

Slide – HOQ: Health Quality Ontario plays a major role in supporting continuous quality improvement with health care delivery in the province of Ontario. Since 2008, quality improvement coaches have been providing support through structured improvement initiatives to primary care teams who are trying to improve access to primary care and improve efficiency in the delivery of their care.

Slide – Accessible Care: HQO identifies accessibility as one of the 9 attributes of a high performing health system. It is defined as "people getting timely and appropriate healthcare services to achieve the best possible health outcomes". Sounds easy? Well, it's not always so easy.

Slide – Time to Do it: "With open access, when we have to do something quickly, there is the time to do it. Let's say for example HINI, we quickly needed to allocate some spots for immunizations and sure we all had breaks in our schedules where we could plug in these sessions. The other thing is if a meeting comes up that was not planned it's easier to slot that into an open access spot than to cancel 4 or 5 patients. So I find that there are less cancellations and more accomplishments, which equals more productivity at the end of the day."

Slide – Delays Are Common: It turns out that delays are actually quite common in our system. Health care system delays are everywhere and they've actually become the 'norm'. Delays in getting to a primary care provider, getting tests, seeing specialists. Delays create dissatisfaction for patients, for staff who have to cope with the backlog and frustrated patients, and over-booked and pressured providers like us who are just trying to keep up having to see more and do more. Delays cost money too. There's system spin and time and stress and waste, and there is evidence that they can live to worse clinical outcomes. Delays aren't anyone in particular's fault. They're not the fault of anyone provider or practice. They are the result of a system that is designed to tolerate delays. We can choose to move toward a system that enables patients to see their provider when they choose by moving away from a traditional scheduling model to advanced access.

Slide – They Won the Lottery!: "When we first started the open access, our patients kept saying they won the lotter – they got to see their doctor that day."

Slide – How Are You Doing: Think about how you are doing. How long do patients wait to see you or the providers you work with? Do you experience any of the situations here? You may benefit from implementing the principles of advanced access and efficiency.

Slide – I Can See You Today?: "... I had absolutely only a little idea before but now I have an actual idea of real fact, real time, of who I am serving, who I am not serving and how best to develop the plan to help serve the community...it's the opportunity to do population care, population health care in the community setting, individual practice setting, within the context of a team...it's been very exciting to hear the people respond to 'what? I can see you today, if I call today' ...they have been amazed that this has been possible in this time of shortness in the number of docs and the number of health care providers, and yes we still provide that.."

Slide – What is Advanced Access: So, just what is advanced access? Advanced access in primary care is about providing patients with timely access to a routine, scheduled appointment. It's usually measured in days from the moment a patient or a client calls in with a request to see their provider, to the day they actually see the provider. It doesn't matter what the reason for the visit is. Our work at HQO has focussed on the gold standard measure which is called the "third next available appointment" or TNA.

Slide – Advanced Access is About: We've got a motto about advanced access. Advanced access is about timely access and continuity - 'see your own and don't make them wait'. It's about reducing delays for an appointment. It's about patients seeing their provider on the day of their choice. It's about doing today's work, today. It's matching provider supply to patient demand. And it's about improving the overall patient, provider and team experience.

Slide – What it's NOT about: It's probably worth clarifying what advanced access is not about. It's not about limiting your patients' ability to book in advance like access by denial. Don't make people call back to book an appointment. It's not about prioritizing access over continuity. Don't send your overflow to another provider or walk-in clinic. It's not about making doctors or teams work harder or faster or longer; this is about working smarter. It's not, for sure not, about promoting a walk-in culture. The focus is on having the ability to book appointments same day, or day of patients' choosing, but not just walk-in any time. And it's not about unleashing limitless demand. It's about the need to understand your current demand for appointments in order to better manage it.

Slide – Get Home Earlier: “Normally I end the day somewhere between an hour and an hour and a half behind schedule. Last week, the first day of open access, I was half an hour behind at the end of the day and I was thrilled and I thought “just a fluke”, and it was the same the next day, and the same the third day and I couldn't believe it.”

