CALIFORNIA HEALTH CARE SAFETY NET INSTITUTE

Recording Link

Foundations of Access Backlog Reduction

December 16, 2021, 12:00 – 1:00 pm

Presenters:
Blake Gregory, MD
Primary Care Director of Population Health
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David Lown, MD, Chief Medical Officer, SNI dlown@caph.org

Recordings of the webinar and slide deck posted on SNI Link: Care Delivery

Agenda

Time	Topic	Facilitator(s)
5 min	**Welcome and Housekeeping**	Dr. David Lown, *Safety Net Institute*
30 mins	**Optimizing Access and Reducing the Backlog in Primary Care**	Dr. Blake Gregory, *San Francisco Health Network*
20 mins	**Jamboard Activity: Strategies and Actions for Working Down the Backlog**	All
5 min	**Next Steps and Wrap-up**	David

Housekeeping

Rename yourself to include your name and organization

Feel free to chat in questions at any time and we will address them at the end

You're encouraged to turn on video during discussion sections

This meeting is being recorded and will be posted online

Materials will be available at: SNI Link: Care Delivery

Optimizing Access and Reducing the Backlog in Primary Care

Blake Gregory, MD

Primary Care Director of Population Health

San Francisco Health Network

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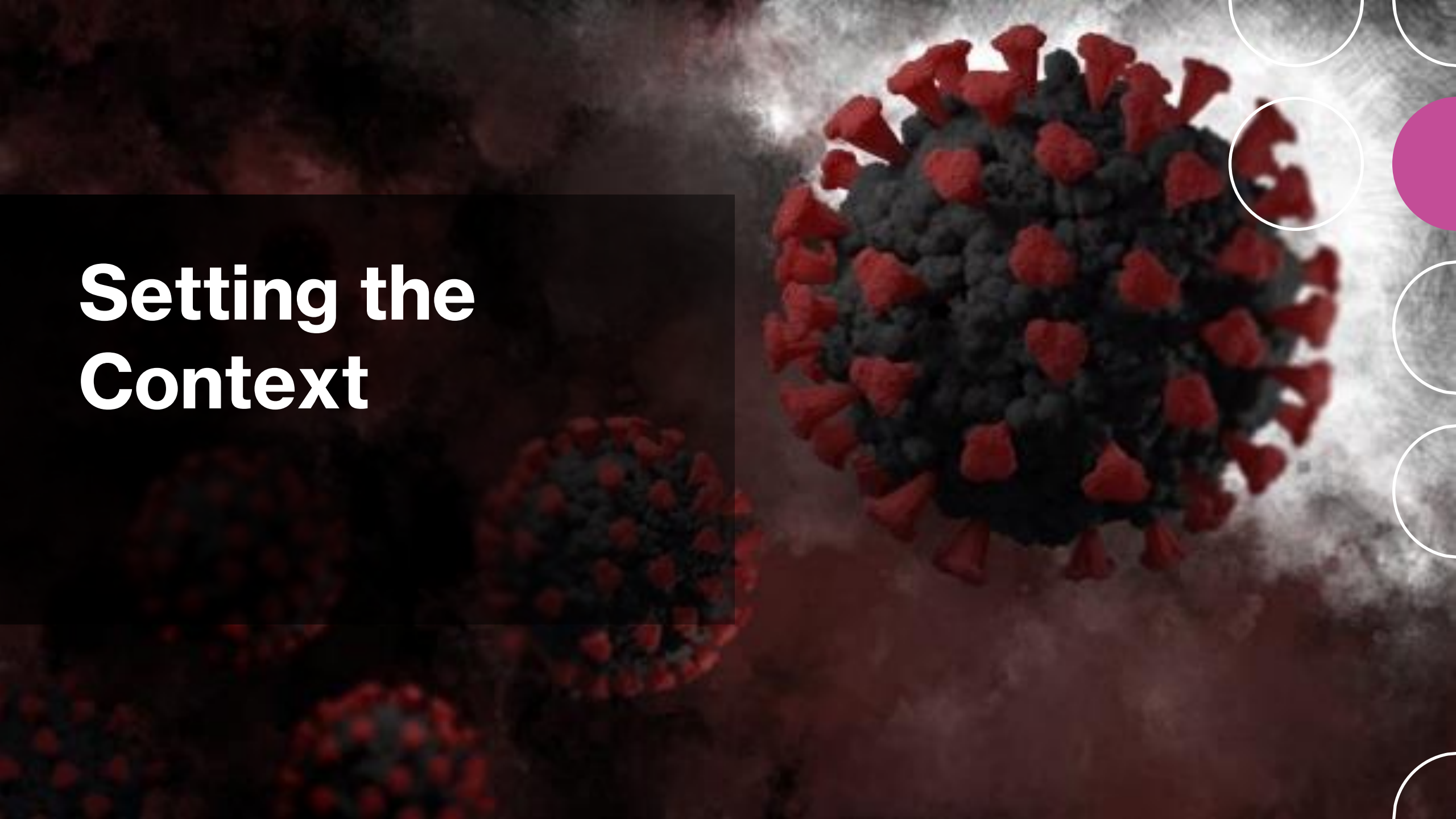
Core topics:

Setting the context
Scheduling practices in the safety net
Reducing no-shows
Optimize existing resources
Reducing the backlog



