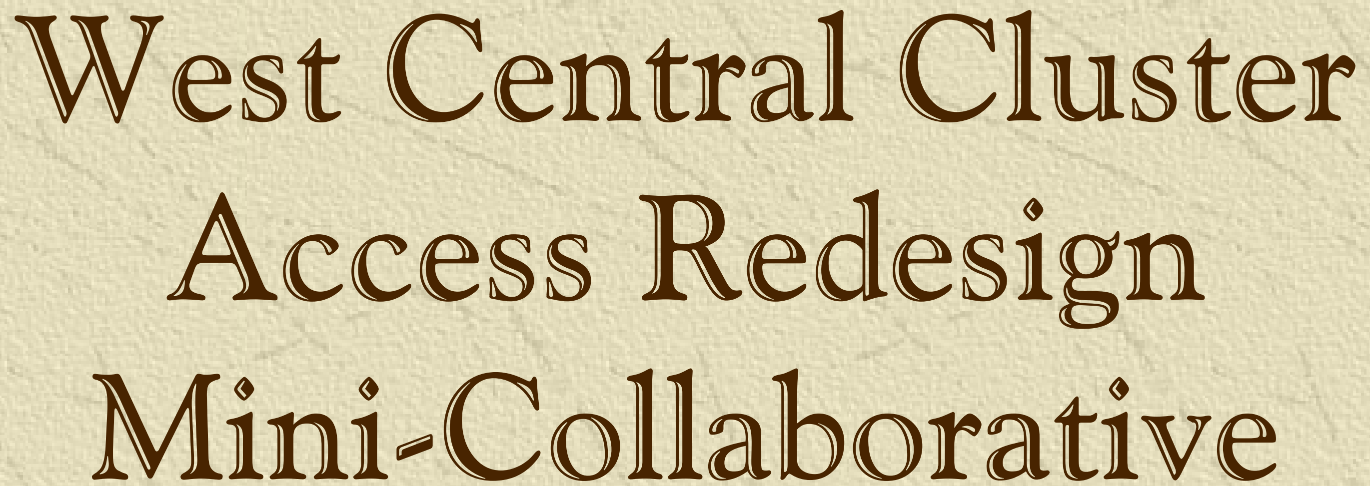

West Central Cluster
Access Redesign
Mini-Collaborative

Access Redesign Mini-Collaborative

- Learning Session 1 was held February 16-17, 2004
- Congress will be March 10-11, 2005
- 17 West Central Cluster teams have actively participated
- Faculty include Dr. Mark Murray, Dr. Mike Davies, and project manager Connie Sixta

ARMC Measures

- Decrease days to 3rd next available appointment (wait for an appointment)
- Decrease the cycle time (wait at an appointment)
- Increase continuity
- Decrease no show rate
- Increase panel size (capacity)

Paradigm Changes Related to Access Redesign

- Major Change In Philosophy
  - Patients will not have to wait <u>for</u> an appointment
  - Patients will not have to wait <u>at</u> an appointment
  - Patients will see their own provider
  - Providers will have a consistent clinical team to work with so that delegation of non-provider work can occur

Work of the ARMC Teams

- All teams are in the process or have completed the process of determining the CHC panel and the provider panels
- Over the past couple of months, at least 1/3 of the CHCs have experienced panel growth
- In that process CHCs discovered that:
  - The CHC total panels were smaller than anticipated (Number of visits may be high - not an indication of total number of patients served)
  - Provider panel sizes were not equivalent
  - Patient Information Systems did not support the process of panel identification - chart review and provider confirmation necessary

Work of the ARMC Teams

- All teams are measuring demand and supply and are using change strategies to decrease demand and increase supply, or to increase patient base
- Days until 3rd **next available** (access to care) have decreased significantly for most of the teams
- All teams are working on decreasing cycle time, about 50% have seen a significant decrease **in cycle time**
- About 50% of the teams have seen a decrease in **no show rate.** At CHCs with improved access and no change in no show rate, the no show slots are filled by patients requesting an appointment that day

Other Aspects of the ARMC

- Every other month the faculty gives each team specific, written feedback
- Team participation on monthly conference calls is excellent
- Monthly reports are received from most of the teams on a routine basis

