On the Fast Track to Health Access: Transforming Vulnerable Patient Access with Rapid Redesign

National Health Care for the Homeless Conference & Policy Symposium
New Orleans, LA – May 30, 2014

Joseph Pace - Barbara Wismer - Mark Alstead
Tom Waddell Urban Health Clinic
San Francisco Department of Public Health

Learning Objectives

- Define scope of challenges to providing ample + responsive patient care access
- Understand a process for transforming care access attuned to dynamic needs of patients
- Identify immediate next steps to embarking on access transformation at home agencies

Today's Roadmap

- Why is access important?
- Our access challenges
- Coleman Rapid Dramatic Performance Improvement Process
- Results
- Lessons Learned
- Group exercise

Let's get to know you…

- Who are you?
  - Administrator, clinician, consumer?
- What are access issues at your site?
- What were you hoping to take away from this workshop?

What is health care access?

- Rand Corporation: the ease with which an individual can obtain needed medical services
- 4 components:
  - Health insurance coverage
  - Having a usual + ongoing source of care, having a primary care provider (PCP)
  - Timeliness - getting health care quickly after a need is recognized
  - Workforce – having enough PCPs

http://www.rand.org/topics/health-care-access.html
http://www.healthypeople.gov/2020/TopicsObjectives2020/overview.aspx?topicid=1

Why is access important?

- Access to health care impacts:
  - Overall physical, social, + mental health status
  - Prevention of disease + disability
  - Detection + treatment of health conditions
  - Quality of life
  - Preventable death
  - Life expectancy
- Disparities in access affect individuals + society
- Limited access impacts people's ability to reach their full potential

http://www.healthypeople.gov/2020/TopicsObjectives2020/overview.aspx?topicid=1

Some measures of access (clinic/practice level)

- Patient panel
- PCP productivity
- Cycle time
- 3rd next available appointment
- Continuity
- Show rate
- Appointment slots used

Tom Waddell

November 1, 1937 - July 11, 1987

- Tom Waddell was physician and Olympian.
- Founded the Gay Games
- Worked for SFDPH, and, after his death, our clinic was renamed for him.

Tom Waddell Urban Health Clinic

- Merged Housing and Urban Health Clinic & Tom Waddell Health Center into a single, integrated, primary care behavioral health clinic and moved to new location
- Primarily serves homeless and marginally housed persons and persons living in supportive housing
- Specialty areas: HIV Medicine, Transgender Health, Office-based Opiate Treatment, Urgent Care Center, Community Based care
- Total Panel Size = ~4,700 patients

Tom Waddell Urban Health Clinic

- Primary Care Staffing
  - Providers (NP, PA, MD) – 6.4 FTE
  - Nurses – 8.5 FTE
  - Medical Assistants – 7.0 FTE
  - Appointment, Registration, Medical Records Staff – 7.4 FTE
  - Psychiatrists – 3.0 FTE
  - Psycho-Social Staff- 8.0 FTE

Care Objectives

- Deliver high-quality, primary care services in a team-based model
- Preserve multi-disciplinary and patient-centered approach
- Maximize patients' access to their care teams
- Low-threshold access for new patients

Team Care

Clerks					
Navigators / FlowNators					
Psychiatry & Substance Abuse Staff					
Clinical Pharmacists / Pharmacy Tech					
Team Earth		**Team Wind**		**Team Fire**	
Teamlet 1	Teamlet 2	Teamlet 3	Teamlet 4	Teamlet 5	Teamlet 6
Provider	Provider	Provider	Provider	Provider	Provider
MEA	MEA	MEA	MEA	MEA	MEA
RN		RN		RN	
Psycho - Social Staff		Psycho - Social Staff		Psycho - Social Staff	
Tactical Nurse					
Managers					
Security Officers					

Our access challenges

- Patient heterogeneity
- Clinic/staff move/merge
- New team model
- No tracking measures in place

- Unhappy patients
- Unhappy staff
- Fights in the waiting room

http://nhop.org/communityhealthpriorities/access-to-care/

Does this sound familiar?

