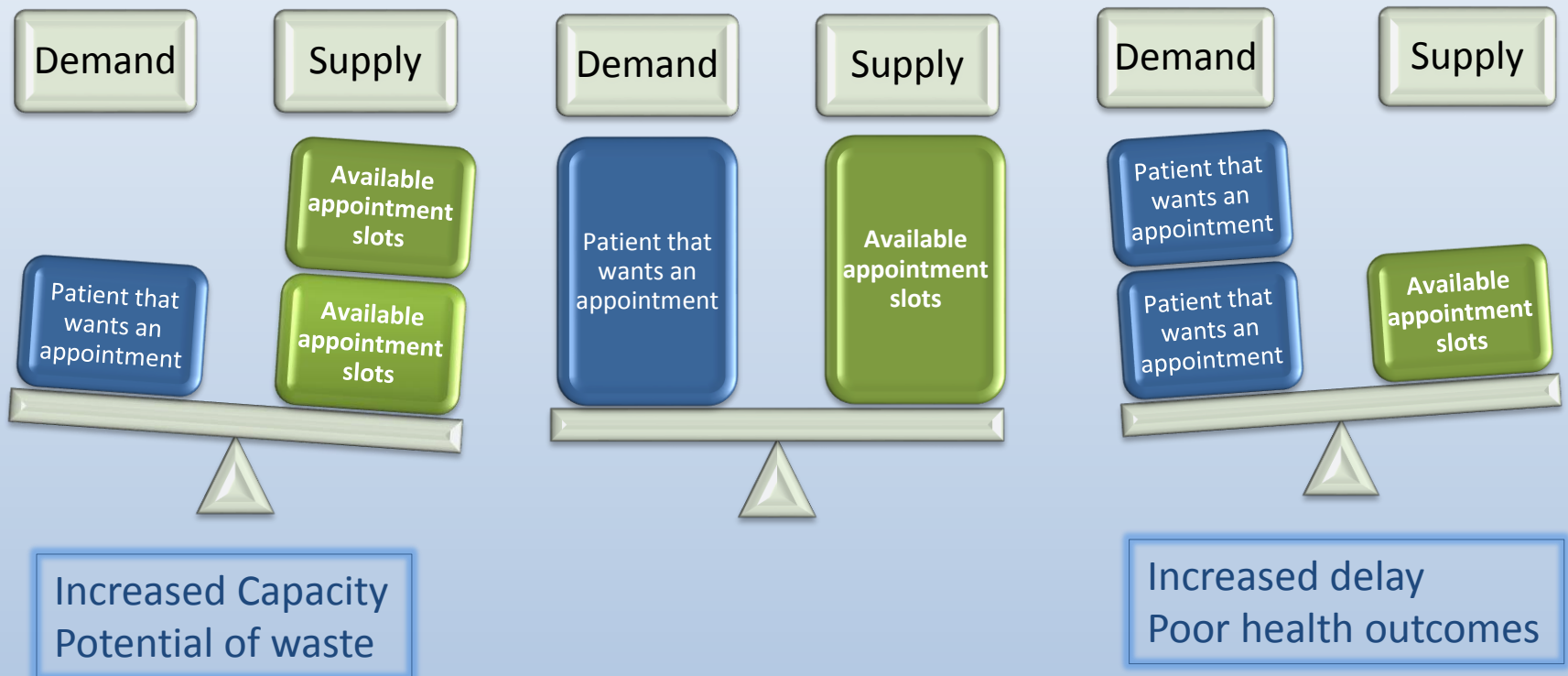
Demand and Supply

What is our Demand and Supply?

