Increasing Access to Primary Care Through Operational Redesign

The Ambulatory Care Restructuring Initiative

Annual Meeting
of the American Public Health Association

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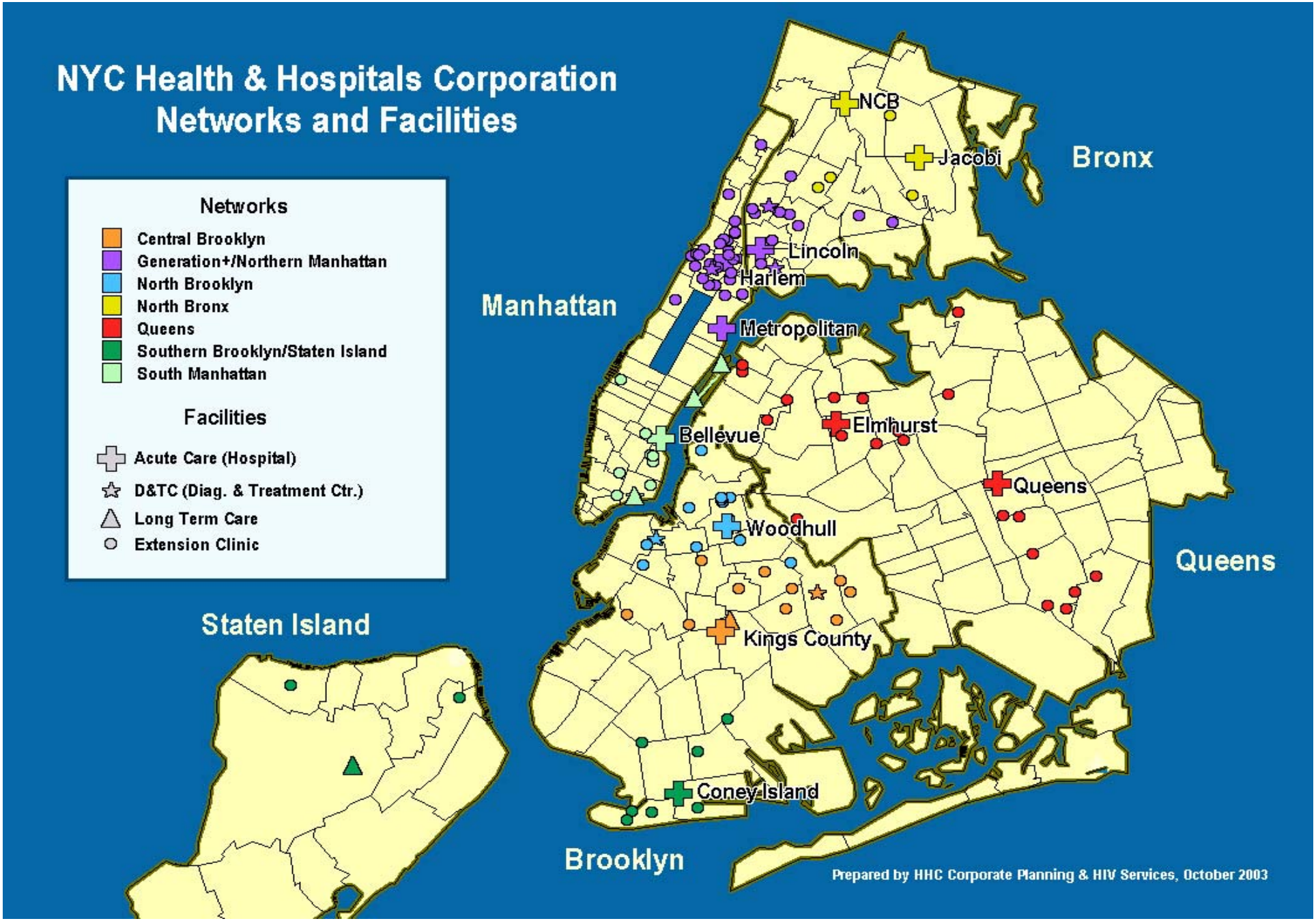
New York City Health and Hospitals Corporation (HHC)