Coleman Associates

Rapid Dramatic Performance Improvement

- January 2014 to present
- Observation, Recommendation, Change, Assess, Repeat
- Staff-led Redesign Team
- Objectives: Substantially reduce patient wait times, patient complaints, and clinical errors while increasing productivity

Consultant Recommendations

- Streamline registration process
- Restructure appointment templates
- Make robust confirmation calls
- Increase communication between front and back
- Eliminate Triage RN role
- Increase teamwork and team consistency
- Restructure team huddles
- Improve visit flow
- Collect / Review Data

Streamline Registration Process

- Eliminate number system: "We are not the DMV"
- Create one line for all patients regardless of appointment type
- Do as much advance work as possible to make check-in faster

Restructure Appointment Templates

- Change from 20 minute to 15 minute slots
- Add blocked slots for catch up & add-on visits
- Add Drop-in (DI) slots and front load them
- Allow new patients to be scheduled in any slot (except first & last appointment)
- Visit target = 8 patient visits per provider per half day

Restructure Appt Templates

Original Template		1st PDSA Template (March 1, 2014)		2nd PDSA Template (July 1, 2014)	
8:20/1:20	RT	8:30/1:30	DI	8:30/1:30	OA
8:40/1:40	RT	8:45/1:45	DI	8:45/1:45	DI
9:00/2:00	OA	9:00/2:00	RT	9:00/2:00	RT
9:20/2:20	NW	9:15/2:15	DI	9:15/2:15	RT
9:40/2:40	RT	9:30/2:30	Block		
10:00/3:00	RT	9:45/2:45	RT	9:45/2:45	RT
10:20/3:20	RT	10:00/3:00	OA	10:00/3:00	RT
10:40/3:40	RT	10:15/3:15	RT	10:15/3:15	NW
11:00/4:00	RT	10:30/3:30	Block		
11:20/4:20	RT	10:45/3:45	RT	10:45/3:45	DI
		11:00/4:00	OA	11:00/4:00	RT
		11:15/4:15	RT	11:15/4:15	OA

Make Robust Confirmation Calls

- Strategy to reduce no-show rate and to reduce unused slots
- Staff call patients on day prior to appointment to confirm and within fifteen minutes of appointment if patient had not yet arrived
- If patient cannot attend appointment they are rescheduled and the appointment slot opens up for immediate use

Increase Communication

- Empower registration staff to “Tetris”
- Create “FlowNator” position
- Establish the MEA as communication point person for “Teamlet” (Don’t ask the provider if they can see a patient)
- Assign “Tactical Nurse” to troubleshoot flow issues
- Use Walkie-Talkies

Eliminate Triage RN

- Triage RN role was carried over from pre-merge model to manage drop-ins
- Observation: Mismatch between the number of patients asking to be seen (demand) and provider visit slots going unused
- The Triage RN role was a bottleneck and a barrier

Increase Teamwork & Consistency

- Established 3 teams: Earth, Wind, & Fire
- Many part-time providers, so created schedule with RNs and MEAs consistent across the week
- Providers paired to provide cross coverage
- Continue to build teams and foster teamwork (on-going)

Restructure Team Huddles

- Principle: Create ways for staff to coordinate and anticipate the patient care tasks and objectives of the session to improve efficiency and effectiveness of visit- every member of the team has something to contribute
- Structure:
  - 1st- All staff who are in clinic meet to review the session's assignments, make announcements, and to review any behavioral concerns or special circumstances
  - 2nd-Teams breakout to meet with psychosocial staff to coordinate warm hand-offs and joint visits
  - 3rd- Teamlets (PCP + MEA + RN) meet to plan the goals of the patient visit and the flow of the clinic session, anticipating any roadblocks

Improve Visit Flow

- Keep providers focused on seeing patients and take them out of decision making regarding patient flow

- Gain efficiency and maintain coordination between MEA and PCP through the use of:
  - "quick start"
  - "mid-way knock"
  - 30 second report in between patients

Performance Data

- Collect data daily
- Monitor data weekly
- Discuss frequently with staff
- Target problem areas
- Make changes, as indicated
- Indicators
  - Cycle time
  - No show rate
  - TNAA
  - Provider productivity