Slide – Moving Towards AA&E: Think about access along a continuum of different models or possibilities. In the traditional model we tend to have a pretty saturated schedule; we're into triage and re-working things. There's multiple appointment types, well-baby visits or follow-ups or initial consults, well-women examinations. There tend to be long delays. This often, inadvertently, leads to deflections to emergency departments or walk-in clinics, things that actually wind up generating increased demand because folks are often referred back to see you. In essence there's a way in which today's work tends to be pushed forward to tomorrow and beyond.

People also talk about the 'carve-out model' . This at least involves some form of a separation between urgent visits and routine visits. You have to try and predict demand for urgent and reserve space to meet that demand. Some of today's work is done today in this model, but some of it is still pushed out into the future.

People sometimes also talk about 'access by denial' when future booking is either not allowed or restricted to a certain time period, i.e., just the next two weeks only. There's an attempt to protect open time. This doesn't allow for good backlog, i.e., that's the pre-booking for appointments that make sense for example appointments that need translators booked or chronic disease appointments or client or patient preference.

In the advanced access model, you're really focused on doing today's work today; this week's work this week. It means offering clients appointments today or when they want it. It really means matching supply and demand and working efficiently. It's more client-centered not provider- centered so it's not about protecting the provider, but it means pulling work into today in order to protect tomorrow. The proportion of open appointments you have each day may be different and will be based on the data you have collected about the daily demand, supply and activity for your practice. Practices often find that the proportion of open appointments they need on a Monday for example, is very different than the proportion they need on a Thursday.

Slide – Improve Access to Care: Access to care CAN be improved. One of the keys to this is trying to understand and balance your demand and supply. Try defining demand. This is typically the number of requests for an appointment from patients or from providers as follow-up or daily, or weekly, or annually. Define your supply. The number of appointment slots according to the schedule daily, weekly, or annually. The key to improving access is balancing demand for appointments with supply of appointments.

Slide – Consider Annual Demand: First, consider your annual demand and supply. You might wonder why we do the annual first but this is the best way to get the overall reading of how in balance your practice is. It's really the ability to serve the number of patients in the panel given the appointments available. Calculating the annual demand and supply is relatively straightforward. First you have to define the visit or re-visit rates. This is the average number of times that patients in the panel visit the whole clinic or practice annually. And capturing the visit or re-visit rate is pretty straightforward as well. Divide the number of unique patients seen in the last 12 months into the number of visits to the practice that these patients generated within the same period.

Slide – Case Studies: Intro- Each team's journey to improve access and efficiency is different, as they apply the principles and concepts to their individual practice style, office settings and patient populations. Have a look at these three case studies, which reflect how three different practices apply the principles and concepts to make access improvements.

Slide – Example 1: Our first case study is that of a solo MD with a panel of 2100 patients working with 1 RN & 1 receptionist in North Bay. He always had good access but when joined the Advanced Access initiative, he was just returned from a 3 week vacation so backlog built up to 6 days. After analyzing his demand and supply, data showed he was in a balanced position. Once his normal supply was back in place his third next appointment dropped to 2 days after Months 2 & 3.

Cycle time data shows minimal waiting due to central office set up but his average time spent with patients was 10 minutes and this confirmed his perception so he moved from 15 minute schedule to 10 minute schedule. This actually removed confusing section of the way they did their scheduling, where his receptionist tried to manage the patients she squeezed in between patient bookings to use the extra time he was having. Now he clearly has one schedule with 10 minute appointments and his receptionist books in units of 10 with some appointments being 20 minute visits. Every other hour has one 10 minute buffer slot for catch- up time. He quickly worked down backlog over the Christmas holidays and began the new year with no backlog – his third next appointment has remained at 0 ever since.

Slide – Example 2: With a panel of 800 patients our second case study physician works in a northern family health team with allied health staff providing program support all under the same roof. She described a chronic backlog of around 3 weeks at the time of entering advanced access and efficiency program. She works every Thursday in a First Nations clinic and Monday, Tuesday, Wednesday with serving patients in her community. She was taking Fridays off.