- Public benefit corporation created in 1969
- Largest municipal hospital system in US
  - 11 acute care hospitals
  - 6 diagnostic and treatment centers (D&TCs)
  - 4 long-term care hospitals
  - 90 extension clinics
  - MetroPlus (health maintenance organization)
  - Home care agency



Background

- In response to a systemwide patient satisfaction survey, HHC embarked upon an effort to improve patient centeredness and access to primary care.
- In mid-2002, HHC began to conduct team-based training to reduce:
  - cycle time to ≤60 minutes
  - wait time to ≤3 days
  - no show rates to ≤20%.

ACRI

- ACRI is an essential component of HHC's ***vision*** of patient-centered excellence in health care.
- ACRI ***complements and extends*** the reach of clinical improvement efforts.
- The overarching ***purpose*** of ACRI is to improve the quality of the patient experience in obtaining and receiving primary care services.
- ***Redesigning the Patient Visit ⇒ Advanced Access ⇒ Patient Centered Scheduling***

Phase One: Redesigning the Patient Visit

- ***Goal: provide primary care visits in ≤60 minutes by December 2005***
  - 6 Redesign Collaboratives were held between November 2002 and December 2005
  - 30 facilities participated
  - 64 primary care clinics affected, including:
    - 28 hospital based
    - 16 diagnostic and treatment centers
    - 20 community health centers

Strategies for Redesigning the Patient Visit

- Don't Move The Patient
- Increase Clinician Support
- Create Broad Work Roles
- Organize Care Teams
- Exploit Technology
- Communicate Directly
- Start All Visits On Time
- Monitor Capacity in Real Time
- Prepare for the Expected
- Get The Tools You Need
- Do Today's Work Today
- Eliminate Needless Work

Phase Two: Patient Centered Scheduling

- ***Goals*: *Offer patients an appointment in ≤3 days with their own providers on a day and at a time of their choice; reduce no-show rates to ≤20% and increase patient-provider continuity***
  - 4 Collaboratives were held between January 2006 and November 2007
  - 62 clinics participated, including:
    - 33 hospital-based
    - 24 diagnostic and treatment centers
    - 5 community health centers

Strategies for Patient Centered Scheduling

- Use one visit type and aggressively manage the schedule template, including maintaining open slots daily
- Review scheduled appointments, cancel duplicate or unnecessary appointments, pull future visits forward
- Extend the visit interval and limit the ability to book appointments past a certain point in time
- Call patients to remind them of upcoming appointments and/or to schedule follow-up
- Start the day on time