Demand = number of patients or visits to be seen in a year

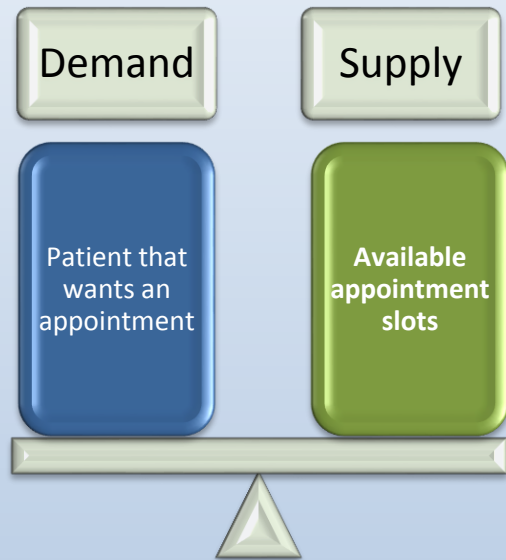Supply = number of appointment "slots" in a year

What we want is for our Demand = Supply

When this is not equal we will have delay and poor access which leads to poor quality and health outcomes for our patients.

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Demand and Supply

How to Balance Demand and Supply

Demand

Supply

Patient that wants an appointment

Available appointment slots

The key to balancing Demand and Supply is in the *Panel Size*.

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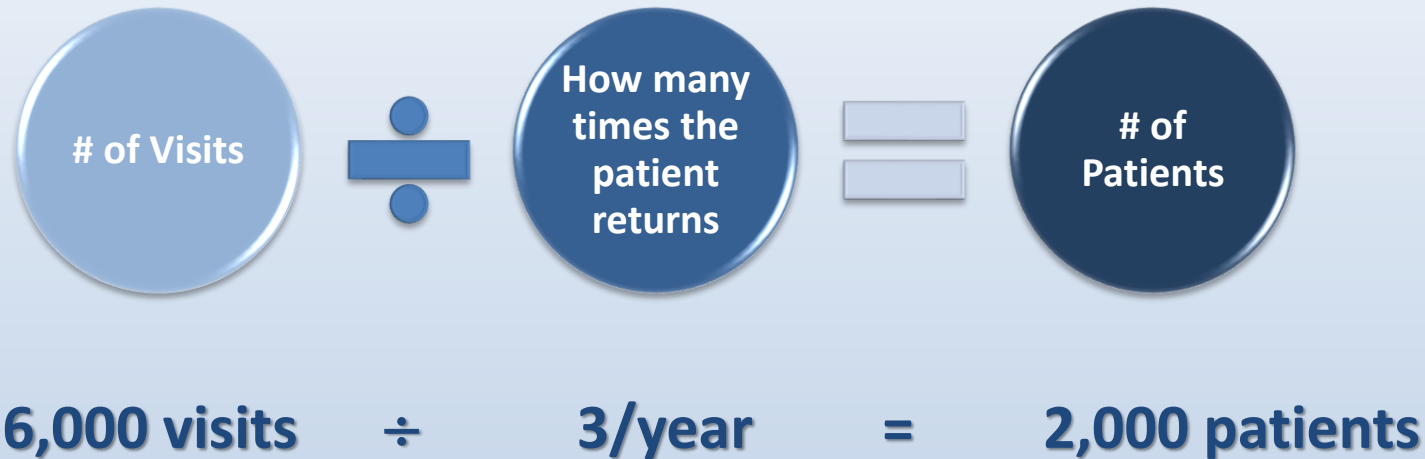QUALITY CARE CLOSE TO HOME

What is Panel Size?

Panel Size

Panel Size is a tool to monitor Demand and Supply. The ***number of patients*** that one provider can see in one year (or 12 Months). If you have the right panel size you will have the right number of visits per year.