Major Changes Related to Access Redesign

- Improved Access means patients can get an appointment when they request it (be it today, tomorrow, next week, or next month)
- To improve Access, **Patient Demand** & the **Supply of Providers** must be balanced
  - Demand = patients requesting an appointment, walking in for care, or scheduled for future follow up appointments
  - Supply = the number of patient appointments the providers can schedule/manage each day

Steps Toward Balancing Demand and Supply

1) Patient Demand Must Be Measured
   - CHC needs to identify its total panel of patients***
   - Each provider's panel must be identified***
     - Essential step to achieve provider accountability
     - Essential step to achieve continuity of care
     - Essential step to achieve patient-centered care

*** Initial expectation was that CHCs would have panels already identified at the outset, but in reality CHCs had neither identified their total panel sizes nor designated specific provider panels. Completion of those steps took time.

Steps Toward Balancing Demand and Supply

2) Daily demand for care must be measured (daily, then one week/month) = number of Patients in each Provider panel demanding an appointment (usually 1% of the panel size)
3) Daily supply must be measured (daily, then one week/month) = number of Provider appointments in the schedule
4) If demand and supply are not balanced, action must be taken to decrease demand or increase supply

Improved Access Can Occur Only When:

- Demand and supply are balanced (there is enough supply to support the demand)
- The backlog of appointments for each provider scheduled beyond today are eliminated (this does not include provider scheduled follow up appointments)

Ways to Balance Demand and Supply

- Decrease demand for an appointment by:
  - Determining which patients can be managed appropriately by phone follow up (done per protocol by nurse/MA)
  - Extending the time between follow up visits
  - Providing appropriate protocols/mechanisms (not visits) for medication refills, referrals, etc.
  - Initiating nurse-run clinics to manage high demand vaccine administration, well-child checks, etc.
  - Nursing case-management of complex high visit volume patients

***** With these approaches, providers must know their patients**

Ways to Balance Demand and Supply

- Increase supply of providers by:
  - Eliminating the non-provider work the provider is doing (i.e. lab report retrieval) to yield more provider time
  - Establishing a clinical team (MA) for each provider that the provider manages (knows, trusts, trains)- this will promote delegation of tasks according to practice, yielding more provider time
  - Decreasing any waste during the clinical visit (decreased cycle time/team synchronized to provider)- this will increase patient flow, maintain value of provider-patient interaction time, yield more provider time

Understanding the Applicability of A & R Changes to Increased Capacity

- Determination of CHC panel size is the 1st step in evaluating/increasing capacity
- Determination of provider panel size is the 2nd step in evaluating/increasing capacity
- Decreasing patient demand for visits through the use of other delivery mechanisms is the next step in increasing capacity.
- Increasing provider supply by making sure the provider is only doing "provider work", giving the provider a consistent team to work with, and decreasing wasted clinical time is the next step.

