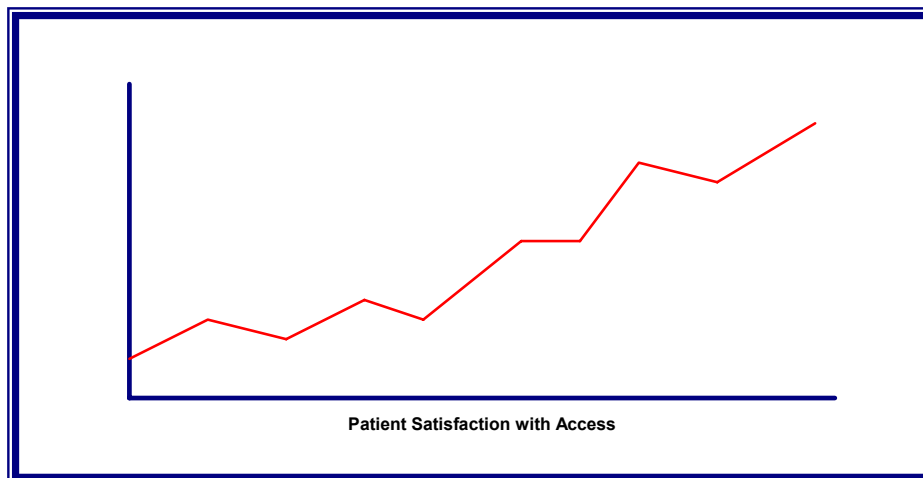


Measuring Access Improvement

Patient Focused Access Measures



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AUTHOR'S NOTE

Mark Murray, MD, MPA and Catherine Tantau, BSN, MPA of Murray Tantau and Associates, have been leading access improvement both national and internationally for many years. We first met them in 1996 when we were engaged in trying to improve access for patients receiving care at Dartmouth-Hitchcock. Their vision of creating processes that meet and exceed patient expectations for access to care was impressive and instrumental in guiding our access work within our own system. We have collaborated with them over the years and are grateful for their continued vision and persistence towards encouraging health care systems to develop patient focused access systems.

Our mentors, Gene Nelson, DSc, MPH and Stephen Plume, MD were relentless in reminding us to monitor and measure outcomes in any improvement work. Our access work was no exception. What started out as a briefcase of disjointed, handwritten forms developed for teams engaged in access improvement is now this collection of measurement tools and tips. As Dr. Plume once said, “Just use a piece of paper and a pencil.” Time and time again we learned that a pencil, a piece of graph paper, and a process to measure was all that was needed to support a team in their improvement work. This workbook of measures and templates attempts to organize our efforts in a way that allows teams to use tested measurement methods for tracking and monitoring their improvement efforts over time.

The templates and forms can be copied and used to “plot the dots” with pencil on paper or some health care teams can create electronic templates to be used for computerized tracking. Both options are viable, as we have found that some health care teams will be comfortable using electronics and technology, whereas other teams will find the paper and pencil method to be more accessible and may make the data more meaningful. Ultimately, our aim is to provide simple tools to allow any team to track access improvement and quality for their patients.

For more detailed principles and action plans specific to access improvement, please refer to the publications referenced in the back of the workbook and the website www.ihl.org.

CHAPTER ONE: INTRODUCTION AND GENERAL PRINCIPLES

What is Improved Access?

"If we keep doing what we are doing, we will keep getting what we got"

-Yogi Berra

The journey to improve access can be a difficult one. This journey requires us to think and act differently. It requires that we examine closely the way we have done our work, look for new ways of doing that work and testing, **trying**, implementing, refining, confirming and sustaining those changes.

But how do we know that all these changes and all this hard work resulted in improvement? We have to measure. Not only do we measure the old way, we measure the change and we measure the new way. In my experience, many groups and practices will adopt a philosophy of "ready, aim, implement!" These groups, if successful, have not only lost the opportunity to tell a great story, but have lost the opportunity to more fully understand that journey. In addition, they are left with a ship without a rudder- with no objective way to determine future improvement and to monitor for the sustainability of their hard won gains.

This book gives the ship a rudder, shows us what to measure and how to measure it. We don't have to build a new rudder, we can simply use the principles outlined here. The principles around access improvement are relatively simple. It is simply a matter of demand and supply and the gap or delay between the initiation of the demand and the application of the resource or supply. We just need to balance the demand with the supply as soon as possible. But it is the implementation that is the difficult part. This book will take lots of the work and anxiety out of that implementation. It offers concise, easily used tools and techniques that add richness and clarity to our journey.

I am delighted to have been a part of this and offer you encouragement, hope and excitement on this journey.

Mark Murray MD, MPA

Murray Tantau & Associates

Introduction

High quality health care delivery depends on great access to care and information. We know from our Institute for Healthcare Improvement national and international work and our Dartmouth local and regional work, that designing access into our care and services is one of **THE** top priorities in most health systems. It is essential that patients be able to get the care they need when and where they want it.

This book will provide you with valuable principles, ideas, tools and techniques that medical practices can use to analyze and improve access to care. It is based on years of work with organizations worldwide -- some have been wildly successful and some have been dismal failures. We believe that you are more likely to be in the "winners" circle if you study and adapt the materials in this book to the realities of your clinical practice.

We wish you the best of luck in your efforts to provide people with all the care they want and need and welcome feedback from you as you gain knowledge and improve quality.