Setting the Context

THE IMPACT OF CORONAVIRUS ON HOUSEHOLDS ACROSS AMERICA

September 2020

npr

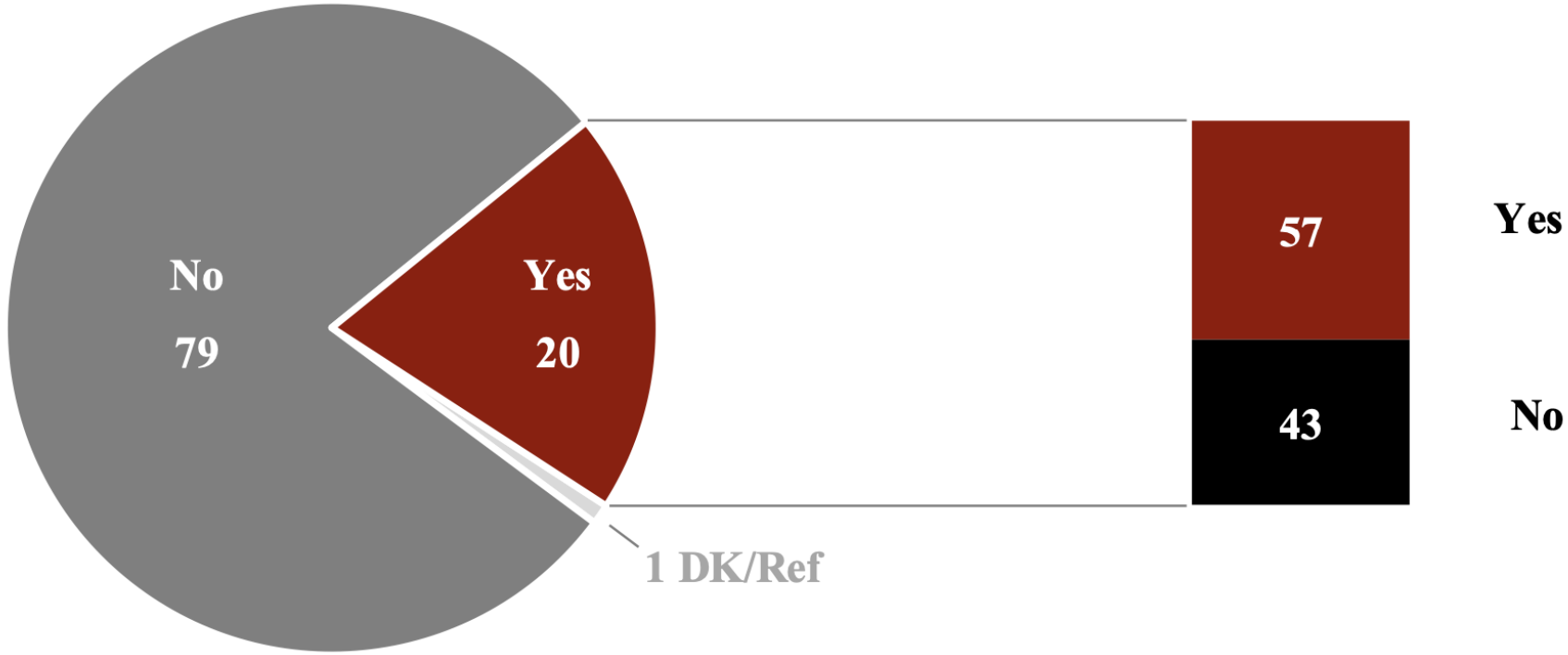
Robert Wood Johnson Foundation

HARVARD T.H. CHAN SCHOOL OF PUBLIC HEALTH

Figure 4. Negative Health Consequences Among U.S. Households Unable to Get Medical Care for Serious Problems During the Coronavirus Outbreak (in Percent)