Maximize vi

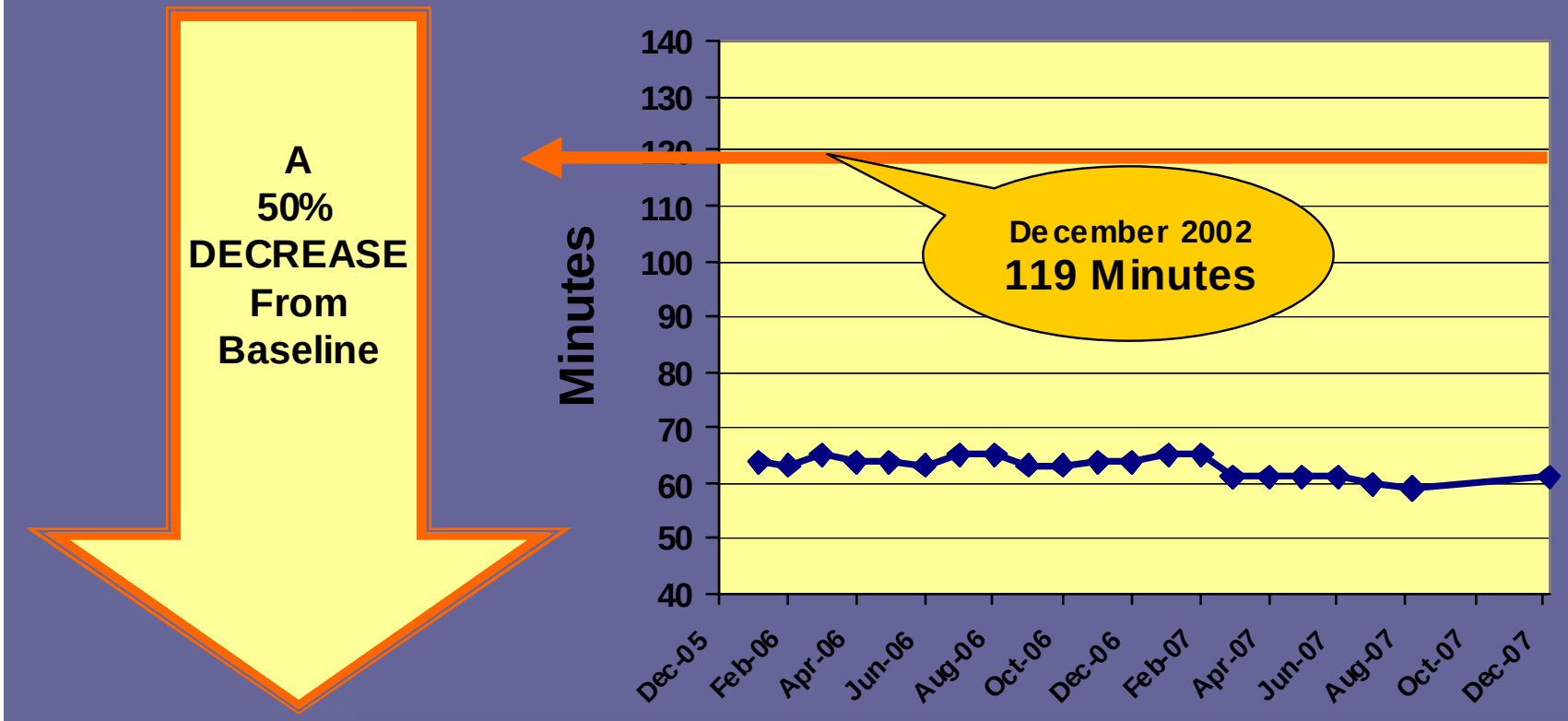
Results to Date

*HHC Corporatewide Average – All Primary Care Clinics**

Indicator	Achievement	Goal
Cycle Time	55 minutes	≤ 60
Third Next Available (TNAA)	6 days	≤ 3
No Show Rate	20%	≤ 20%