Eugene C. Nelson, DSc, MPH

Dartmouth Medical School

Dartmouth-Hitchcock Medical Center

Institute for Health Care Improvement

How to use this Guide

- ◆ This guide is set up to allow you to electronically navigate directly to the sections you wish to view. The table of contents contains hyperlinks that will bring you directly to the page you wish to visit.
- ◆ Within each section you will see examples of forms for data collection. The printable form for that template can be reached by clicking the  icon next to the heading for that form..
- ◆ You can return to a previously viewed page by clicking the black back arrow  in your tool bar

Goal of this Guide

The goal of this guide are to provide a collection of key measurement tools that will show progress as you make improvements in patient focused access. We have made a very user-friendly format with definitions, examples, tips and worksheets for you to use.

Features of this guide

- ◆ Key measures for tracking improved access initiatives
- ◆ Easy to use “Click and Print” report/graphic templates.
- ◆ Suggested models for implementing measures
- ◆ Red flags for data interpretation
- ◆ Examples and case studies
- ◆ A framework for evaluating outcomes

Is Our Access Model an Improvement?

Any organization that decides to embark on a new access model for their patients is painfully aware of the unique access symptoms of their current system. Frustrated patients, over-worked staff, stressed physicians and stressed employees are just a few of the key symptoms of a department suffering from access issues. At the end of the day no one feels like the work that was done resulted in satisfied patents or content employees.

Once a new access model is implemented with the full intention of improving some of the fundamental flaws in the current system, ultimately the question will arise: ***“How do we know that the changes we have made are an improvement?”*** Tracking the outcomes of a change initiative is a critical aspect of any improvement project. Typically, subjective observations can provide immediate insight into the answer to this question, but objective, quantifiable measures can provide more substantiated objective insights into this important question. Changes can be quantified and process modifications made as needed.

Measures also provide validation to the team members that the extra work they have done to implement change is worthwhile. The measures also can provide tracking over time to monitor changes in progress.

On the other hand, measures can also alert team members when a change is not having the desired effect. Measurement and monitoring over time provides valuable data to those who might consider improving access to care. Data can convince skeptics to give it a try.

General Principles of Measuring and Monitoring Access Improvement

Based on years of experience, we have come to understand the following principles.

Identify the question that you are trying to answer.

When thinking about any data collection opportunity, the first issue to consider is “*what is the question we are trying to answer?*” While the question seems obvious, it is often difficult for a team to identify the question that needs to be answered. Defining the answer will establish a defined measurement need and where the data collection can focus. Additionally, there is a tendency to collect either too much or too little data. By defining your needs up front, irrelevant data collection can be avoided.

Build measurement into daily workflow.

Collecting data is often perceived as additional work to an already burdened staff. Hence, all efforts should be made to incorporate data collection into the normal workflow process. Linking data to the normal work process often ensures that it is collected in an efficient and predictable way. Link data collection to team members who can see meaning in the data.

Post your data where all members of the team can review it.

Data walls are an effective model for displaying data. A data wall is a designated place where any team member can view all the department measures. Create a data wall in a non-patient area. Often a back hallway near offices or a break room has available wall space for data display. Data graphics can be posted on bulletin boards or directly on the wall. Successful data walls have multiple contributors from the team who oversee the measures.

Create team ownership for the data.

Having all team members contribute to the data collection will help reinforce the message that the data and its value is the responsibility of every member of the team. It is not uncommon for one person in a work team to be saddled with the data tracking responsibility for the whole team. At first glance this may seem logical, but the approach generally backfires, as other team members now take ownership or responsibility for the data outcomes. Accurate, reliable data then becomes the data person’s job. Without team ownership, there is little incentive for a team member to feel that their accurate coding or scheduling will have an impact on the data reported out.

Use data to drive decision-making.

Educate all team members to read and interpret their data, graphics, and tables. Use team meetings as an opportunity to discuss data outcomes and then use data for decision-making. As the team begins to understand and use their collected data, the incentive will build to maintain and monitor measurement systems.

CHAPTER TWO: MEASURES TO START WITH AND MONITOR OVER TIME

A. 3rd Available Appointment

The 3rd Available Appointment¹ Report. *“How long do my patients need to wait for an appointment?”* We measure 3rd available based on experience, which shows that 1st and 2nd available appointments are often the result of cancellations.

Why Do This Report?

- ◆ To learn if Improved Access² has resulted in increased capacity for patients to be seen today.
- ◆ To learn if Improved Access is being operationalized or if old habits have emerged and patients cannot be seen in a timely way.
- ◆ To learn whether patients can get appointments with their desired provider.

Suggested Process

Some teams can extract the 3rd available appointment data from organizational information systems. Other teams can use a manual process to evaluate 3rd available appointments. If you are in a “carve out”³ model, you can choose to measure 3rd available pre-booked appointments. [See Example](#). (page 8)

Maintenance

This measure should be monitored by the scheduling staff and reviewed weekly by the provider and the team. Once Improved Access is operational, 3rd available continues to be monitored, but often it is the same day! At this point, the practice should move to evaluating patient ability to get an appointment by measuring future open appointments through the [Future Capacity Measurement Report](#). (page 17)



Red Flags

The 3rd available appointment begins to extend further into the future

- ◆ Evaluate daily use of appointment schedules – review with scheduling staff. Are same day appointment⁴ (SDA) slots being used inappropriately? Review improved access scheduling guidelines and scripts for receptionists offering options to patients.
- ◆ Evaluate provider availability. Part-time staff should share a panel of patients with other part-time providers to equal 1.0 FTE.
- ◆ Evaluate provider availability. Based on patient demand, providers should spread out their availability. Discussions should occur around time away policies and contingency plans to cover providers and meet patient needs.
- ◆ If a provider goes on vacation, put into place the following plan, if in a carve-out model.
 - ◆ Freeze⁵ the week the provider has requested off

¹ 3rd Available Appointment refers to the third occurrence in a Provider schedule where a certain appointment type is available.