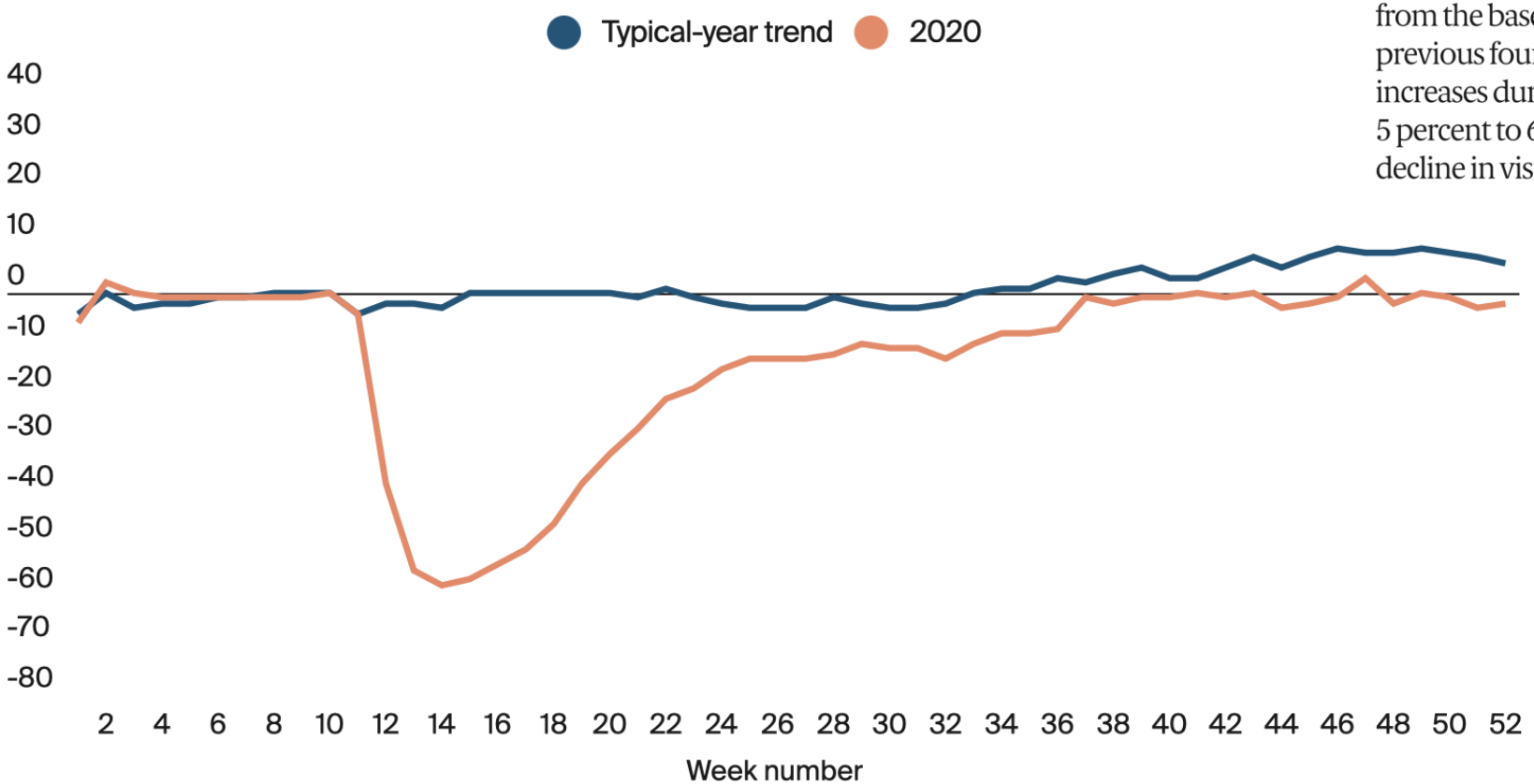
Q17. At any point since the start of the coronavirus outbreak, has anyone living in your household been unable to get or delayed getting medical care for a serious problem when they needed it, or not?

Among the 20% of households where anyone has been unable to get medical care for a serious problem when needed: Q18. And overall, do you think delays or being unable to get medical care had any negative health consequences for them, or not?



NPR/Robert Wood Johnson Foundation/Harvard T.H. Chan School of Public Health, *The Impact of Coronavirus on Households Across America*, 7/1//20 – 8/3/20. N=3,454 U.S. adults ages 18+ reporting on behalf of their households. DK/Ref – Don't know/refused/web blank.

Percent change in visits from baseline



Download data

Despite the surge in COVID-19 cases at the end of 2020, outpatient visits per week were stable over the last three months of 2020 and unchanged from the baseline week of March 1. However, the pattern over the previous four years (blue line) shows that the number of visits usually increases during winter months. The number of weekly visits in 2020 was 5 percent to 6 percent below this typical pattern, suggesting a cumulative decline in visits.

The Commonwealth Fund

Note: Data are presented as a percentage change in the number of visits in a given week from the baseline week (Week 10, or March 1–7, 2020). "Typical year" data from 2016 to 2019 were also calculated as a percentage change from the baseline week — week 10 — in those years. Data are equally weighted across the four years.

Source: Ateev Mehrotra et al., The Impact of COVID-19 on Outpatient Visits in 2020: Visits Remained Stable, Despite a Late Surge in Cases (Commonwealth Fund, Feb. 2021). https://doi.org/10.26099/bvhf-e411