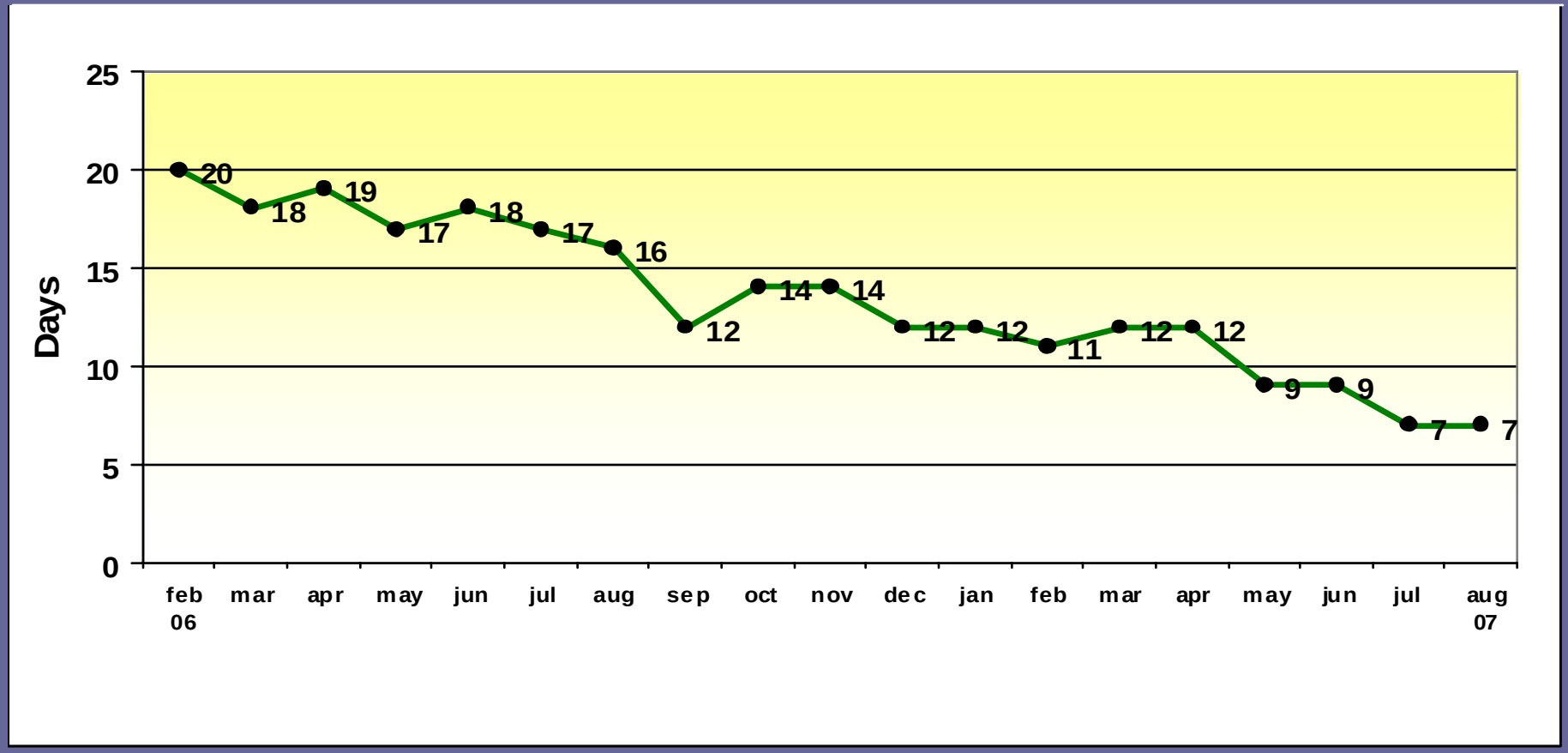
*as of September 30, 2007

Acutes and D&TCs
Average Visit Cycle Time*



* Cumulative Average of 51 primary care clinics (17 facilities)

