

Slide - Course Overview: At its core, Advanced Access is the reality of patients calling to schedule an appointment being offered an appointment with their primary care provider on the same day or a day of their choosing. Improving Access & Efficiency in Primary Healthcare, applying the principles of Advanced Access in your primary care practice can improve office efficiency, reduce delays, and result in a better balance between your supply of appointments with patient demand for appointments. Advanced Access is achievable, and although it presents a challenge, most practices are, in fact, closer to achieving it than they realize.

Based on Health Quality Ontario's Advanced Access and Efficiency Workbook for Primary Care and success stories to date, this module is the first of six 'how to' modules that will expand on the concepts of Advanced Access and Efficiency. Intended to guide you and your improvement team through the key steps of implementation and sustained change, you'll have access to downloadable resources, tips and tools that will help your team achieve your quality improvement goals. Additional online support from a Quality Improvement Coach will be available in the module's Forum, so you'll have access to their expertise every step of the way.

Slide – Learning Objectives: To facilitate quality improvement initiatives in Ontario, Health Quality Ontario (HQO) has developed a comprehensive Quality Improvement Framework that brings together the strengths of several QI science models and methodologies, such as the Model for Improvement from the Institute for Healthcare Improvement (IHI), and traditional manufacturing quality improvement methods like Lean and Six Sigma.

HQO's QI Framework consists of six phases. Each of the six phases is iterative and designed to build on the knowledge gained from the previous phase. 'Getting Started' begins with assessing your readiness and capacity to implement Advanced Access and Efficiency principles. This critical exercise, to help you determine what roles and tasks need to be addressed by your team, big or small.

Slide - What Are We Trying to Accomplish: Before we jump into assessing your readiness and capacity for change, let's briefly review what we are trying to achieve with Advanced Access and Efficiency, and why. Delays in access to a primary care provider, tests, a specialist are common in our system. This creates dissatisfaction for patients and for staff. Moving away from a traditional scheduling model is possible and is what advanced access is all about.

Slide - Advanced Access: Why Do It? : Advanced access and improved efficiencies can address the long wait times and complaints from patients, busy waiting rooms and high use of walk-in clinics and emergency rooms, hectic work days and stressed staff, as well as the lack of time for prevention screening, patient self- management and the demands associated with our aging population and chronic disease. So we've learned that primary care providers who decide to implement these principles and improve access to patient care are well aware of the daily challenges in their current practice. Next, we'll hear from Dr. Cathy Faulds of the London Family Health Team, she started into quality improvement strategies as a solo physician in 2008 and shares some her insights from the provider, patient and system perspective.

Slide – Cathy Faulds, MD: Hi, my name is Dr. Cathy Faulds from the London family health team. And I'm going to talk with you this afternoon on open access efficiency and practice, office practice redesign. "Why bother with all of this? Why are we going to look at open access? Why do we care how efficient we are? And why do we really care about the systems?" I broke it down into three levels: first of all

looking at it from a patient perspective, looking at it from the provider perspective and looking at it from the system perspective. When we talk about the patient perspective we're talking about improved patient outcomes. And I get really excited when I talk about quality improvement because I've been able to realize with standardization of office visits by implementing evidence-based care, that the patient benefits in the end. The second is looking at my own practice satisfaction and how much I enjoy practice now as compared to how I did four years ago before I got involved with all of this. I am running more on time, I feel like I have more control over my schedule, my allied health professionals that I employ in my office are much happier working up to scope in their practice. And also we see great system benefits. The system in particular we're looking at fewer unnecessary visits in our office, we're looking at team care and the introduction of a broader team - when I started all of this I was a fee-for-service physician, with a very small office staff, and now we've expanded to be six physicians, a nurse practitioner, multiple social workers, dietician, so you can see that there are many changes that have taken place to allow open access to come in. We look at the financial benefits and this is where we really, I really, get excited because we look at influencing the system in which we work in.

Slide – 6 Principles of Access: As Dr. Faulds results indicate, the relationship between supply and demand is the key to overall workflow and balancing the supply of visits with the demand for visits is the core principle of Advanced Access. If you understand supply (the number of appointments available) and demand (the requests for appointments) and that they need to be in balance, then you will be able to organize your practice to reduce delays, improve flow and improve patient, staff, and your satisfaction.