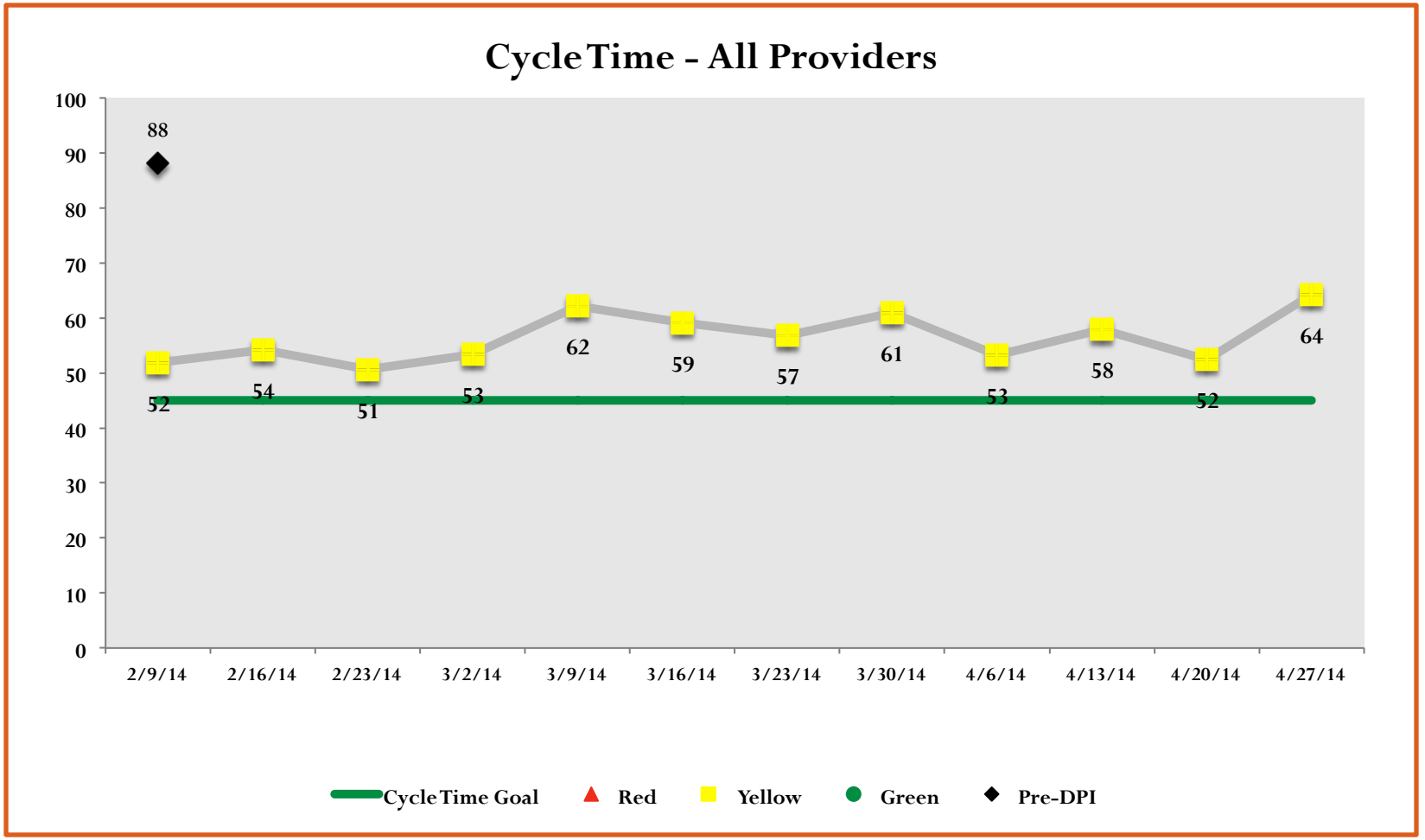
Results- Key Improvements

- Key Improvements
  - Average Cycle Time –
    - Baseline- 88 minutes
    - Goal- <45 minutes
    - Actual- 64
  - No-show rate –
    - Baseline- 41%
    - Goal- <30%
    - Actual- 35%