After reviewing her demand patterns, she realized that Mondays and Tuesdays were the busiest days of week but most of her supply those days were booked by demand that came in Thursday and Friday the week before. She decided to work Friday morning in exchange for Wednesday morning. This move significantly allowed her more availability at the beginning of the week yet her third next appointment was still around 11.

Then she tested the use of phone calls for relaying follow up information versus booking a face to face appointment. As well, she worked with several RNs in the family health team to identify patient visits that they could help with (e.g., B12 injections, blood pressure follow up for hypertension patients, diabetes patients who were in good control, etc). This helped move her third next appointment to 7 days at the 6 month mark. Then she took 2 weeks off at Christmas and her third next appointment climbed back to 10 days. Weekly demand data shows that she has enough supply to meet demand but has too much backlog. Working with experts in the advanced access community she created a backlog reduction plan where she's agreed over a 3 week period to work all day on Wednesdays to get caught up.

Slide – Example 3: With a panel of 1800 patients our third MD works in Central Ontario with a practice of 7 physicians, 3 nurses, and a centralized reception staff of 4 people. Like our second case study, she also found herself with consistent backlog of around 2 weeks when she first started working toward advanced access and improved efficiency. She doesn't work Monday as a result her Tuesdays were always jam packed with 3 days of demand waiting for her. The front office began booking follow up appointments later in the week - Thursday and Friday mornings leaving her Tuesday afternoons open as much as possible to accommodate Monday and Tuesday demand. Her schedule included 6 carved out slots each day for urgent issues. When she began working on improving efficiency she kept those in place until she was ready to remove her backlog - then they were converted into regular slots with no restrictions for reception staff to schedule into.

Her frustration was really with patient flow. She was always feeling rushed from one patient to the other with no breaks. Her lunch hour was used for catching up or dealing with squeeze ins. When she analyzed her cycle time she found several things. Her first appointment of the day was usually behind when she had personal obligations in the morning. This then made the entire day behind. So her first appointment was moved to 9:30 instead of 9.

Next she observed she was constantly getting interrupted by reception staff or nurses looking for squeeze ins or direction for follow up. She had a hard time saying no to patients who brought their kids in for medical attention as well. She tested different things to keep her on schedule. For example, quick lunch huddles to review the schedule and discuss patient needs, reducing interruptions to things that could be answered in 15 seconds or less between patients. She also identified repeat offenders - people who brought in multiple family members and tried to schedule more time for their appointments.

As reception staff scheduled a patient for an urgent same day appointment, they scanned the future schedule to see if those patients had an additional appointment already booked. If they did, the physician covered both the urgent issue and the future issue at the same appointment saving a future supply spot. For example, if John was booked for an urgent issue and he had an appointment two weeks later to discuss his diabetes, with John's permission, these were discussed during the same appointment. By the 6 month mark, she was convinced that her demand and supply were in a balanced position and she committed to work down the backlog slowly over a three month period - working an extra 2 hours per week.

Slide – Conclusion: Conclusion - Again, while each team's journey to improve access and efficiency is different, these case studies illustrate that you can apply the principles and concepts to different practice styles, office settings and patient populations to make access improvements.

Slide – The Patients Were Happier: "We found that one of the docs had gone on sabbatical for about 6 months. She came back, with the open access in full swing, she noticed such a difference. The patients were happier, the appointments were far more productive because the fact is the patients came in, with not a list of things, but they had one item that they had to deal with at which point then the physician had more time to basically discuss other things as pertaining to prevention and getting them on board for that too. So it's been very very positive."

Slide – What do Teams Say: There is a lot in it, both for you and your patients. Teams find their patients are more satisfied with their care. They get timely access to care with their own provider. But, you and your staff are also going to be more satisfied. There is less triage, rescheduling and appointment confirmations. Things are more predictable and more manageable in terms of your schedule. Patients have shorter complaint lists. They are not waiting around and accumulating. It feels like you are keeping up. The team is better able to organize their care processes and provide continuity of care, when you are doing today's work today. Ultimately too, there's less cost to the healthcaresystem. Fewer no-shows, a decrease in unnecessary visits to the ER and improved continuity also means less system spin, where people are going around and around.