² Improved Access is a model where patients are seen when they want to be seen and in a schedule where time is not saved.

³ Carve Out is blocking time in a schedule for same day appointments or pre-books.

⁴ Same day appointment refers to the process where a patient calls to be seen that day.

⁵ To “freeze” an appointment is to hold it open so it cannot be scheduled.

- ◆ While the provider is on vacation, offer “choices” to patients to see other members of the team.
- ◆ The week the provider is on vacation, “unfreeze”⁶ the pre-book times.
- ◆ The week the provider returns, “unfreeze” Same Day Appointment time.

Here are two methods to track 3rd available. The first method utilizes a table matrix. The second option uses a graphic. You decide which method works for you.



Form Example 1a: Collect your data in table form.

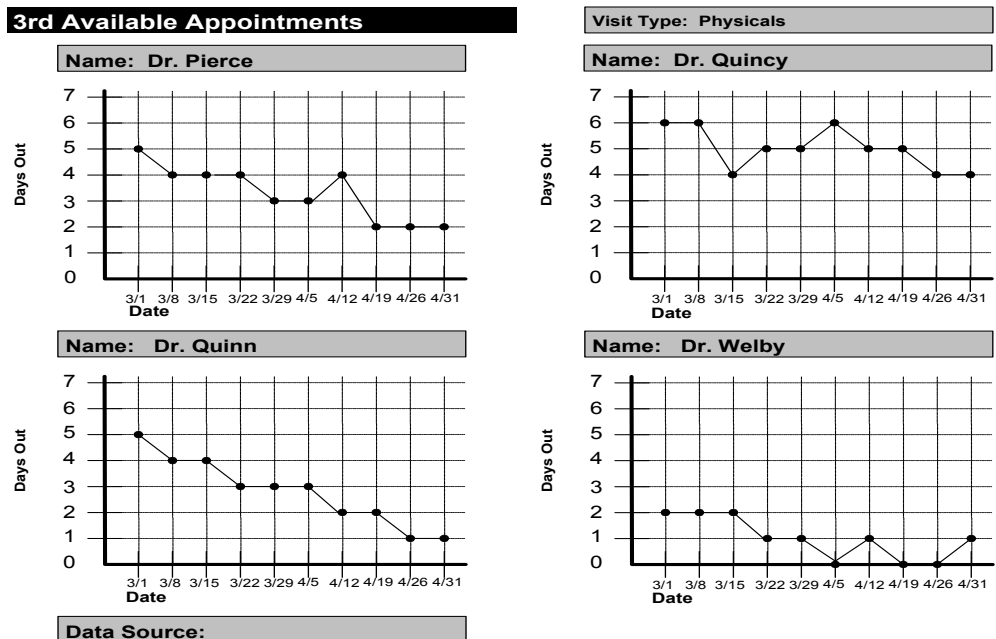
- Instructions:**
1. Identify person who can build collecting data into their daily workflow. (Suggestion: Scheduler)
 2. Choose one day and time to collect data.
 3. Fill in dates and provider names as illustrated in the example.
 4. Decide which visit types to track and create one sheet for each visit type.
 5. Count 3rd available appointment by provider. [Determine if you want to count weekends and holidays]

3 rd Available Appointments		Appointment Type: Physicals										Source: Office Scheduler	
Provider	Week of:												
	3/1	3/8	3/15	3/22	3/29	4/5	4/12	4/19	4/26	5/31			
Dr. Pierce	5	4	4	4	3	3	4	2	2	2			
Dr. Quincy	6	6	4	5	5	6	5	5	4	4			
Dr. Quinn	5	4	4	3	3	3	2	2	1	1			
Dr. Welby	2	2	2	1	1	0	1	0	0	1			



Form Example 1b: Plot your data in graph form.

Instructions: Follow the above steps and plot your data on the graph. Be consistent with scales in graphs to allow comparison.



⁶ The act of “unfreezing” involves releasing previously held appointments.

B. Under and Over Counts

How many times is a provider overbooked⁷ or under booked⁸ during the month?

Why Do This Report?

- ◆ To identify whether the Improved Access model has “opened the flood gates” and will result in a never-ending demand for same day appointments.
- ◆ To identify whether certain providers on certain days have higher demand, which require adjustment in staffing or schedule modifications (i.e. less pre-booked slots, work flow modifications)
- ◆ To identify whether a department (or provider) may have excessive schedule capacity on a daily basis.
- ◆ To measure demand/capacity equilibrium.

Suggested Process

Build this measure into the daily work of someone who reviews the schedules each day. For example, each morning a secretary may print a schedule for each provider, and previous day’s schedule could be reviewed.

Maintenance

Provider-specific tracking should be done daily. The data should be reviewed on an individual basis and as a team. Typically, teams track this measure on an ongoing basis, especially when changes in staffing and seasonal variation occur.



Red Flags

- ◆ One provider consistently shows *overbooked* schedules.
 - ◆ Review and critique appointment types, especially follow-ups.
 - ◆ Evaluate whether this provider could benefit from shifting some tasks to an associate provider⁹ or other clinical staff¹⁰ for better match of resources.
 - ◆ Evaluate “administrative”, teaching, research and outreach activities to consider shifting non-patient time to another day of the week when demand may be lower.
- ◆ Providers consistently show *under* utilization of schedule.
 - ◆ Review the Team Concept of care delivery.
 - ◆ Create a script¹¹ for receptionists to ensure that front office staff is utilizing all providers and guiding patients to underutilized providers. See [Script Example](#). (page 10)
 - ◆ Ensure constant communication amongst team and with patients about team approach to care.
 - ◆ Evaluate strategies to increase patient volumes (open panel). e.g. marketing, recruiting and thereby schedule demand.