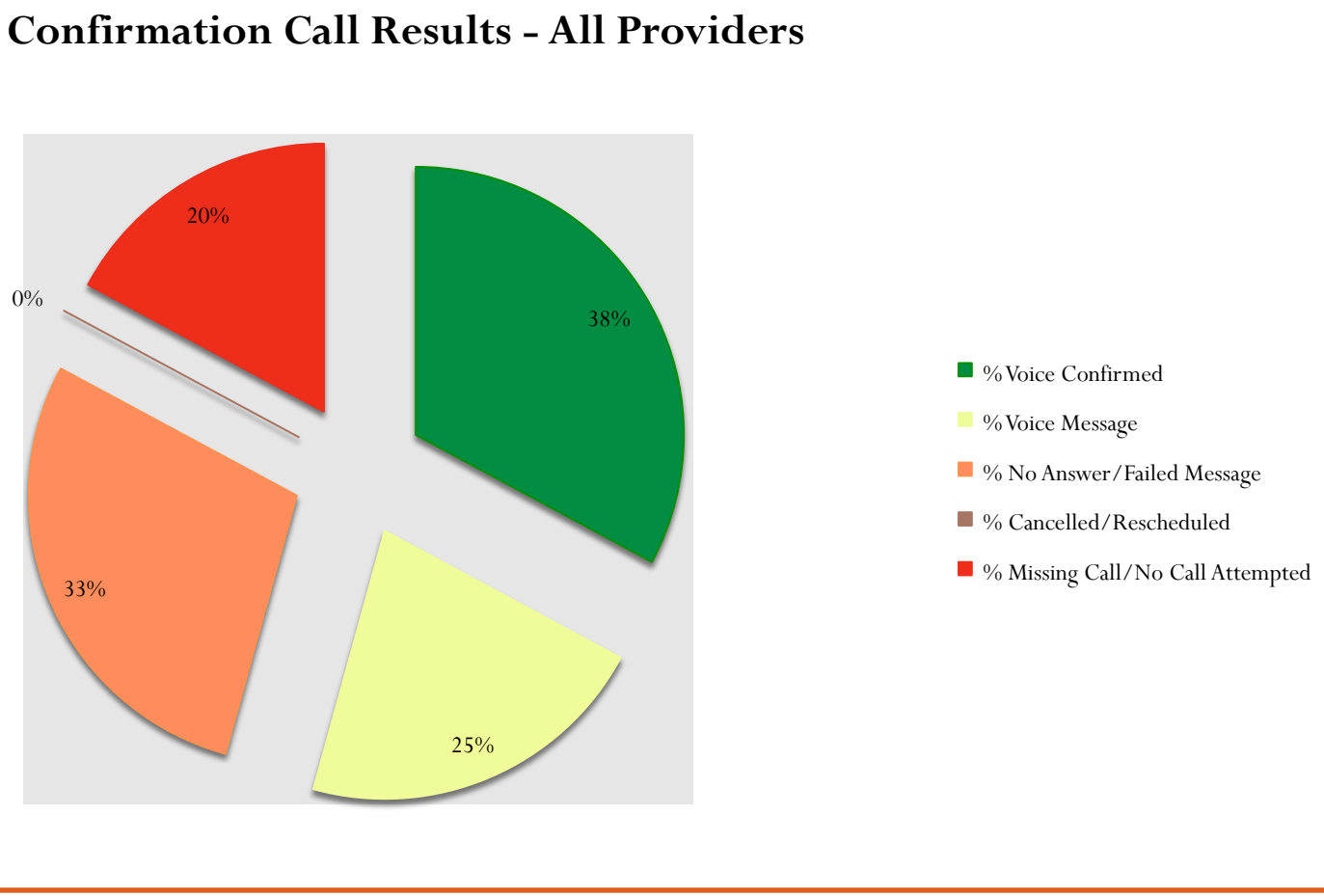
Results- Ongoing Challenges

- Ongoing Challenges
  - Visits per session-
    - Baseline- 6.3
    - Goal- 8
    - Actual- 5.7
  - TNAA-
    - Goal- <16days
    - Actual- 38