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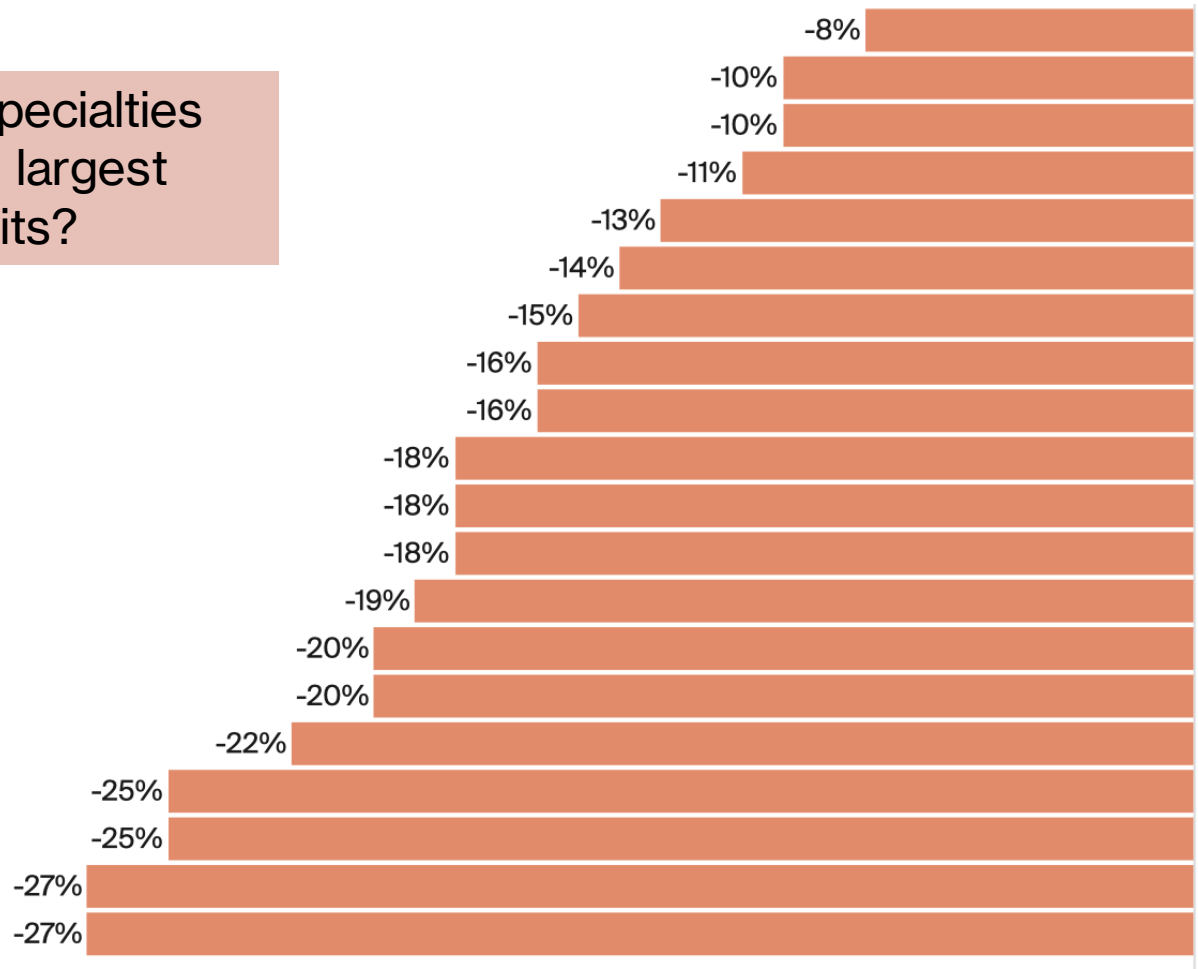
There was a substantial cumulative reduction in visits across all specialties over the course of the pandemic in 2020. One critical question is whether visit volumes will rise above the baseline level as we gain increasing control over the pandemic and people receive care that had been deferred.

Cumulative decline in visits during pandemic, by provider specialty

Poll: What two specialties experienced the largest reductions in visits?



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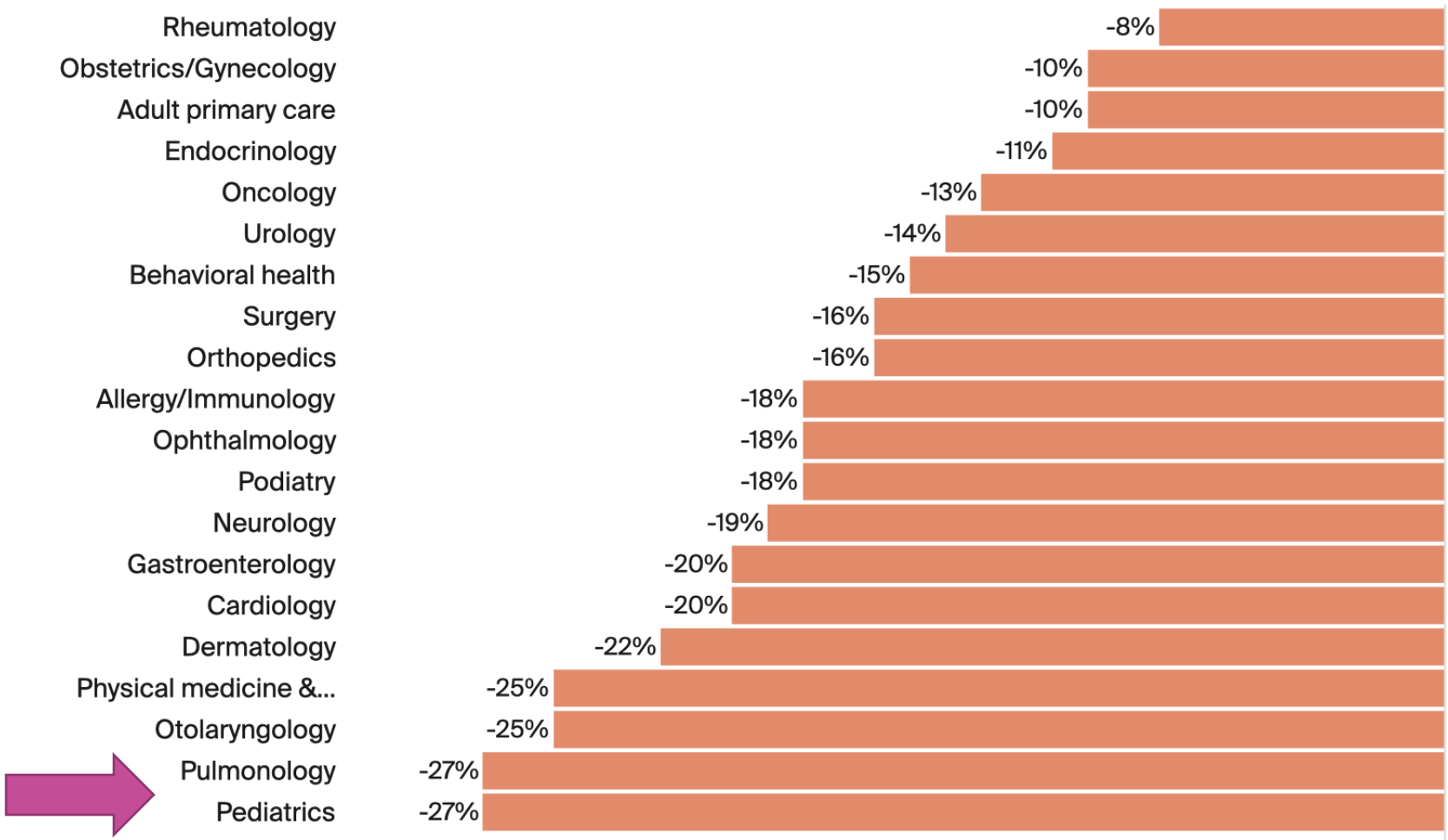