Understanding the Applicability of A & R Changes to Care Model Implementation

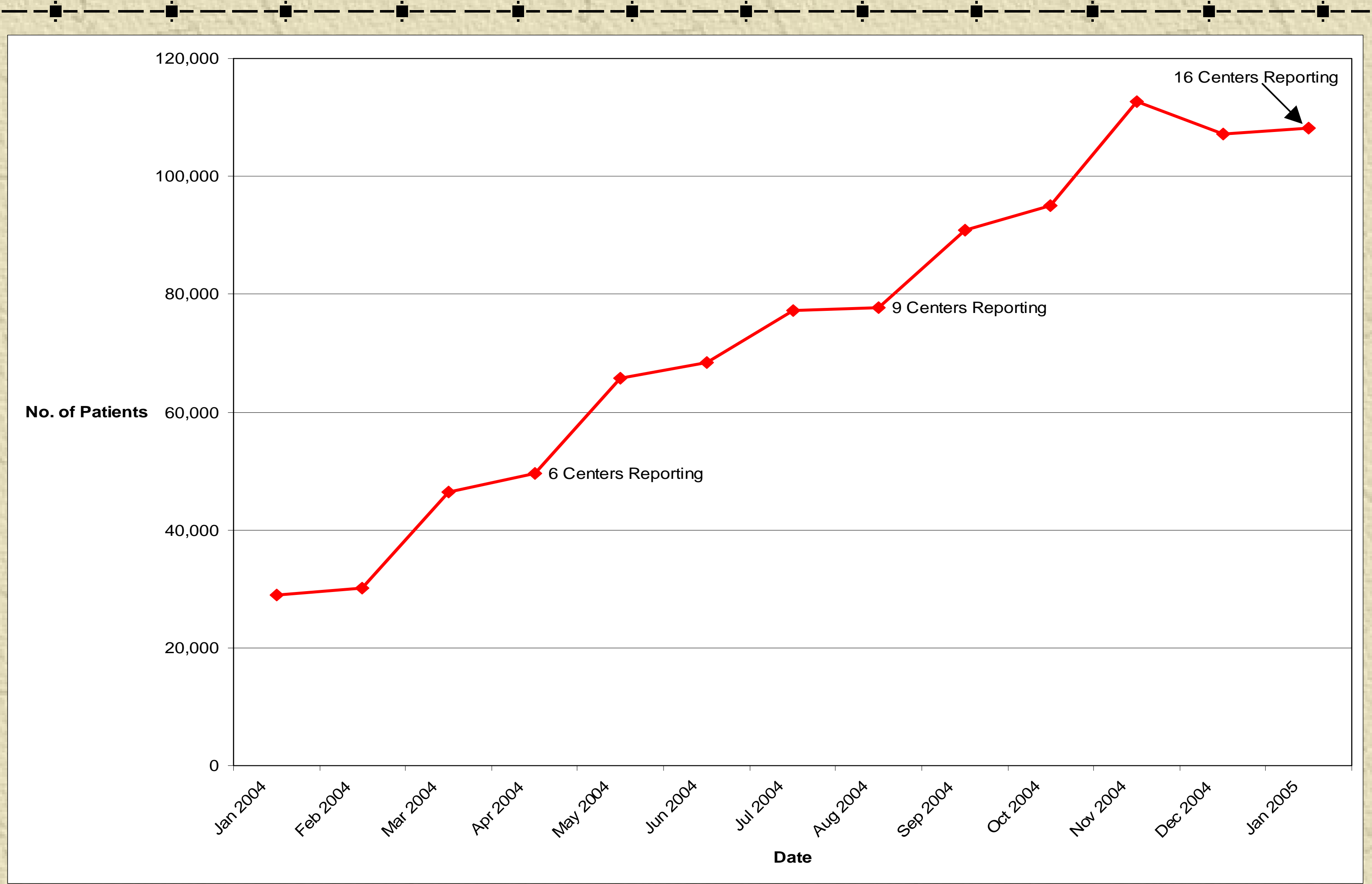
- Determination of CHC panel size and actual CHC patients with the chronic illness (ICD-9 code) is the 1st step in spread registry design (Total POS identified)
- Determination of each provider's panel and actual patients with the chronic illness within each panel is the 2nd step in spread registry design.
  - Essential step in defining the population each provider is accountable for and must manage
  - Essential step in developing patient-centered care and supporting patient self-management.
  - Essential to the continuity of care and the determination of appropriate follow up.

Understanding the Applicability of A & R Changes to Care Model Implementation

- Decreasing patient demand for visits through the use of other delivery mechanisms is essential to chronic disease follow up (prevents overloading the system) and is the next step in population management.
- Increasing provider supply by using unique care delivery models such as group visits and disease clinics and maximizing the work of team members by giving the Provider a consistent team to work with are essential steps in population management.