# of Patients **X** **How many times the patient returns** **=** **# of visits**

1,500   **X**   **3**   **=**   **4,500**

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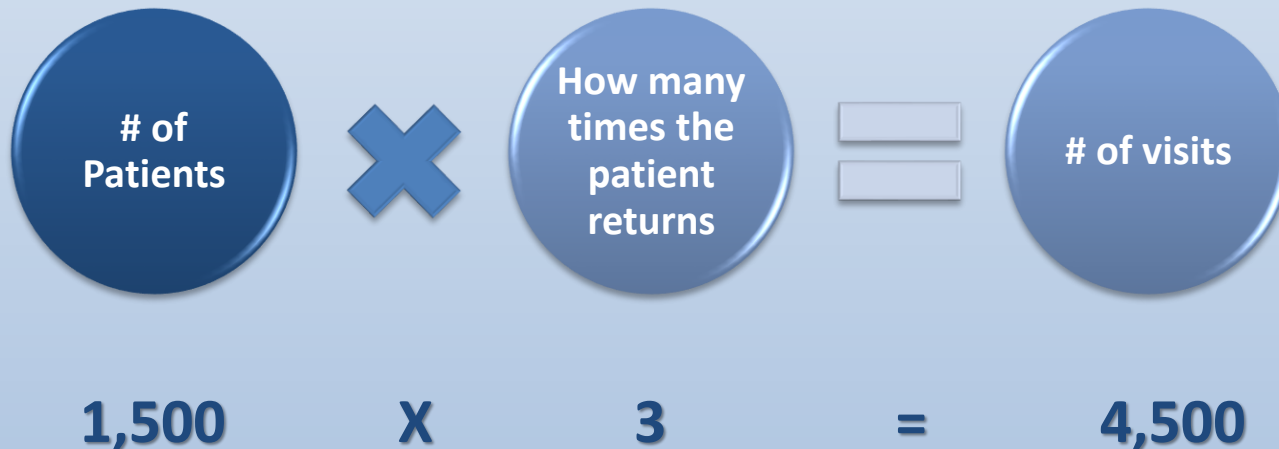
Calculate Actual Panel Size

# of Visits ÷ **How many times the patient returns** = **# of Patients**

6,000 visits   ÷   3/year   =   2,000 patients

This calculates your **actual** panel size which needs to be

balanced against the **ideal** panel size.

Calculate Ideal Panel Size

= Days worked/year x Number of daily appointments

Return Rate of patients/year

= 220 days/yr x 24 appts/day   = 1,760 patients/year

3 returns/yr

This is best calculated over 12 months and then every month after that.

So is our Demand and Supply balanced?

Understanding our Dilemma

Why can't we fit

10lb of nuts into a 5lb bag?

The same holds true for our number of patient visits and

appointment times available. Demand and Supply must be

equal or we will have . . . . . .

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Balancing Demand and Supply

There is no way for the provider to have an additional 240 patients (or 720 visits as each patient returns 3 times per year), so this system design is that either there will be delays to get an appointment and or a lack of continuity.

Monitoring Panel Size (Demand & Supply)

Team Name	Current Clinical FTE	Current Panel	Pt return rate/yr	Provider visit rate per day	Provider days work/year	Ideal Panel	Current Over(Under) Ideal Panel
Divas	0.65	565	2.84	20	143	1,007	(442)
Butterfly Bhandaids	0.75	1,092	2.84	20	165	1,162	(70)
Austin Angels	0.90	1,160	2.84	20	196	1,380	(220)
Divas	0.20	297	2.84	18	44	278	19

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Balancing Panel Sizes

The Actual Panel Size was 2,000 patients/year

The Ideal Panel Size based on available appointment slots was 1,760 patients/year.

Thus 2,000 > 1,760 and this is not a balanced system.

Demand is greater than Supply!