The Commonwealth Fund

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Staffing shortages

CORONAVIRUS

Nurse shortages in California reaching crisis point

BY KRISTEN HWANG , AUGUST 26, 2021 UPDATED SEPTEMBER 28, 2021

WORKFORCE | HEALTH CARE

Hospitals innovate amid dire nursing shortages

Patrick Boyle, Senior Staff Writer

September 7, 2021

Healthcare staff shortages projected for every state by 2026: 4 report findings

Cailey Gleeson (Twitter) - Wednesday, September 29th, 2021 Print | Email

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Year	DPH COVID Leave Hrs (total)	DPH Sick Leave Hours (total)	DPH COVID and Sick Leave Hrs (Combined)	Total Leave Hrs: Difference from Prior Year
2019	0.00	4,295,806	4,295,806	
2020	4,550,298	8,905,751	13,456,049	213%
2021 Year to date (usually reported through September)	2,937,817	8,227,374	11,165,192	-17%

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The Bottom Line

- The pandemic has created a massive access backlog
- Health systems are experiencing historic staffing shortages and burnout

How can we make up for lost time with such scarce resources?

Optimizing access

...starts with maximizing the resources you already have

Strategies for Improving Access

Optimize existing resources:

Reduce no-shows

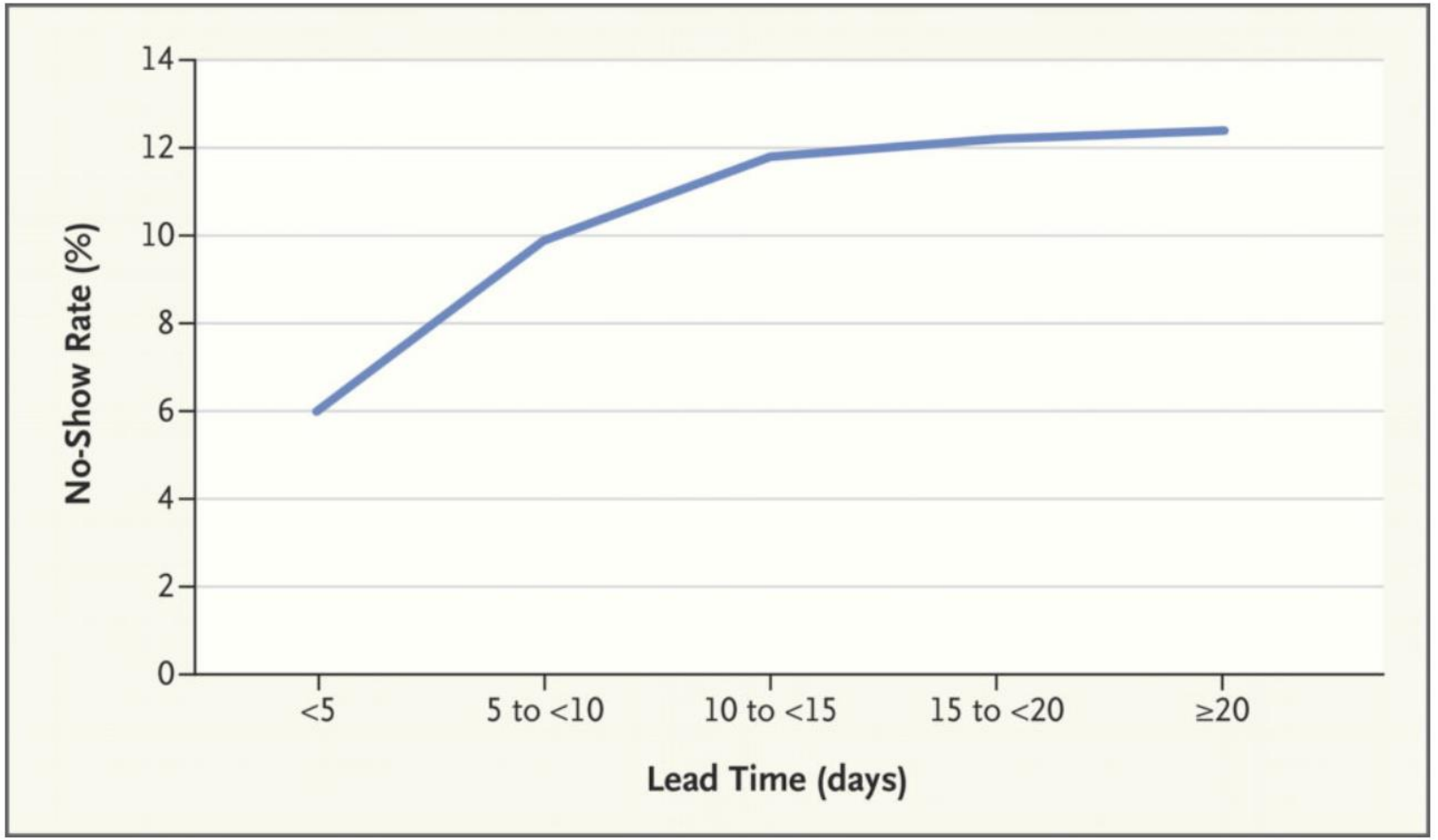
Simplify scheduling templates

Adjust scheduling practices

Reducing no-shows

- Make sure that follow up visits are value-added for the patient
- No-shows increase when there are access delays and lack of continuity with PCP
- Identify barriers: transportation (a covered MediCal benefit), time of day, cognitive impairment, childcare
- Offering telehealth options may improve show-rates:
  - No-show rate for telehealth visits during the pandemic at a network in Ohio was 7.5%, compared to 36.1% for in-office visits
- Max-packing appointments: addressing as many needs as possible during one visit
- Avoid cancelling appointments:
  - Develop policies for clinic cancellations and finding coverage
  - Contingency planning when multiple people are out at once

Reducing no-shows