⁷ Overbook refers to the number of appointments booked above available slots in a session/day.

⁸ Under booking is the number of appointment slots not filled on during a session/day

⁹ Associate provider is any non-MD provider, i.e. Nurse Practitioner, Physicians Assistant

¹⁰ RNs are considered other clinical staff

¹¹ Scripts are verbatim statements to standardize communication with patients with regard to scheduling options.

Script Example: Phone Script

- ◆ “Hello, Internal Medicine, this is Marcy, how can I help you?”
- ◆ “Would you like to be seen today, talk with the nurse, or leave a message?”
- ◆ “Your doctor can see you at 3:00 pm today, or the nurse practitioner who works with him can see you any time this morning.”
- ◆ “If you prefer tomorrow, your doctor could see you anytime in the afternoon.”

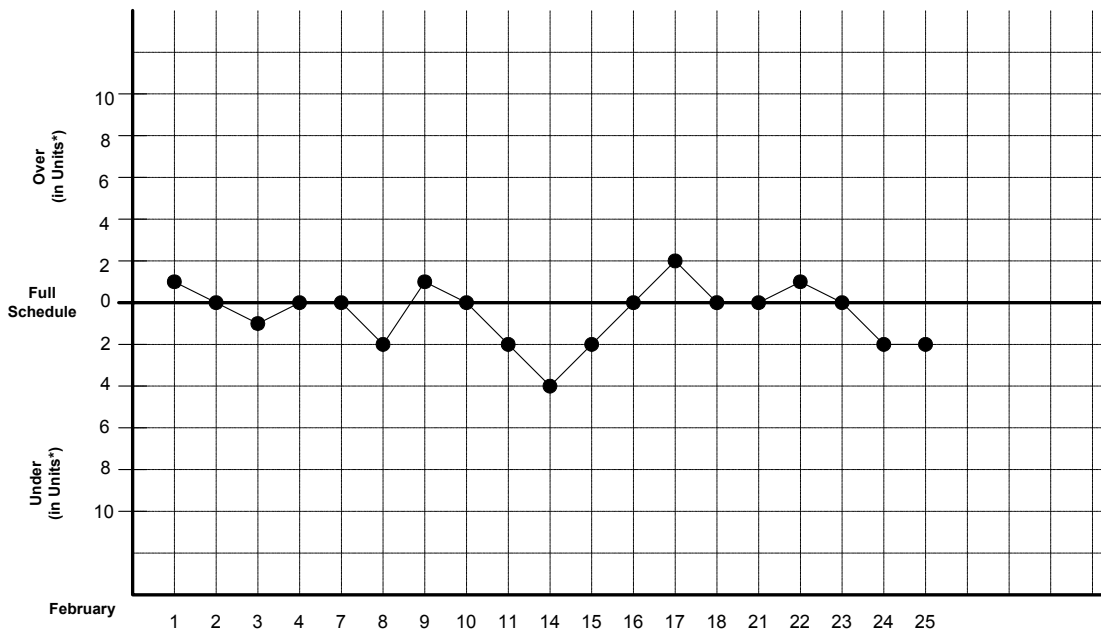


Form Example 2: Over/Under Books.

- Instructions:
1. Identify the person who can build collecting this data into their daily workflow.
 2. Collect data at the end of each day or at the beginning of the next day for the day before.
 3. Fill in dates and provider names as illustrated in the example. Determine unit of measure and insert on the graph, e.g. 10, 15, or 20-minute blocks.
 4. Plot data on graph as in example.
 5. If a provider has overbooks, the dot should be ABOVE the central line, if a provider has under books, the dot should be BELOW the central line.

How many times am I Overbooked/Underbooked during the month?

Provider: Dr. Jones



*Unit = 15 min. time blocks

Date:

Data Source: Janet Smith - Manager

C. Total Daily Visits

How many visits did we do today?

In an advanced access model, this measure reflects true demand and supply, assuming all of today's work is done today, where all patients who wanted to be seen today were seen.

Why Do This Report?

- ◆ To understand how many patients have been into the department for the day/month.
- ◆ To use for understanding historical supply patterns for the department. This can help with schedule modifications and vacation/CME planning.
- ◆ To validate the subjective sense of “we worked hard today!”
- ◆ This measure can drive celebrations of efficient teamwork.

Suggested Process

This measure can generally be collected electronically or manually. Most scheduling systems can generate a monthly report that gives total visits for the day. If gathered manually, data collection should be incorporated into the daily workflow process of a staff member who reviews the schedules (this might be the person who collects over/under counts and no-show volumes).

Maintenance

Maintenance of this measure can vary depending on the needs of the department. To understand the impact of Improved Access, maintain this measure for several months after the Improved Access model is implemented. Then this measure could reasonably be modified to track total monthly visits beyond this point. However, if the department wants to understand demand variation over the course of the year, maintain this measure over the full year and continue to do a daily count to ascertain *seasonal demand variation*.



Red Flags

Daily visits decreasing. A decrease in daily visits can be a result of innovation and improvement strategies or a declining patient volume. A positive decreasing patient visit example:

- A. Decreasing visits may occur if the department implements alternatives to office visits, increasing phone triage services with self care options, Web use, and E-mail.