Acutes and D&TCs
Average TNAA



*** Cumulative Average of 51 primary care clinics (17 facilities)**

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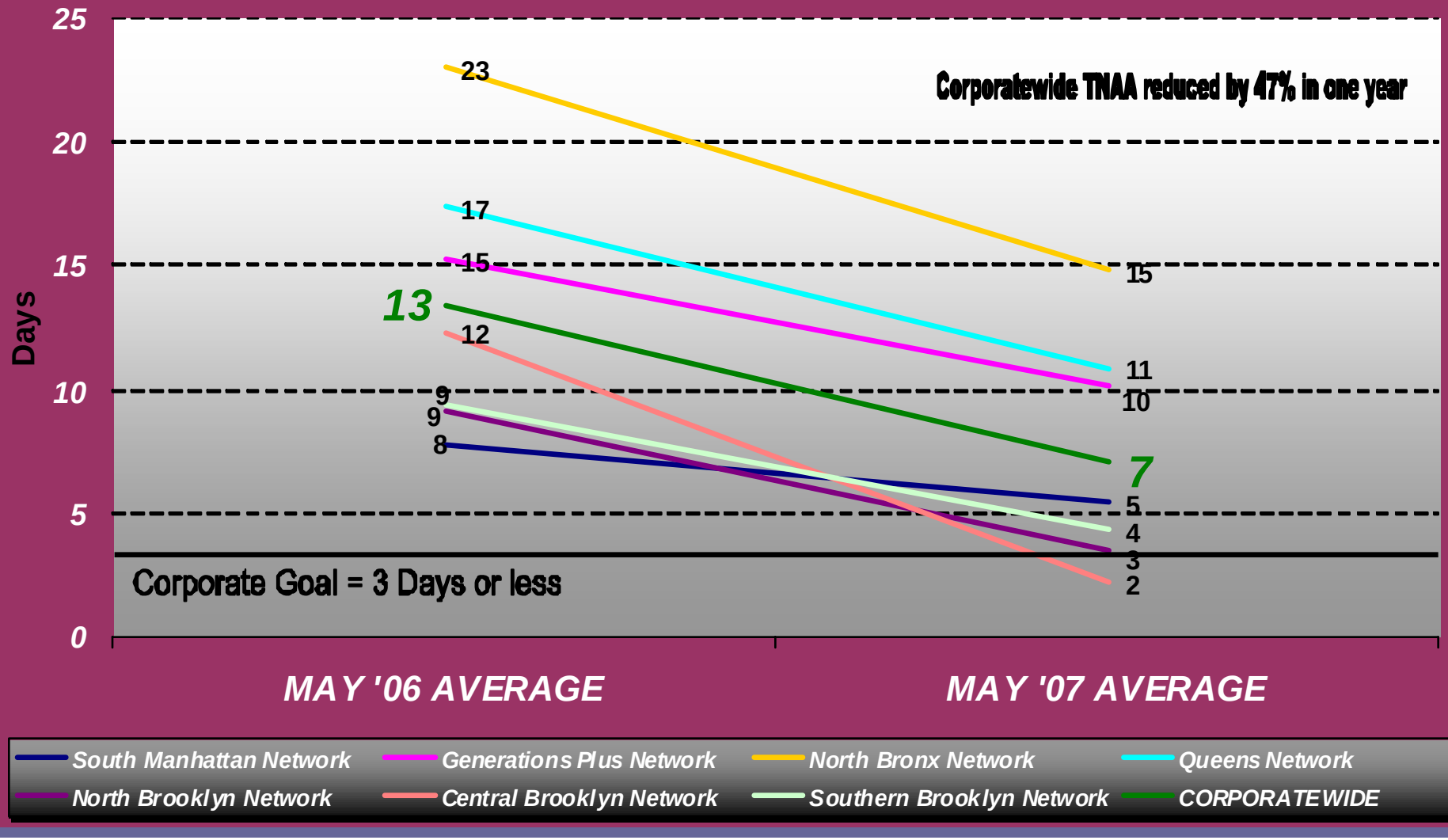
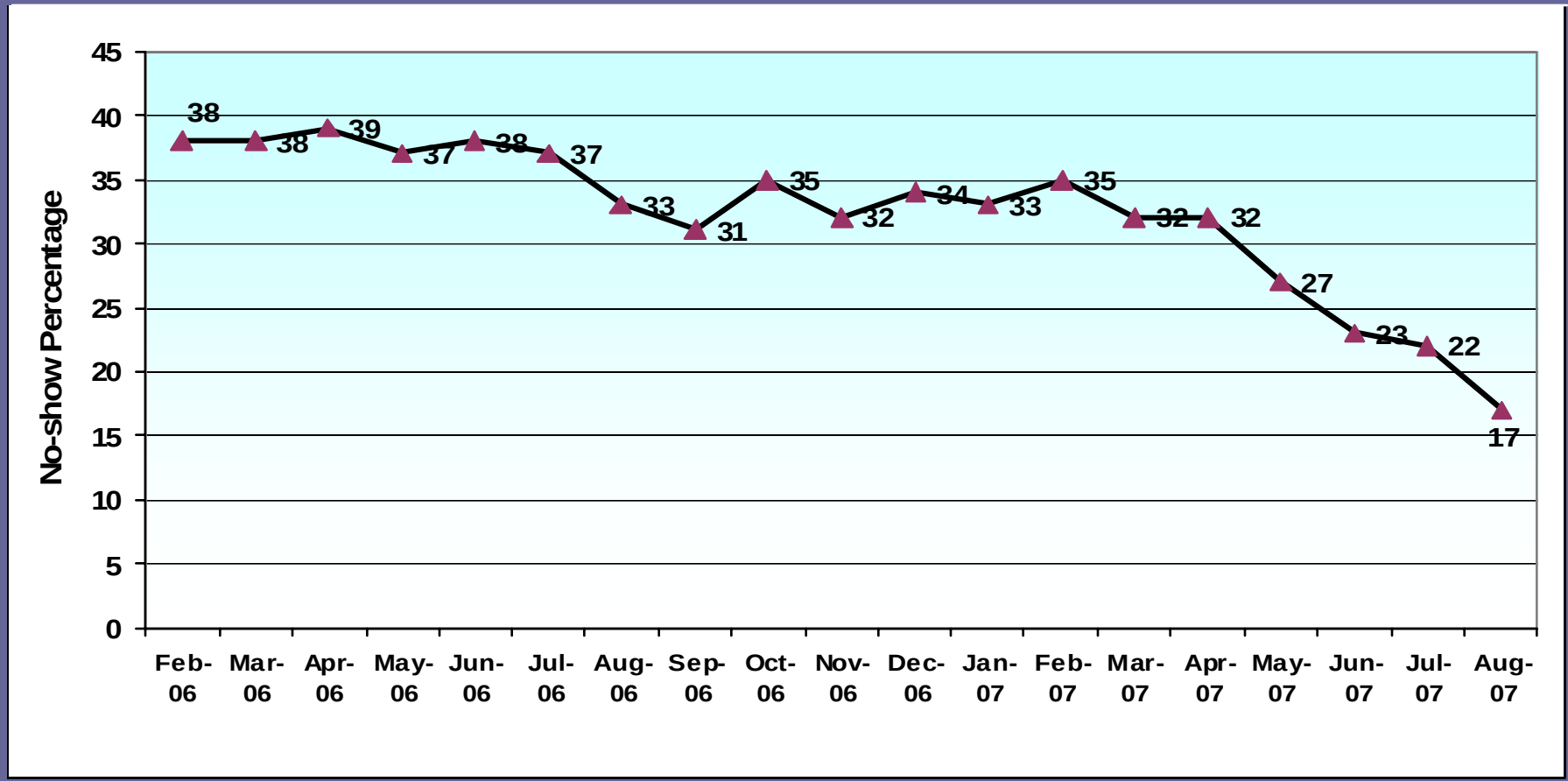
Patient Centered Scheduling