Slide – This Was an Amazing Change: "...this was an amazing change. I had gone from patients waiting a number of weeks and sometimes months to see me to being able to see them almost as soon as their problems come up...and obviously getting these things seen, treated, diagnosed as soon as possible make a big difference. This morning I had a mom who brought in her 13 year old daughter who had not been feeling well for just a few weeks and it looks like this girl is going to unfortunately develop diabetes but is someone we were able to see right away and we were able to get her into the system and seen quickly. Almost every day I come across a patient who has benefitted from being able to get in to see me so quickly...the other advantage of open access as I've discovered is that my patients are much happier and as a by-product, I 'm much happier. So this was an insight- apparently happy patients make happy doctors and not the other way as we used to think maybe. And certainly my colleagues have seen me a lot happier and many of them have been inspired by that and they are thinking about switching to open access, some already have so we are starting to spread that across the group."

Slide – Challenges: But I'm not going to kid you either. There are some challenges and road blocks along the way. Measuring stuff is crucial. If you can't measure it, you can't improve. Somebody on the team has to actually look at the data and do the math around demand and supply. You've got to try to engage your staff. People do better when they have been involved in the change. Try and involve everybody you can in the practice, who is going to be part of this process. Change is tough for lots of people. It is good to think about developing a strategy. You could imagine that not everyone in the practice is necessarily going to see the need for change. It's important to try and come up with a plan where sustainable, and often that is where improvements fail. There is always a tendency to try and flip back to the old way of doing things. So you want to try to build strategies to sustain and spread the change.

Slide – Positivity & Flexibility: "At the beginning it took a lot of energy and a lot of hard work by the receptionist to sell it. Once it was sold, in a very positive and flexible way, the patients seem to have caught on to it very well and now our whole clinic is open access"

Slide – machealth Site Learning Community: The machealth advanced access and efficiency program community is a group of improvement minded primary care providers and advanced access experts with a common goal, who leverage and deepen their knowledge and expertise by interacting on an ongoing

basis. By working together, communities support the exploration of innovative approaches and novel solutions, leading to true improvements.

The machealth advanced access program community has a few main elements. There's the program home. That's the homepage, where you first accessed this course. It has the program menu, where you can access the related applications and elements.

We've got a blog. Look for tips and insights from experts on our program blog.

The forum is where you can connect with colleagues to ask questions, or discuss barriers and insights.

Our resources section has outstanding resources to help you on your journey, like the advanced access and efficiency workbook. The Resources referred to in each course are also available on the course landing page, where you accessed the individual learning modules.

Don't forget to check out the calendar. The Ontario College of Family Physicians', CME on the Road, often includes events with topics related to advanced access or quality improvement.

Subscribe to our email newsletter.

And, we've some key related programs. Check out quality.machealth.ca for other online programs related to the quality in family practice movement. They're based on this similar model for improvement in the plan, do, study, act cycles of change that we touched on a little bit today. And look for our Chronic Disease Management course, coming soon.

Slide – Benefits of a Learning Community: We think there's many benefits from participating in the advanced access machealth community. They include some of the following.

You are going to learn and apply the model for improvement and other quality improvement tools to a specific area focus, and to be able to take this knowledge and skill hopefully to other areas of your practice down the road.

Share tests of change and ideas, outcomes, challenges, strategies, successes, and developed resources with your peers in this initiative.

You're going to start to innovate. You are going to create new approaches, or revise old approaches to the way care is delivered.

To improve by engaging in regular measurement of a common set of measures that will indicate whether changes are being made and whether they are resulting in improvement. You can share these changes with members of the machealth community. Once again, the overall goal is to build capacity and capability to improve and sustain access and efficiency improvements in primary care, as well as spreading improvement approaches to new areas of focus and to other providers in primary healthcare in Ontario.

Slide – Questions: No narration.

Slide – Acknowledgements: No narration.