Decreasing patient visit volume of concern could be:

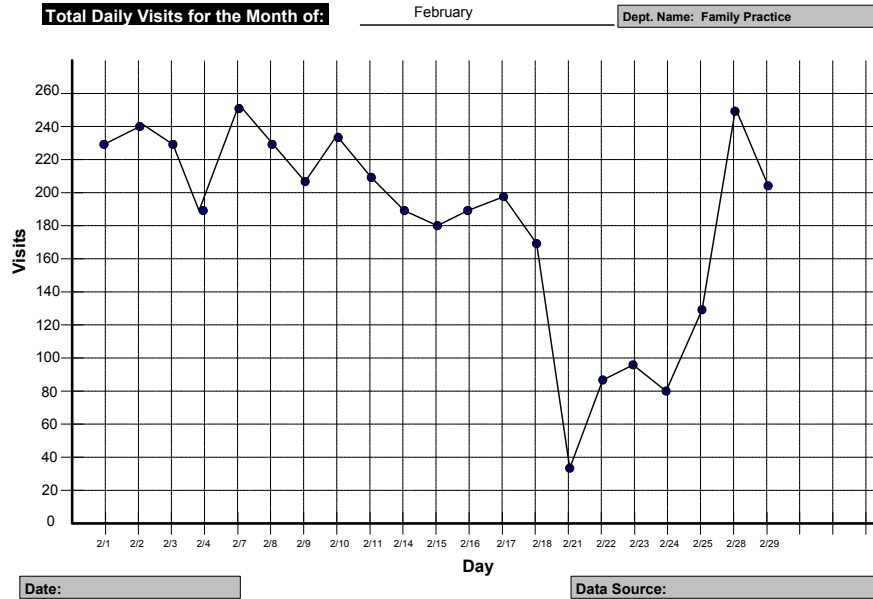
- B. Decreasing visits may be a sign of decreasing panel size. This visit measure should be interpreted in the context of other departmental and organizational trends and actions.



Form Example 3: Total Daily Visits.

- Instructions:*
1. Identify the person who can build collecting this data into daily workflow.
 2. Select end of day or early next day data collection.
 3. Fill in template dates
 4. Count the number of daily visits
 5. Data is reviewed in regular team meeting.

Daily Visits Increasing



D. Number of Times Contingency Plan¹² Implemented

How many times are we using our contingency plan?

Why Do This Report?

This is another measure to determine the equilibrium of demand and capacity. Contingency plans are developed by the team to ensure flexible responsiveness to variation in patient demand, specifically additional demand. Contingency plans are proactive methods to implement; yet repeated use of them can add additional stress on the team and requires re-evaluation of the practice demand and supply.

Suggested Process

Identify the contingency plans the team can support. Below are some contingency plan options:

- ◆ Add time at the end of the day
- ◆ Work through lunch
- ◆ Double book in the hour
- ◆ Add a session
- ◆ Start earlier/end later
- ◆ Use administrative time

¹² Contingency Plan – A plan of action that can be used in the event of unplanned demand or decreased supply in order to meet patient needs

Maintenance

This measure should be maintained continuously to determine the balance of patient demand and practice supply. The office scheduler could track the number of times contingency plans are put in place throughout a month.



Red Flags

Increase in the number of times contingency plan is implemented

- ◆ Check appointment-scheduling patterns with an eye towards follow up.
- ◆ Re-evaluate provider schedule
- ◆ Link to predictable seasonal changes that could be planned for in a pro-active fashion.
- ◆ Review if provider is out, how to cover patient needs by hiring locum tenens¹³, adding sessions, or part time staff increasing hours to cover absence.



Form Example 4: Number of Times Contingency Plan Implemented.

- Instructions:*
1. Identify the person(s) who will have first hand knowledge of contingency plan implementation.
 2. Fill in the dates as illustrated in the example.
 3. Locate data sheet in a physically accessible location for tallying.
 4. Review monthly data in regular team meeting.

Contingency Plan	Number of Times Implemented	
	Month : <u>January</u>	Total
Add time at the end of the day		6
Work through lunch		13
Double book		3
Add session		1
Source: _____	Total:	23

¹³ Locum tenens are contract physicians hired on a temporary basis to help provide services and capacity for patient care.

E. Patient Satisfaction

How satisfied are our patients with the new access model of care? Patients are our customers. Inability to get access to care is the number one reason for dissatisfaction for patients. Measuring patient response to practice improvements helps to keep perspective on meeting patient needs.

Why Do This Report?

- ◆ To identify whether the Improved Access model has improved patient satisfaction.
- ◆ To monitor ongoing patient satisfaction with the Improved Access model.
- ◆ To gather feedback information for clinical and administrative staff on the impact of the new model.

Suggested Process

We have developed a standard methodology for implementation of the survey process that will ensure the integrity of the data collected.

Month One: For the first month you will survey 50 patients each day; 25 in the morning and another 25 in the afternoon. Your practice will need to determine if you will survey 25 consecutive patients, or every other patient. It is important to decide on this and then consistently sample your patients by this method. Your survey sample should cover your practice hours, to include pre-booked and same day appointments. Begin handing out the surveys for the a.m. session, passing out the 25 surveys until they are gone. Repeat this process for the p.m. session. The sample size of 250 patients per week should provide adequate data that will answer the question: “Are our patients satisfied with our new access model?” Note: Some practices may need to sample a smaller size during the first month based on patient volumes.