Relationship between Waiting Times for Appointments and No-Show Rates. Data are observations across all patient types, based on a random sample of appointments booked through MyHealthDirect, a commercial scheduling vendor. $\chi 2=443$; N=47,087; $P<0.05$. Click To Enlarge.

Ryu J et al. N Engl J Med 2017; 376:2309-2311
DOI: 10.1056/NEJMp1704478

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Shorten lead time by optimizing existing resources

Look at how frequently patients are seen for follow up:

- Can this interval be spaced out?
- Leverage care team more robustly (e.g,. RN calls for lab follow up, clinical pharmacist-led chronic care, etc.)

Overbook slots for patients who are likely to no-show (Neighborhood Healthcare)

Shift scheduling practices away from using appointments to track patients

- Rationale: keep patients from “falling through the cracks”
- Downsides:
  - Higher no-show rate
  - Clogs up the schedule, worsens access
  - Lose track of patients who cancel without rescheduling
- Alternatives: registries, work lists, care gap lists, automated appointment reminders
- Lessons from Alameda Health System: identify patients who truly cannot schedule their own follow up (10-20%), ask all other patients to call for a return appointment→ TNAA reduced from 43 to 22 days

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Adjust scheduling templates

- Simplify! Avoid carve-outs, minimize visit types
- Incorporate more hold-and-release slots (e.g., 3-, 7-, 14-day hold/release)
- Restrict how far out appointments are booked (e.g. max 30 days)
- Open access scheduling

WOMENS SERVICES						
STANDARD TEMPLATE						
Start Time	**End Time**	**Visit Duration**	**BLOCK TYPE**	**Regular Slot**	**Overbook Slots**	**Time Release**
0820	0835	15 mins	New / Return	1	0	45 Days
0835	0850	15 mins	New / Return	1	0	45 Days
0850	0905	15 mins	New / Return	1	0	15 Days
0905	0920	15 mins	New / Return	1	0	15 Days
0920	0935	15 mins	New / Return	1	0	10 Days
0935	*0950*	*NO TEMPLATE*	*NO TEMPLATE*	*NO TEMPLATE*	*NO TEMPLATE*	*NO TEMPLATE*

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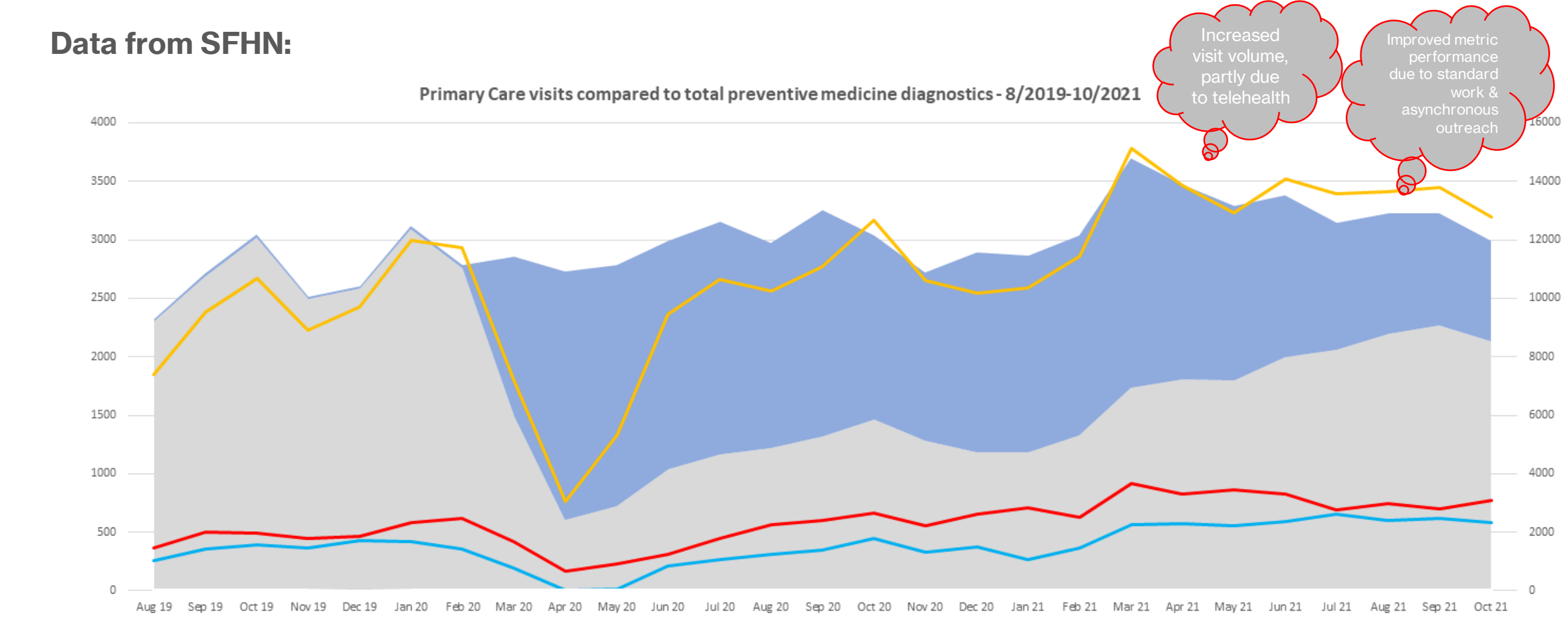
Data from SFHN:



	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21
Telehealth visits	63	123	122	70	62	91	124	5430	8519	8242	7808	7944	7017	7730	6303	5755	6836	6734	6825	7861	6649	5940	5544	4326	4126	3855	3441
In-person visits	9225	10730	12062	9992	10355	12374	11020	5977	2406	2878	4159	4658	4889	5285	5846	5117	4732	4722	5320	6928	7234	7212	7974	8247	8770	9064	8533
A1c	1849	2383	2668	2227	2424	2998	2930	1800	762	1330	2363	2663	2563	2774	3168	2656	2546	2586	2858	3783	3469	3231	3522	3395	3412	3450	3191
Mammo	257	357	396	363	428	421	360	190	8	12	212	265	313	352	447	330	378	269	367	563	570	552	594	657	597	619	583
FIT	370	498	492	446	462	584	618	422	165	227	309	450	569	597	666	557	659	713	625	916	825	862	828	693	745	699	775
TV ratio	0.7%	1.1%	1.0%	0.7%	0.6%	0.7%	1.1%	47.6%	78.0%	74.1%	65.2%	63.0%	58.9%	59.4%	51.9%	52.9%	59.1%	58.8%	56.2%	53.2%	47.9%	45.2%	41.0%	34.4%	32.0%	29.8%	28.7%

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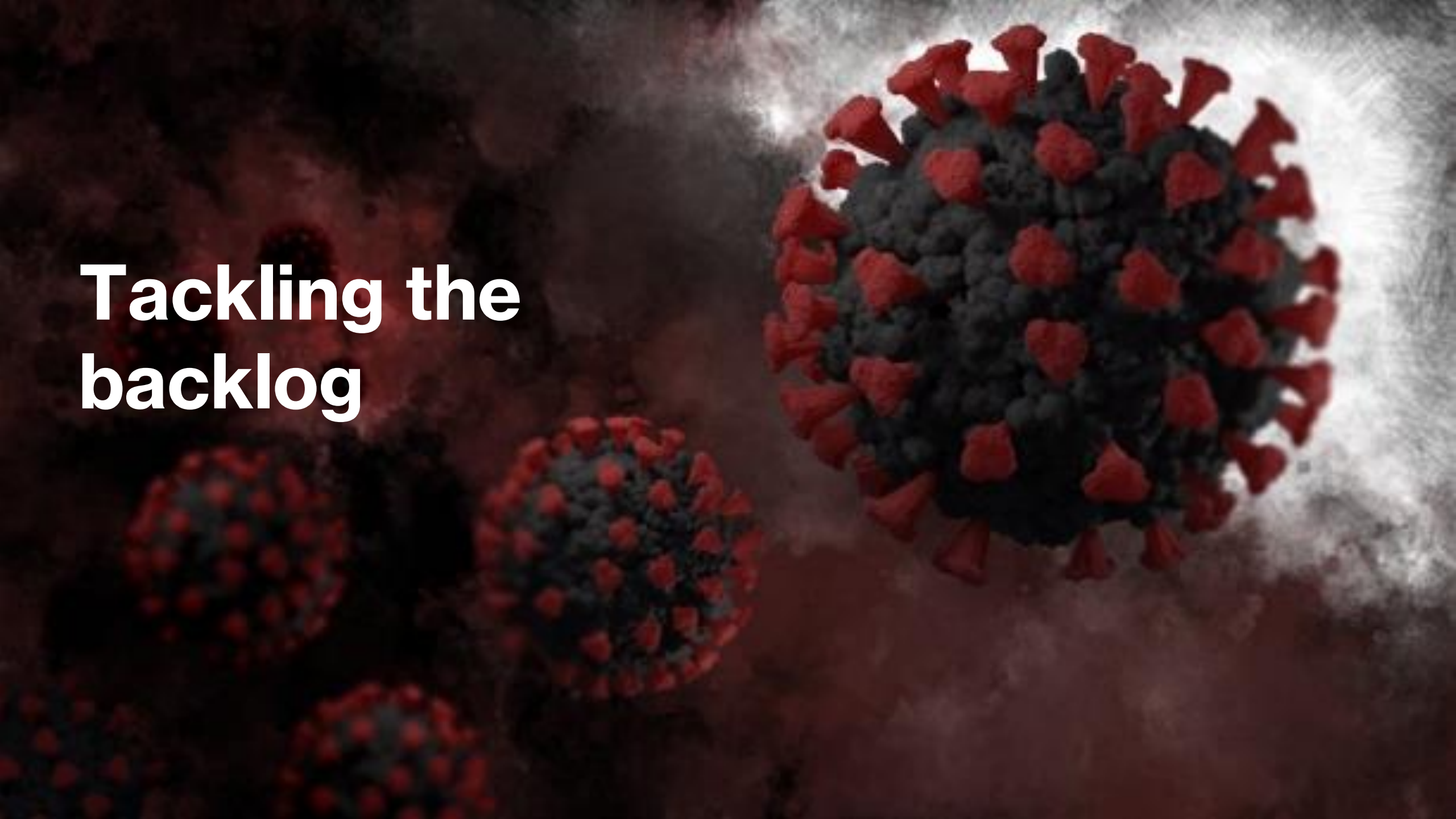
Tackling the
backlog