What is Backlog?
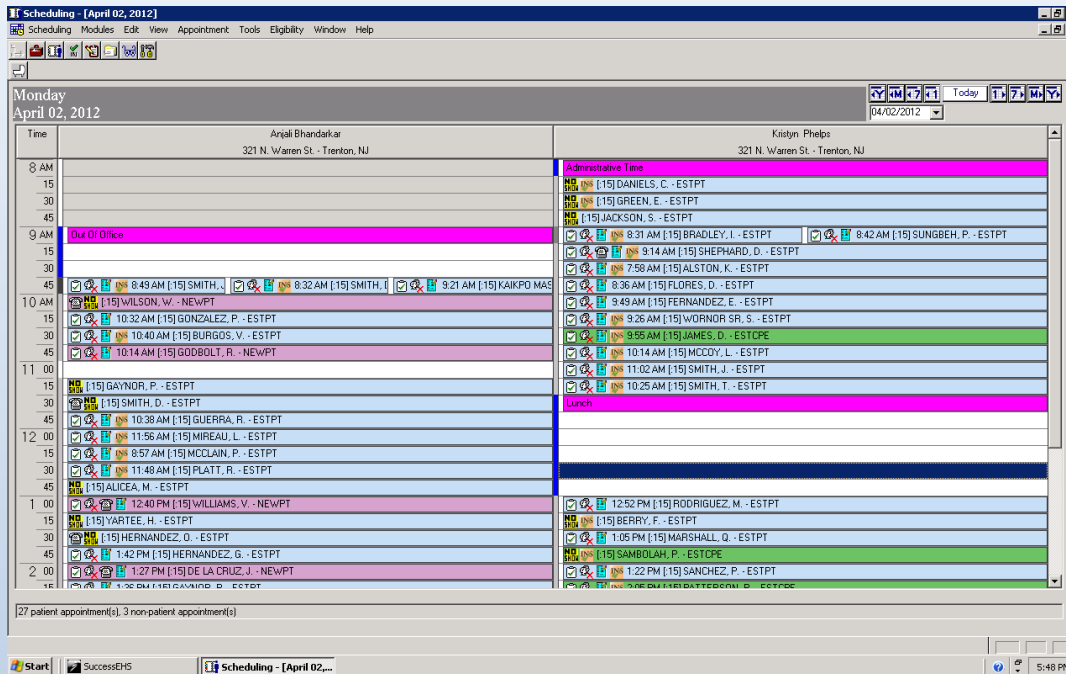
Reducing **Backlog** is how we get to deliver Same Day care.

The number of patients that were scheduled into the future

ONLY because we could not give them an appointment today.

Calculating (Counting) Backlog

AND how do
we know how
many patients
are in the Backlog?

We count them

Example: A provider has 4 weeks of future appointments and there are 625 patients with future appointments. If you see 5 extra patients each day it will take the team (625/5=125) 125 days or approximately 25 weeks or 6 month to work down the backlog.

This is the **tricky** part, because what teams have to do is see all the

patients they would have usually seen in a day

AND THEN SOME MORE!

So if a team on average sees 22 patients a day then they will need

to see 25 a day, or 27 a day or 30 a day to work down the backlog.

The more patients you see the faster the backlog is worked down.

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Backlog - Types

When Calculating Backlog there are

Good Appointments and **Bad** Appointments

Do not count the Good Appointments in Backlog

Good Appointments	Bad Appointments
Can be scheduled into the future	Should be Same Day Access
Have a physiological reason for being scheduled into the future	No reason why patient cannot be seen today

What is Third Next Available (TNA)?

Third Next Available (TNA)

TNA appointments measure Backlog or delay.

TNA is the <u>number of days</u> it takes to get the third next

available appointment. For example,

- First available appointment is in 5 days . . . . .

- Second available is in 15 days . . . . .

- Third available is in . . . . .

Third Next Available

1. TNA is the Gold Standard measure for Delay (Backlog).

2. TNA is measured in days (> 2 days)

3. TNA may vary by discipline. Thus Dental is different

   from Pediatrics which is different from OB/GYN.

4. TNA varies over time. With providers on vacation,

   seasonal demand etc.