Month Two and Subsequent Months: Depending on the outcome of the first month of sampling, you may need to repeat the sample size described in Month One. Once it is determined that you can move to a smaller sample size, you will survey 20 patients per day; 10 in the morning and 10 in the afternoon. Follow the *same procedure* as in Month One.

It is important to be **consistent** in the survey collection process. Placing an entire batch in an easily accessible location will ensure that all of the surveys are handed out during each session. You may also choose to use the attached [tally sheet](#) (page 16) to help receptionists know they are sampling correctly.

Create a “[Month at a Glance](#)” report to show monthly results. Take key measures and track them over time. (See “[Trend Graph](#)” example)

Maintenance

This survey should be implemented at the time the Improved Access model begins. If possible, running the survey for one month prior to initiating Improved Access would be preferred to allow for pre and post access improvement measurement. Specific details on sample size, sampling technique, survey distribution and completion, collation and tabulation will need to be discussed with the department manager and front office staff.



Red Flags

- ◆ Patients resist completing surveys
 - ◆ Evaluate whether a smaller sample size can be used.
 - ◆ If survey results have been consistently stable, with acceptable results, consider discontinuing the detailed survey process and replace it with a higher-level measure such as the “[Bulletin Board Measure](#)”. This will give a general feedback score and if it starts to drop, the more detailed survey should be re-implemented.

- ◆ Staff resists passing out surveys.
 - ◆ Evaluate whether a smaller sample size can be used.
 - ◆ Be sure that survey results are posted and that ALL office staff has the opportunity to review the results. Celebrate improvements with staff. This helps them realize that the “start up” pains on a new process reap generous rewards.
 - ◆ Begin in-depth evaluation of schedules to identify increased use of pre-book appointments (resulting in decreased same day access); consider phone question tally sheet to evaluate key drivers of dissatisfaction; brainstorm with team members to identify cause of negative trends; stratify survey results by time of day, day of week, and/or by age and sex to identify problematic patient cohorts.



Form Example 5a: Patient Access Satisfaction Survey:

Patient Satisfaction with Access Survey				
Practice:	Date:	AM	PM	(circle one)
<p>We are asking some of our patients to tell us what they think about their ability to get an appointment. Your answers are confidential and the results will be used to improve service to our patients. Please take a moment to record your answers on the sheet below. For each question, please select the option that most closely matches your answer.</p>				
<p>1. How would you rate your satisfaction with getting through to the office by phone?</p> <p> <input type="checkbox"/> Excellent <input type="checkbox"/> Very Good <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor </p>				
<p>2. How would you rate your satisfaction with the length of time you waited to get your appointment today?</p> <p> <input type="checkbox"/> Excellent <input type="checkbox"/> Very Good <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor </p>				
<p>3. Did you see the clinician, or team member, that you wanted to see today?</p> <p> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Did not matter who I saw today </p>				
<p>4. How would you rate your satisfaction with the personal manner of the person you saw today (courtesy, respect, sensitivity, friendliness)?</p> <p> <input type="checkbox"/> Excellent <input type="checkbox"/> Very Good <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor </p>				
<p>5. How would you rate your satisfaction with the time spend with the person you saw today?</p> <p> <input type="checkbox"/> Excellent <input type="checkbox"/> Very Good <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor </p>				

Thank you for your help.



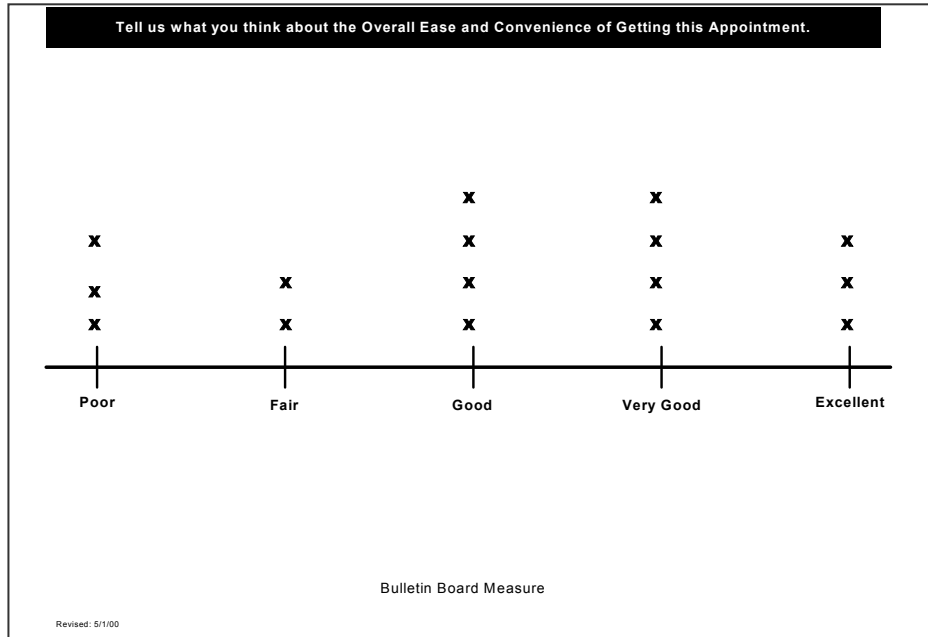
Form Example 5b: Patient Access Satisfaction Tally Sheet:

Patient Access Survey Manual Tally

Questions	Excellent	Very Good	Good	Fair	Poor
1. How would you rate your satisfaction with getting through to the office by phone?					
2. How would you rate your satisfaction with the length of time you waited to get your appointment today?					
3. <i>See Below</i>					
4. How would you rate your satisfaction with the personal manner of the person you saw today (courtesy, respect, sensitivity, friendliness)					
5. How would you rate your satisfaction with the time spent with the person you saw today?					
	Yes	No	Did not matter		
3. Did you see the clinician, or team member you wanted to see today?					