Access: supply vs. demand

Improving access is all about getting supply and demand in equilibrium, which means that there is no backlog of appointments and no delay between when the demand is initiated and when the service is delivered.

Demand is not really insatiable, but actually predictable. In fact, the demand for any kind of service — appointment, advice, or message to a provider — can be predicted accurately based on the population, the scope of the provider practice and, over time, the particular practice style of each provider.

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http://www.ihi.org/Topics/PrimaryCareAccess/Pages/default.aspx

Calculating supply

To calculate number of slots per week, multiply:

- Provider clinical FTE in a given period
- Number of patient visits each provider is capable of seeing per week (# of slots per hour x hours per day x working days per week)

http://www.ihi.org/Topics/PrimaryCareAccess/Pages/default.aspx

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Calculating demand:

- Demand is the daily number of patient requests for appointments, no matter when the appointment is actually scheduled.
- Demand should not be confused with the number of visits made or appointments completed.
- Demand comes from two sources: internal and external.
    - External demand is generated by requests or referrals for an appointment (e.g. phone calls, walk-ins, faxes, emails, deflections to urgent care)
    - Internal demand is generated by the practice itself in the form of return appointments and planned visits.
- Formula: Demand = External Demand + Internal Demand

http://www.ihi.org/Topics/PrimaryCareAccess/Pages/default.aspx

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Defining backlog

- Appointments on the future schedule that have been put off due to lack of space to do this work sooner (supply/demand imbalance)
- The traditional office practice scheduling philosophy has been to push out appointments into the future to protect today's schedule, creating backlog
- Working down the backlog recalibrates the system to improve access

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http://www.ihi.org/Topics/PrimaryCareAccess/Pages/default.aspx

Measuring backlog

- TNAA (daily dashboard helps)
- Counting number of backlog appointments
- Waitlists

http://www.ihi.org/Topics/PrimaryCareAccess/Pages/default.aspx

Working down the backlog

- Once schedules and resources have been optimized, if backlog still exists:
  - Temporarily add appointment slots to the schedule (e.g. weekend or evening appointments, or extra slots during the day)
  - Set a start date and an end date when backlog reduction will be completed
    - Gain and add enough supply that backlog reduction is not a prolonged process.
    - Pace for backlog reduction should not be too rapid to avoid burning out providers and staff.
  - Confer with senior leaders to be clear about organizational support for various options for working down the backlog (e.g. OT, locums, increasing hours of part-time staff, etc.)

http://www.ihi.org/Topics/PrimaryCareAccess/Pages/default.aspx

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Backlog reduction: Example PHS approaches

- Working with Managed Care Plans to:
  - Incentive patients to get preventive or chronic care
  - Paying (unreimbursed) out of network providers to see patients (e.g., specialists, radiologists)
- Paying for (unreimbursed) remote monitoring devices & overhead for RN monitoring
- Expanding the care team through cross training of MA's, nurses, BH staff, etc
  - Use of the digital retinal camera
  - Screening for Depression, Tobacco use, etc
- Mobile phlebotomy vans
- Implement patient texting programs to bring pts in for care, labs, diagnostics
- After maximizing schedules and resources, prioritizing "more urgent" preventive or chronic care:
  - Expediting colonoscopy appts for positive FIT tests
  - Prioritizing appointments for people with the most out of control BP or DM

Strategy and next steps?

What is your current strategy for improving access and working down the backlog?

If you don’t have a current strategy, what is one thing you will start doing to work down the backlog?

Core topics:

Setting the context
Scheduling practices in the safety net
Reducing no-shows
Optimize existing resources
Reducing the backlog

Resources

Resources for improving access

- New England Journal of Medicine
  - The Waiting Game — Why Providers May Fail to Reduce Wait Times
- AHRQ: Ambulatory Care Improvement Guide
  - Strategy 6A: Open Access Scheduling for Routine and Urgent Appointments
- Institute for Healthcare Improvement (IHI)
  - Improving Patient Access Doesn't Mean Increasing Workload
  - Open Access at Primary Care Partners
  - Improving Access and Efficiency in Primary Care at HealthServe Community Health Center
- Journal of Telemedicine and E-Health
  - Reduced No-Show Rates and Sustained Patient Satisfaction of Telehealth During the COVID-19 Pandemic

Questions?

Thank you!

don’t forget to fill out the survey