Slide – 6 Principles of Efficiency: Just as supply and demand must be balanced, it is equally important to identify waits, delays, and inefficiencies in non-appointment work such as phone message management, prescription refills, referral management, and diagnostic tests and reports. We'll get into the 'hows' of implementing these principles and what strategies can make a difference in our next modules. To further lock in on what we are trying to achieve and the impact that can be had, you'll hear more from Dr. Faulds as she discusses how these principles played out in the positive changes she made within her practice.

Slide – Panel Size, Supply, Demand by Cathy Faulds: In particular I want to talk about three measurements because this is the very basics that you need to do to be able to understand how you can implement open access. To begin with we're going to define panel size and for many of you that just simply means roster. We talk about rosters with the Ontario government now with whether or not we're a FIG payment scheme, whether or not we're a FOE payment scheme, or whether or not we're even salaried. Everything depends upon our roster. Unfortunately, that's not an easy thing to find a number for and I know that many of the facilitators will teach you the different ways to do it but I'll let you know that what we do is we look at what the government has as a roster, we look at what we have on our computer, and we also look at what we have in our chart racks. So defining that panel size is very very important. One of the things that often happens is I'll hear from many physicians about open access, one of the arguments about why they can't do it, why it wouldn't work in their practice is that they have too big of a practice. And I agree with you. If you're not able to look at your panel size, you're not able to reconcile whom you're really looking after, then you can't start to do open access. Open access isn't a quick fix for a supply of office visits that is too little for the demand that you want to put in there.

So moving on to demand we want to look at how many patients we have and how many visits those patients will need in our clinic. We have to look at revisit rates and there's scads of literature on revisit rate but you have to figure out whether you're the type of physician that brings someone back a lot in your practice or whether you're the type of physician who will dispense treatment and then educate the patient about why perhaps they would need to revisit and you give them the ability to decide when they need to come back. Revisit rates in general will be anywhere from three to four per patient in your practice and I think that when you look at that revisit rate and you see what you're actually doing then you can decrease the demand on your practice by making some subtle changes in how you actually do medicine. We want to look at the supply and so you have to look at your own behaviour.

So I have to look at my own behaviour, I have to look at the velocity that I see patients in, and I have to be prepared to make changes for that. I have to look at whether or not I can hire or whether or not I can expand my teams so that I can put more directive work on their shoulders. So I have to look at how much supply I have in my office and I have to be creative and progressive to say how can I increase that supply. So you need to do these standard measurements. You need to take the time to do them. Nobody is going to give you these measurements. You have to sit with your office staff, look at your computer, your EMR, your chart rack and come up with a panel size, figure out your demand and figure out your supply and only then can you begin to look at efficiency in your office.

Slide – Measure Daily Demand and Supply: Recall the importance of balancing supply and demand. Your panel size or number of patients multiplied by your re-visit rate gives you demand, the left side of the equation Supply on the right is calculated by the number of appointments per week multiplied by weeks you see patients in a year. Now you want to try to measure your demand and supply on a daily basis. Balancing demand for appointments and the supply of appointments on a daily and weekly basis is key to achieving an advanced access working environment. To do this you must understand your daily demand and supply.

Slide – Demand from your Panel: When we think about daily demand we differentiate between internal demand and external demand. Internal demand are appointments made today for a future date as the patient leaves the clinic; a follow-up appointment for example. External demand are call-ins or walk-in requests for an appointment.

Slide: Supply by Your Care Team: Now that we've covered demand, let's talk a little bit about supply. It's really the number of appointment slots according to the schedule. What you're going to do is compare the total daily demand for each day to the supply for each day. When collecting supply and demand data, it is important to use the shortest appointment slot as the basic unit of measure. For example, when calculating your supply you will count the number of 15 minutes appointment slots available in your day. Likewise when counting demand, you will base the count on the number of 15 minute slots that are requested by your patients.

Slide - Backlog: Now let's talk about backlog. Backlog consists of appointments on the future schedule that have been put off because of lack of space on the schedule to do the work sooner; working down the backlog recalibrates the system to improve access. It is what we should have done but haven't.