Status Report - Third Next Available Appointment



Acutes and D&TCs
Cumulative Average No Show Rate



*** Cumulative Average of 51 primary care clinics (17 facilities)**

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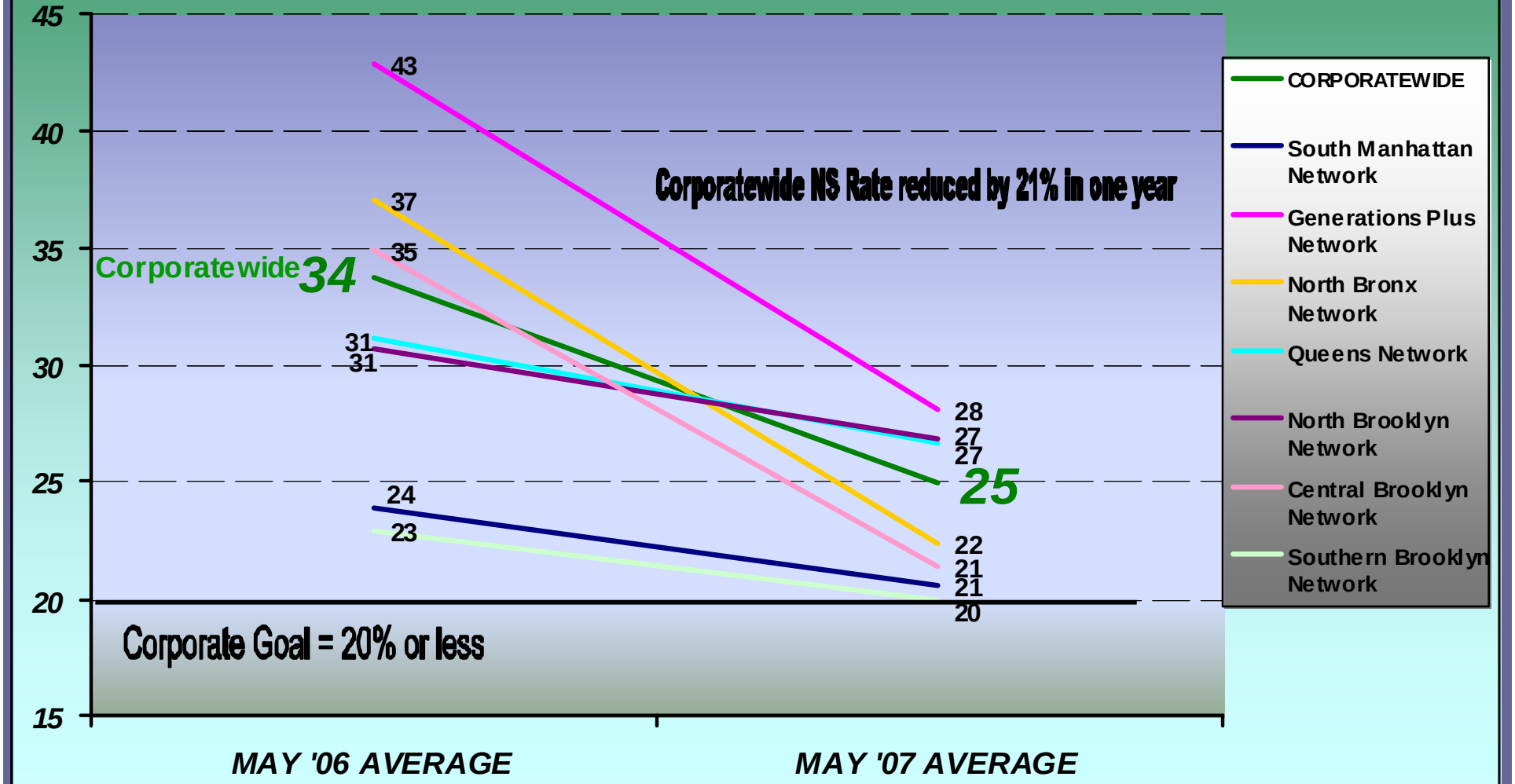
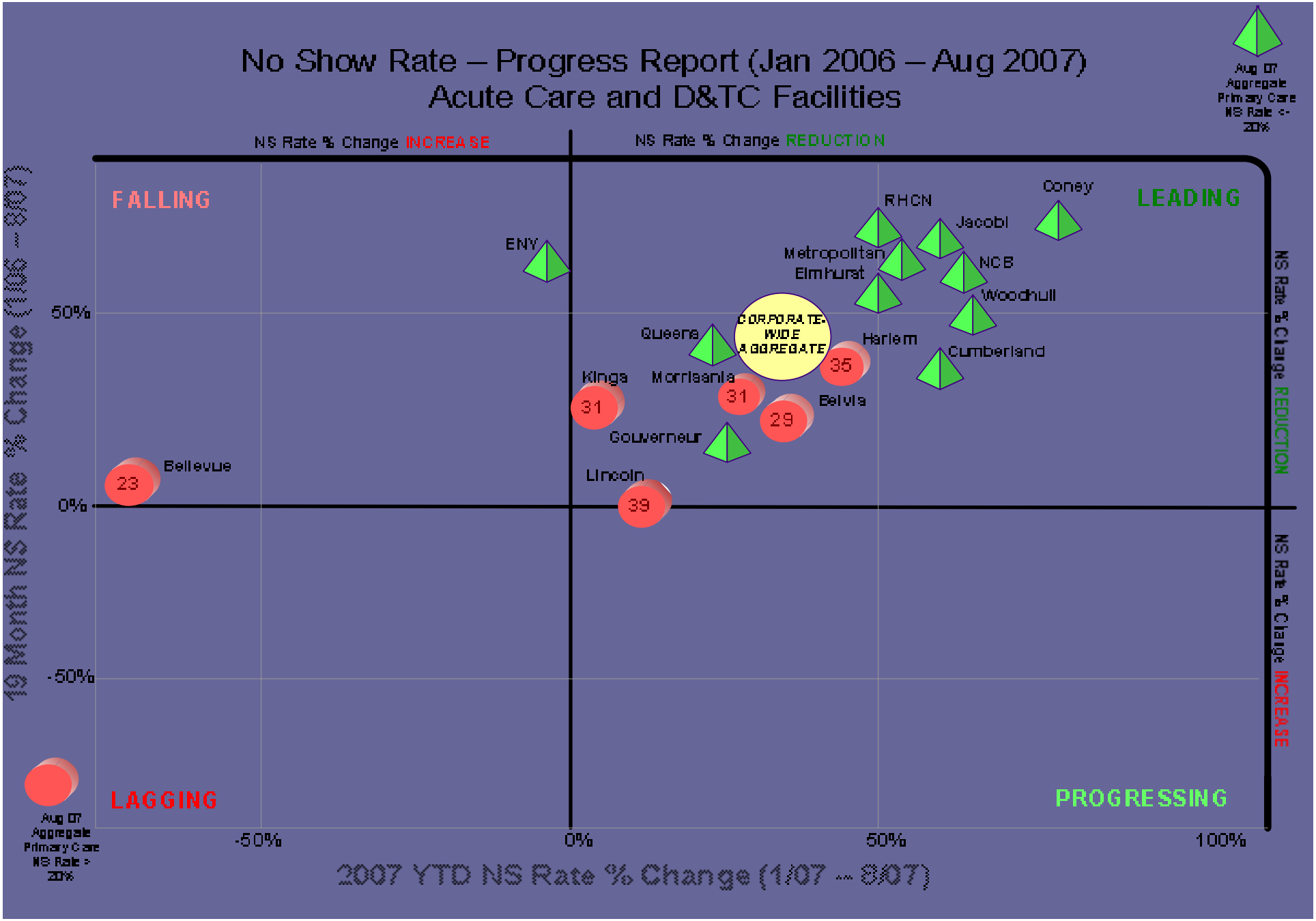
Patient Centered Scheduling