Access Redesign Mini-Collaborative Data

Average Panel Size



Panel Size (By Center)

Panel Size

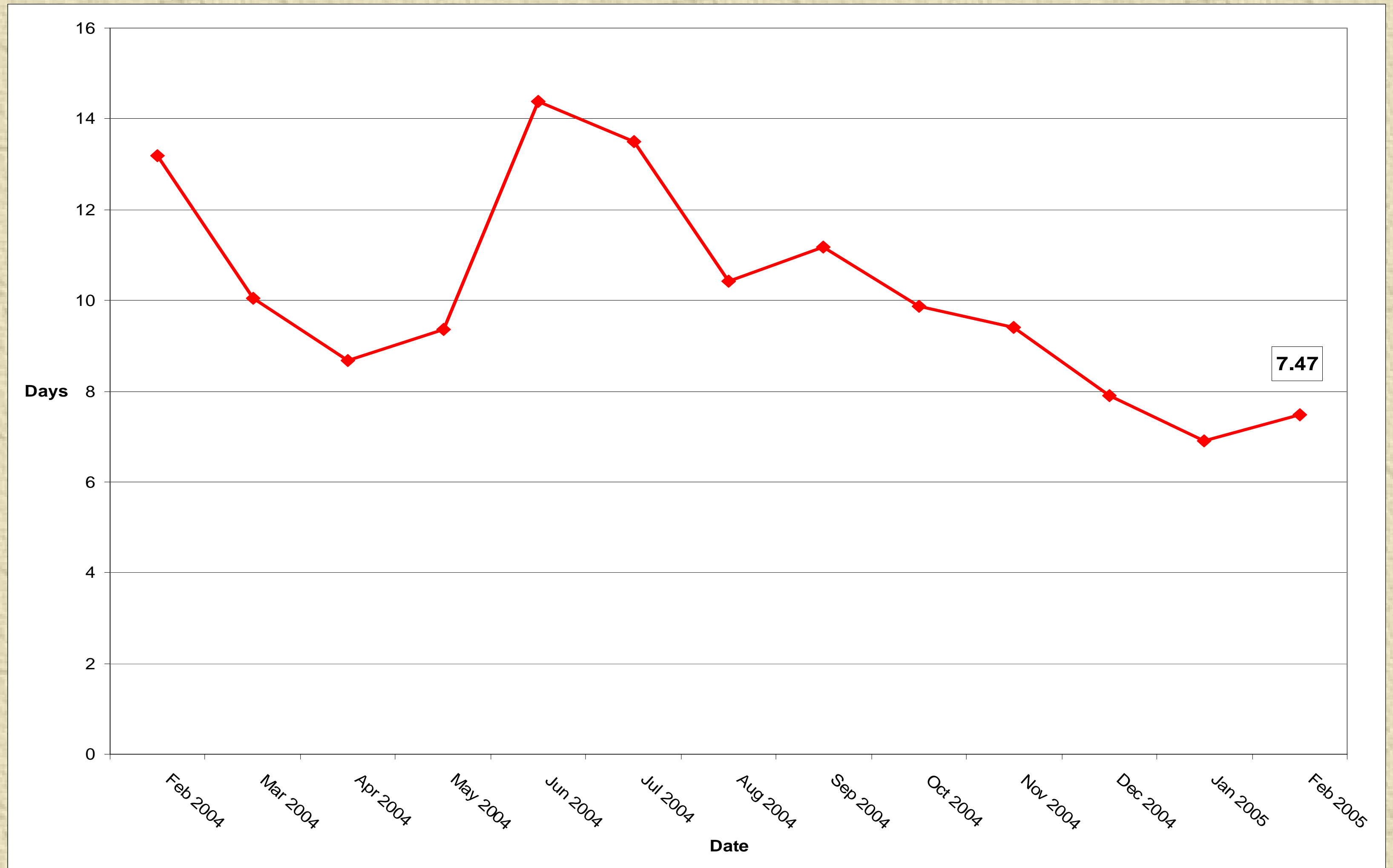
16,000
14,000
12,000
10,000
8,000
6,000
4,000
2,000
0

Jan 2004
Feb 2004
Mar 2004
Apr 2004
May 2004
Jun 2004
Jul 2004
Aug 2004
Sep 2004
Oct 2004
Nov 2004
Dec 2004
Jan 2005
Feb 2005