Form Example 5c: Bulletin Board Measures:



Form Example 5c: Bulletin Board Tally Sheet Example

Patient Rankings of Ease and Convenience of Getting the Appointment						
Date	Poor	Fair	Good	Very Good	Excellent	
1/4/00	3	2	4	4	3	
1/5/00	2	2	4	5	4	
1/6/00	1	1	5	6	6	
1/7/00	0	2	7	2	5	

F. Same Day Appointments Daily/Pre-Books or Future Capacity

What percent of the future schedule is available for patients?

Why Do This Report?

- ◆ To identify if the next month has needed availability.
- ◆ To discover if systems are over-filling future appointments. This identifies system breakdowns for doing today's work today.
- ◆ Prospectively plan and revise future schedules.
- ◆ Anticipate time away and create strategic plans.

Suggested Process

Some office systems will be able to pull the availability of future appointment slots directly off electronic scheduling systems. However, most offices will need to pull this information manually from their computerized scheduling systems. This measure should be collected for the next day and can be easily compiled at the end of the day. A provider-specific tally sheet can be used track the number of slots that are open for the next day and the number of slots that are pre-booked. Percentages can then be calculated and displayed. On a weekly basis it will be necessary for the office to do this same analysis 4 weeks into the future.

Maintenance

This measure should be aggressively maintained for the first few months after moving to Improved Access. The tendency is to begin to “cave-in” to pressure and pre-book future appointments. Over time this will bring a department back to the previous scheduling backlog problem. Once stability is reached with the schedule, this measure should be monitored for more proactive maintenance of the schedule for the 4 weeks into the future. This will be helpful for managing schedules and provider time for those times when provider staff is out (vacation, CME, etc.).



Red Flags – Carve Out Access Systems

- ◆ Percentage of same day appointments declining. Begin detailed audits of schedules and discuss concerns with scheduling staff. Pre-books and follow-ups are probably being put into schedule as staff resort back to old methods of scheduling patients.
- ◆ Provider/staff discussion about follow up appointments is key:
 - ◆ Return visit intervals should be lengthened
 - ◆ Return visits should be questioned. Is it really necessary? Could the follow up be done over the phone or by E-mail? Could another member of the Care Team (e.g. RN) do the follow up?
- ◆ When should you reduce the number of Same Day Appointments?
- ◆ When should you increase SDA (goal to strive for)?
- ◆ **Success Tip:** Keep Monday, Thursday and Friday open for same day appointments. Book follow-up visits on Tuesdays and Wednesdays.
- ◆ **Success Tip:** It is especially important after a holiday on Monday to keep Tuesday open or keep the day after any holiday open.



Form Example 6: Future Capacity:

- Instructions:**
1. Identify the person who can build collecting this data into daily workflow.
 2. Fill in date as illustrated in example.
 3. Review the schedule and determine the number of free and pre-booked slots.
 4. Data is reviewed at regular team meeting.

Date: January 4, 2000								
Future Capacity		Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	% Total Open
Week 1	Open	2	4	2	3	0	0	7%
	Pre-book	38	36	38	57	30	18	93%
Week 2	Open	8	7	12	14	6	3	12%
	Pre-book	32	33	28	46	24	15	88%
Week 3	Open	14	12	12	22	8	7	27%
	Pre-book	26	28	28	38	22	11	73%
Week 4	Open	18	23	22	28	13	11	46%
	Pre-book	22	17	18	32	17	9	54%

Action Plan:

1. Call to confirm all new patient appointments and physical exams
2. Look at provider capacity on Thursday and Fridays - we are understaffed on Friday, and possibly have too many providers on Thursday

G. No Show Data

How many "no show" patients did the office have today?

Traditional scheduling models typically have double digit no show rates. Since the appointment was made so far in advance, patients forget scheduled appointments or have received appointments they cannot keep. In an Improved Access model, patients schedule dates and times that are in the immediate future and are more likely to attend the appointment. In many Improved Access models, the no show rate drops to 4-7%.

Why Do This Report?

- ◆ No show appointments are costly to a department in terms of lost revenue and reduced access.
- ◆ One advantage of the improved access model is that patients do not typically forget appointments or have scheduling conflicts for appointments made earlier in the day.
- ◆ Practices that adopt Improved Access models typically see no show rates from 4-7%.

Suggested Process

This measure can generally be collected electronically or manually. Many scheduling systems can generate a monthly report that gives no show patient volumes as a percent of the total volume. This data can also be collected manually and should be incorporated into the daily workflow process of a staff member who reviews the schedules. (This might be the same role, but different person, who collects the over/under counts.)

Maintenance

This measure is an important one since no show patients represent wasted time and wasted resources. If this measure is easily derived electronically, this report should be run on a monthly basis and reviewed by the practice team. If it must be derived manually, the office may decide that this is something that should be run on a weekly or bi-weekly basis as opposed to the daily schedule used when the improved access model was first initiated. Some judgment may be needed here. Additionally, if this must be derived manually, incorporate the data collection into an existing work process of one of your team members.



Red Flags

No show rate increases.

- ◆ Suggests that patients are being pre-booked for future appointments. A schedule audit should be completed.
- ◆ May indicate that confirmation calling should be done, particularly if the department uses a carve-out model with a substantial percentage of pre-booked appointments.
- ◆ Determine if there is a correlation between providers and no show rates, which may indicate some improvement opportunities.