Status Report - No Show Rates (%)





Challenges to Sustaining Spread– Redesigning the Patient Visit

- Not all sites have an adequate number of swing rooms
- Additional experienced Template Managers are needed in both Acutes and D&TCs
- The existing scheduling system and processes are not as flexible as needed for real time adjustments to be made, particularly when the clinic flow is impaired

Challenges to Sustaining Spread—Patient Centered Scheduling

- The large number of part-time providers in many clinics reduces continuity of care and extends appointment delays
- PCS strategies work - but the Collaborative may not be adequate to address the system issues that limit the benefit of interventions
- Leadership must walk around and 'talk the talk'

Lessons Learned

- A participatory process that includes training, empowerment of staff and teams and the adoption of changed processes can improve access.
- Effective management of clinic flow requires that all staff have real time information regarding patient queues and needs.
- It is possible to anticipate much of the 'unanticipated'.
- Operational redesign strategies may be successfully adapted to many different types of settings.
- Staff and patients report significantly increased satisfaction with how clinics operate.

Lessons Learned

- Success requires acceptance of a culture of change as well as active engagement at all levels.
- Ongoing and effective communication among Providers, Nurses and PCAs is necessary for optimal results and improved productivity.
- Optimization of PCA functions is critical to sustaining PCS gains achieved.
- Change of this magnitude takes time. Organizational behavioral change requires ongoing leadership support.

The Future of ACRI

- Tactical, site-specific interventions provided at underperforming primary care clinics
- Reinforce proven strategies
- Create opportunities for sister facilities to share best practices and innovative solutions
- Key indicators added to Corporate dashboard
- Implement in specialty and dental clinics.
- Ensure the models and strategies allow for incorporation of new Corporate priorities
- Incorporate Lean strategies in ongoing ACRI interventions