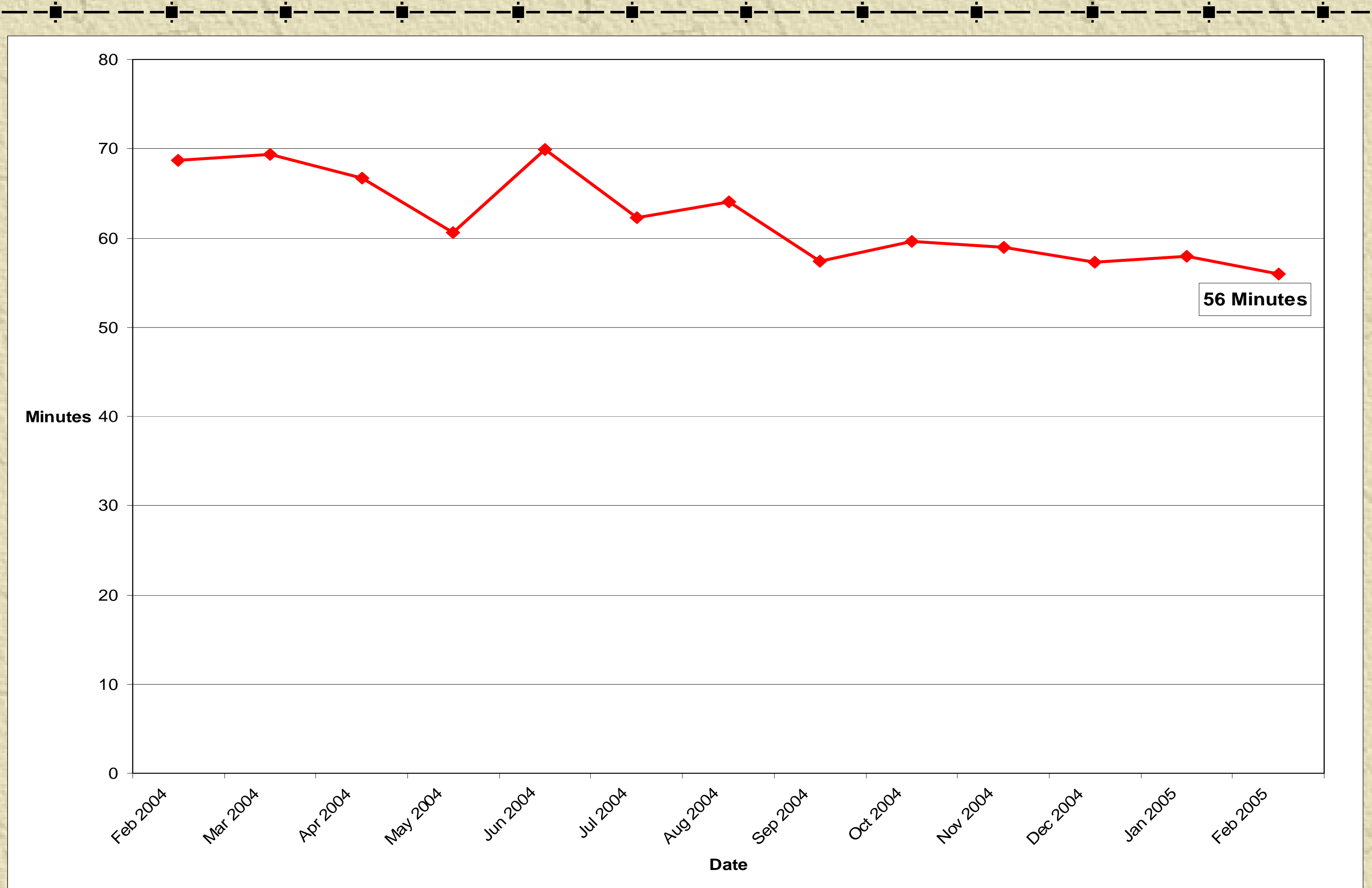
Date

Atascosa
Butte CHC
Catahoula
Centro Del Barrio
CHPartners
Cooperative
CSV
Family HealthCare
Fort Bend
Gateway
Mary Mahoney
Morton
Mountainlands
Ben Archer
SPHPO
SRVCHC

Average Days Until Next Available Appointment



Average Cycle Time (Minutes)



Average % of Cancelled/No-Show Appointments