Form Example 7a Collect Your Data:

- Instructions:**
1. Identify the person who can build collecting this data into daily workflow.
 2. Fill in dates and provider names as illustrated in the example.
 3. Count the number of no shows.
 4. Data is reviewed in regular team meeting.

NUMBER OF NO SHOWS		Appointment Type: All Appointment Types									
Provider	3/1	3/2	3/3	3/4	3/5	3/8	3/9	3/10	3/11	3/12	Total
Dr. Pierce	//// //	//// /	//// /	//// /	///	//	////	////	//// /		43
Dr. Quincy		//// /	///	//	////	//// //		/	//	//	28
Dr. Quinn	////	////	////	///	///	///	//	//	/	/	28
Dr. Welby	//	//	//		/		/	/	/		10
Total	14	16	15	11	12	12	7	9	10	3	109

...



Form Example 7b: Graph Your Data.

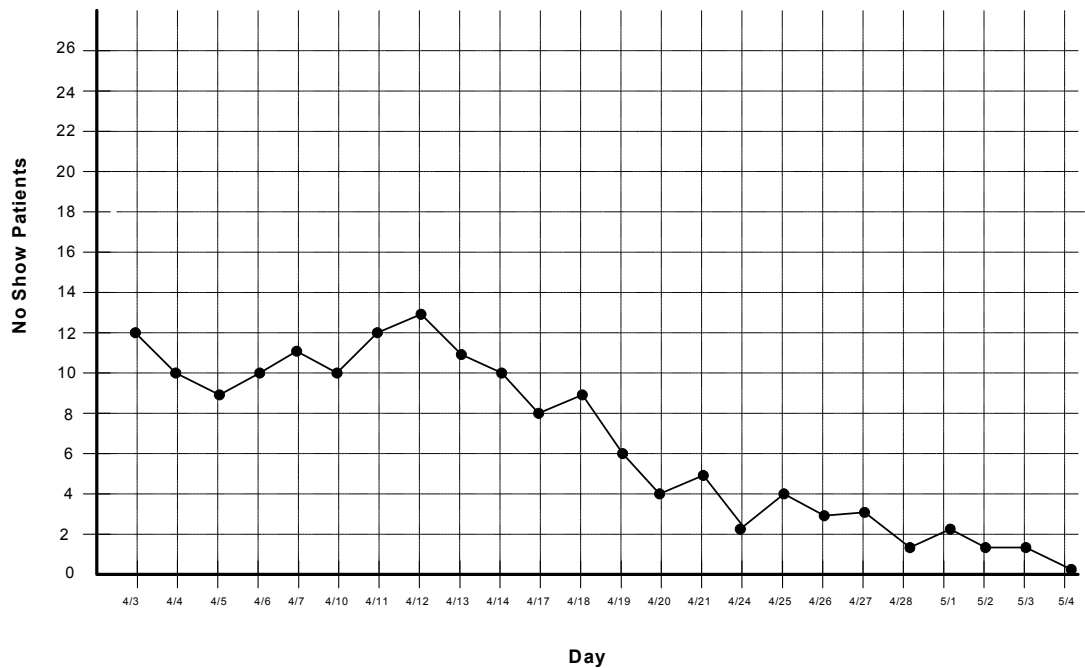
- Instructions:**
1. After following the steps above, calculate the total of no shows, for all providers each day.
 2. Fill in dates along the x-axis.
 3. Enter a dot representing the total for each day along the y-axis, which corresponds with the appropriate day along the x-axis, as illustrated in the example.
 4. Data is reviewed in regular team meeting

Total by day of all Providers

How many No Show Patients did we have this month?

Dept. Name:

Month of: _____



Date:

Revised: 5/1/00

Data Source:

CHAPTER THREE: RECOMMENDED MAINTENANCE AND MONITORING

What's Next?

Once your team has gone through the difficult and challenging job of Improved Access implementation, it is important to know how to track and monitor the processes and systems.

Monitoring the access system is an ongoing function of the practice. We have reviewed key tips through this workbook such as identifying key people to be responsible for tracking and reporting performance of the access system. It is important for practices to hold regular team meetings to review performance measures and identify, in REAL time, improvements that need to be made. Assuming the access system will manage itself is an operational flaw.

The measures that have been defined and outlined in this workbook may not always need to be measured. However, any measure should be measured over time to observe trends and identify clues about the system that may need to be addressed. In a high performing improved access practice, a few key measures are monitored over time, and if these measures show indications of system problems, the more detailed measures are resumed as described in this workbook.

Key Improved Access Measures to Track Over Time:

- ◆ 3rd available appointment (or future capacity if 3rd available is today)
- ◆ No Show rates
- ◆ Patient satisfaction with access

The Importance of Measurement

It is imperative to measure and monitor access systems when significant changes have occurred in the practice or in the patient population. For example, if a provider leaves or additional staff is added on, reviewing the measures are important to develop strategic plans during the absence of the provider.

Additionally, if the practice assumes the care of an additional population of patients, it will be essential for the practice to track all of the measures through the transition of adding the additional patients.

Maintaining a “data wall” that displays the important improved access measures help to keep the practice focused and disciplined in monitoring and tracking progress.

CHAPTER FOUR: RESOURCES AND READINGS

Resources used in this Guide

Case studies and helpful tools can be found in the IDCOP FieldGuide. A Guide to Idealized Design of Clinical Office Practices.

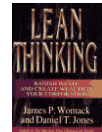
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