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Third Next Available

Third Next Available Appointment for New Patients (Non-Surgery)

DAYS UNTIL THIRD NEXT AVAILABLE APPOINTMENT

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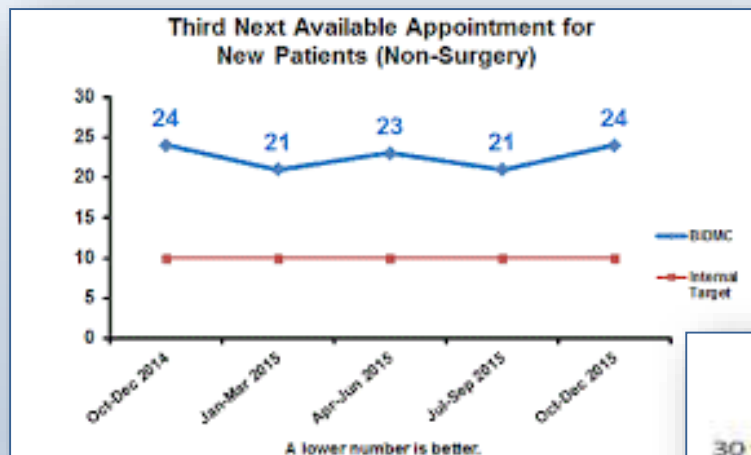
What is Continuity?

Continuity

Continuity is an useful tool to asses quality of care.

An important note, Continuity is measured from the

eyes of the patient. *Of all the patients that are on the panel of a*

provider how often did they get to see **their PCP**

when they came into office.

Here's an example:

300 patients with Dr. Smith listed as their PCP came into the center in the month of

Jan. 150 of these patients saw Dr. Smith but 150 saw Dr. Jones. This means Dr. Smith's

panel had 50% continuity.

Continuity

30%

Dr. X

My Provider

My provider **60%**

Dr. Y **10%**

In this scenario there is 100% continuity

In this scenario there is 60% continuity

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Advance Access – Team Dashboards

As of October

	Panel	Panel Goal	Percent Paneled	Continuity	Continuity Goal	Activity	Activity Goal	TNA	TNA Goal
Kids First	1,665	1,769	94%	89%	>61%	21	20	9.5	<2
Genesis	1,322	1,659	80%	98%	>98%	20	20	2.0	<2

As of November

	Panel	Panel Goal	Percent Paneled	Continuity	Continuity Goal	Activity	Activity Goal	TNA	TNA Goal
Kids First	1,651	1,800	92%	84%	>59%	20	20	6.4	<2
Genesis	1,283	1,688	76%	94%	>91%	18	20	7.6	<2

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Advance Access and Technology

- Ensure you are using all the modules in your EMR

  - Ability to send emails

  - Ability to send text reminders

  - Ability to automatically calculate

    TNA, Panel size, Continuity or

    No Show rate

- Work with partner vendors of your EMR if necessary

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Re-Designing our systems

HOW DO WE GO FROM THIS . . . . TO THIS?

Implementing Advance Access

1. We must match **Demand** and **Supply** and through the **Panels**.

2. We must work down the **Backlog** of patients and then monitor **TNA**.

3. We must ensure quality care and measure **Continuity**

And then . . . .

Implementing Advance Access

4. We must do *Todays work Today* by . . . . .

- Ensure Teams have a **Panel** → Management must

    ensure accuracy of panels

- Hold Teams accountable to **Continuity** → Management

    must provide environments for Continuity

- Hold Teams accountable to 0 (to 2 days) **TNA**

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Time line for Implementation

- 3 to 6 months to gather and analyze baseline data

- 3 to 6 months to work down the Backlog, with
  continued data monitoring and PDSA cycles of change

Anticipate this process will take 6 to 12 twelve months to
implement the advance access scheduling model.

Questions?

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Upcoming Webinars

3/13/17 12:00 PM – 1:00 PM EST

Organized, Evidence Based Care with Mike Renzi, DO, FACP

Chief Medical Officer

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