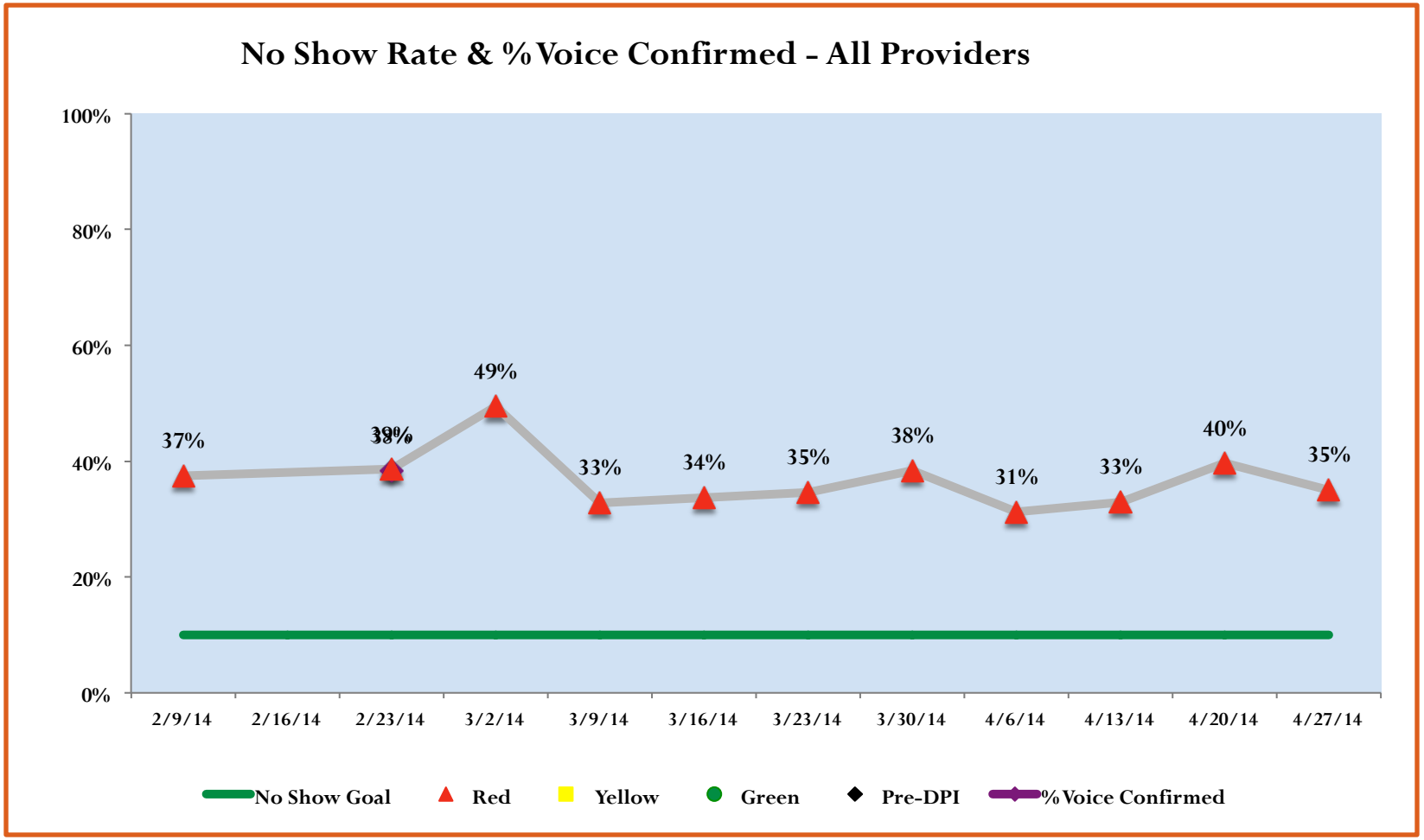
Results- Cycle Time



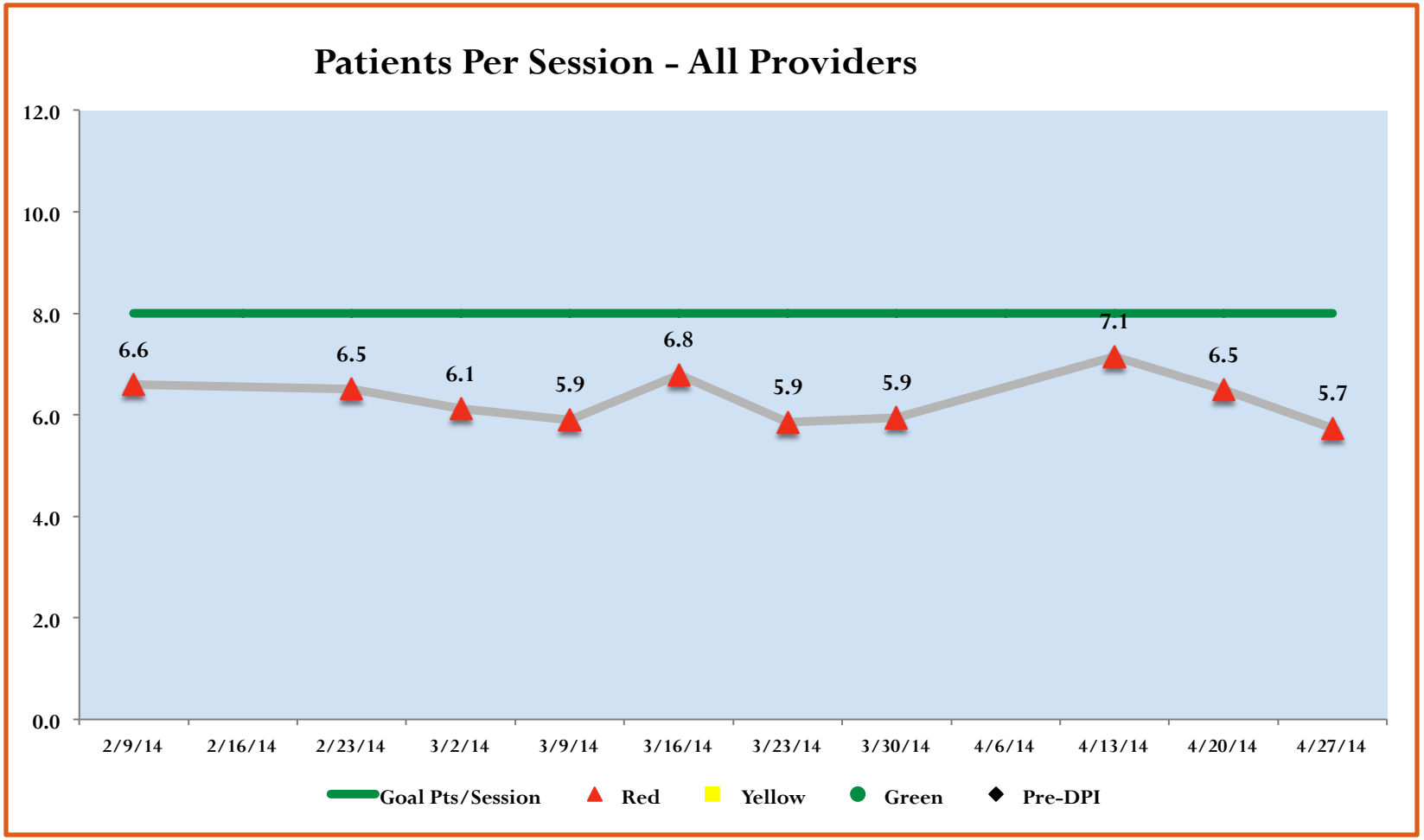
Results- Robust Confirmation Calls



Results- No-Show Rate



Results- Visits Per Session



Unanticipated Improvement

- Disruptive/Violent Incidents
  - Baseline – 6-10/month (2013)
  - 0-2/month – (2014)
  - No violent incidents in 2014

Change Management Principles

- Change takes:
  - Engaged staff
  - Engaged leadership
  - Realistic goals
  - Data to identify targets for improvement and inform your progress
  - Frequent re-tooling based on your data
  - Coaching and sustainability plan
  - Resources to devote to change process above and beyond those allocated for daily operations
  - Constant communication
  - Tolerance for frustration and failure

How did we do?- Successes

- Staff and leadership were engaged in a process of change
- Staff led the change
- We were able to achieve improvements in our access measures not only at the experiential level but at a data level
- We created new systems and roles
- The change process was one of positive disruption that helped us realize breakthroughs in areas that had been hard to change historically

How did we do?- Process Matters

- Staff engagement- Not all staff were able to participate in the change but all staff was affected by the implementation of change
  - Our change process didn't permanently change institutional culture
- Leadership engagement- Leadership was not represented on Redesign Team
- Data- We did not have an easy way to validate the reliability of the data we were collecting
- Frequent re-tooling- Our IT systems are not nimble enough to act on data in a rapid fashion
- Coaching and sustainability plan- Our staffing issues made this difficult to implement (flu season)
- Communications- Our inability to saturate the staff and environment with information about the change process limited our success

Next Steps

- Short-term
  - Recognize our successes
  - Analyze where and why we fell short
  - Re-engage in a process to get us back on track

- Long-term
  - Explore how we can better anticipate demand by using risk stratification methods to predict future utilization

Group Exercise

- Divide into groups of 4-5; do introductions
- Discuss:
  - What are the access issues at your site?
  - What strategies have you tried that work?
  - What have been your barriers to change?
  - What can you try next?
- Report back to group.

What are the access issues at your site?

What strategies have you tried that work?

What have been your barriers to change?

What can you try next?

Thank you!

- joseph.pace@sfdph.org
- barbara.wismer@sfdph.org
- mark.alstead@sfdph.org