How do we calculate backlog? It is the number of appointments booked between now and the third next available appointment. There is good backlog, which is necessary, and bad backlog which needs to be eliminated. 'Good' backlog consists of appointments in the future that need to be there, including:

return appointments scheduled by the provider, appointments requested by patients (patient calls in today, but wants to come in tomorrow), or appointments automatically scheduled at certain intervals due to physiology or clinical condition. 'Bad' backlog consists of appointments for anyone who was scheduled for a future date who could've been seen today.

Slide – Going Forward: Going forward, you are going to want to offer supply that matches demand. Once that balance has been found, it will be possible to assess the ratio of pre-booked to open appointments that is required to meet daily demand. Tracking daily demand, supply and activity data, or DSA data, will help you understand the ratio of pre-booked to open appointments needed to meet daily demand in relation to supply.

Slide – Create a Visual Cue: Sometimes it's helpful to actually create a visual cue for booking by mapping your average demand onto your scheduling template. Subtract the daily demand from daily supply to determine the daily ratio of pre-booked to open appointments. A different number of open appointments will be made available each day, based on the findings of the daily demand data. So it's the ratio that's really the important thing don't get bogged down in the different colours on the slide so much, they don't denote specific appointment types. It's just to show you that the ratio of pre-booked and open appointment spots that are needed per day to meet the internal and external demand. The pre-booked appointments can occur any time of day based on the need of your patient population.

Slide – Important Strategies: If demand and supply are in balance, access to care on patient's day of choice will be achieved on most days. Have a look at some of the strategies on this screen. Never ask a patient to call back on the day they want the appointment. Book return visits when the practice is less busy with external demand - for many this is early in the morning and later in the week. Don't forget about contingency planning for vacations, flu season, snow birds returning from south for check-up and med renewal, and those types of things.

Slide – Change is Possible by Cathy Faulds: So if we go back to the beginning, and we look at how do we improve patient outcomes. What do I mean by this? Again we talk about standardization of visits with evidence-based care and I've always maintained that it's not that physicians don't know about the evidence that's out there that we don't go to CME and we don't read about and there's scads and books of literature that talks about why physicians have been lousy at implementing evidence-based care. One of my big contentions is that we don't have the foundation, we don't have the staff, we don't have the support structures to do it. And so if we look at standardizing patient visits, how are we able to do that in our office and what programs in particular did we target. With QIIP's help we started with Diabetes Mellitus and we advanced on to insulin Starts. We then have gone into COPD, Asthma, Osteoporosis, and you can see the list goes on and on. We went into counselling. We went into standardizing our smoking cessation programs, our cholesterol, our obesity approach. We then started with case finding and standardized looking for COPD saying how can we improve our management of COPD by picking up all of the patients that actually have COPD in our practice. And we introduced spirometry, something which is becoming more popular in primary care but when we started it was quite unique. Glucose monitoring as well will feed into our diabetic program so we're not missing our pre-diabetics. Once we had our diabetic program organized we decided that we needed to begin to move it back and look at patients that had blood sugars between 6 and 7 and target them before they could even become diabetic. For dementia, we looked at trying to pick up patients that had early onset dementia or MCI early on to give families and to give patients help before there was a crisis situation in the office. And

that was very simple by putting a MOCA assessment or a mini-mental status assessment for everybody over age 65 at a routine physical or visit in the office.

Slide – Athens Family Health Team by Dr. Ben Stobo: No Narration Text

“typically medicine is a reactive type business where you react to whatever complaints or challenges come through the door... .. we 've become able to use the tools to be more proactive or work on preventative medicine. This is something I've been interested in for many years but just not had the right tools to do it.....with the program over the last year it's given us a lot of ideas, shared stories through other teams and it's often a story is better than anything else and when you see somebody else, it's always 'if they can do it, we can do it' and I think that that's the attitude we've taken.

Slide – Next Steps: So we've reviewed the key principles of Advanced Access and Efficiency that were discussed in detail. Dr. Cathy Faulds shared her success in creating an Advanced Access environment which gives a clearer picture of what is achievable. Your practice is unique; however, and your journey will be your own. In the next modules you will assess your practice to move forward or determined what areas you need to work on to prepare your practice for implementation in the future.

It is helpful to review the tips and information posted in this module's forum, as much of this information is provided by an experienced QI Coach who has anticipated the questions that may arise during your 1st QI team meeting. Remember, a QI Coach is available to support you the whole way, just post your questions or concerns in the module forum.

Slide – Acknowledgements: No narration / text.