Continuity & Access:

Applying the Clinic First Model in a Post-COVID World

Clinic First Miniseries Session 1, May 26, 2021

UCSF Center for Excellence in Primary Care

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Welcome!

- Reminders:
  - Mute when not speaking
  - Enter questions in the chat

https://cepc.ucsf.edu/

Intros & Icebreaker

Poll: Who's in the Room?

- Program directors/assistant program directors
- Faculty members
- Clinic directors
- Nursing leaders
- Front desk
- Residents
- Other? (Share in the chat!)

And how's your mood today?

- Sunny
- Partly cloudy
- Cold and windy
- Dark and stormy

Agenda for Today

- Brief overview of Clinic First
- Continuity: Reorientation after COVID-19
- Access: Reorientation after COVID-19

Poll: Who has heard of Clinic First?

- Clinic what?
- Is this about 2+2?
- I've heard of it, but am not too familiar on the specifics.
- I know it well!

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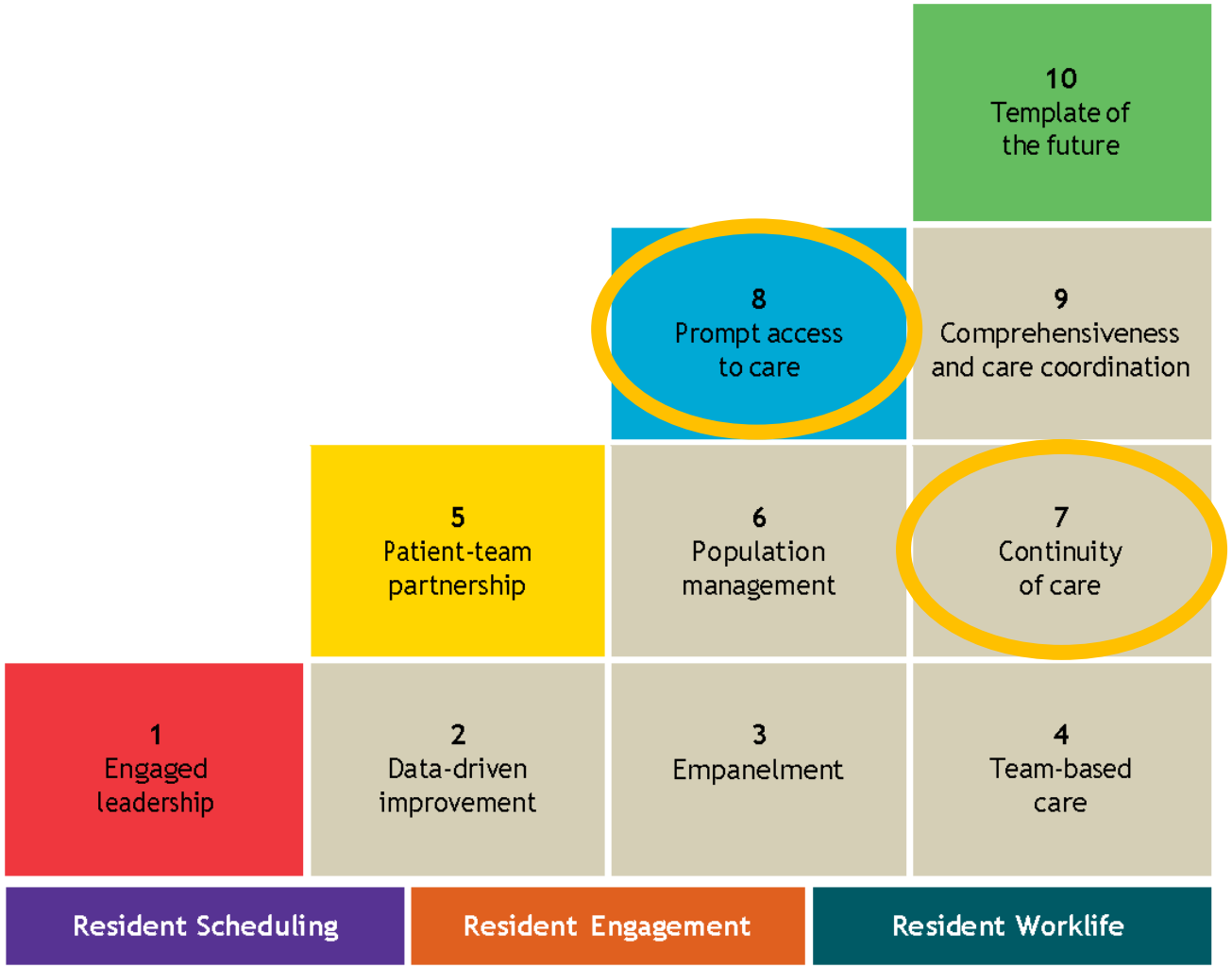
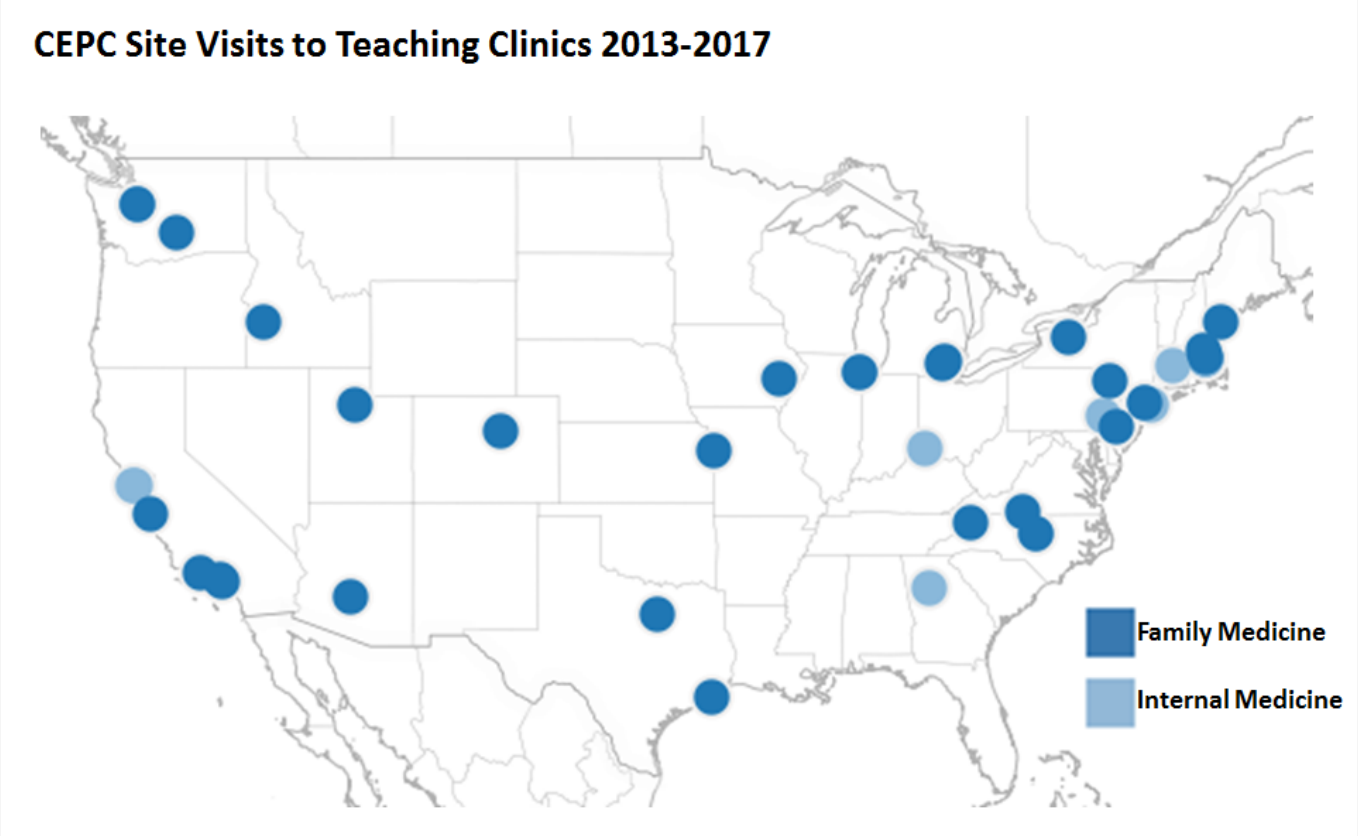
The 10+3 Building Blocks



T Bodenheimer et al AnnFamMed March 2014

Teaching Clinic Study

45 primary care family medicine, internal medicine, and pediatric residency practices



A New Teaching Clinic Paradigm: Clinic First

Highest performing teaching clinics took a common group of actions to improve the clinic

We call these actions “Clinic First” in contrast with the traditional paradigm of “hospital first, clinic second”

Clinic First means that the primary care clinic has at least equal (or perhaps greater) priority with other rotations in a residency program

Clinic First - Origins

Initially coined in the Valley Family Medicine program in Renton, Washington in 2000

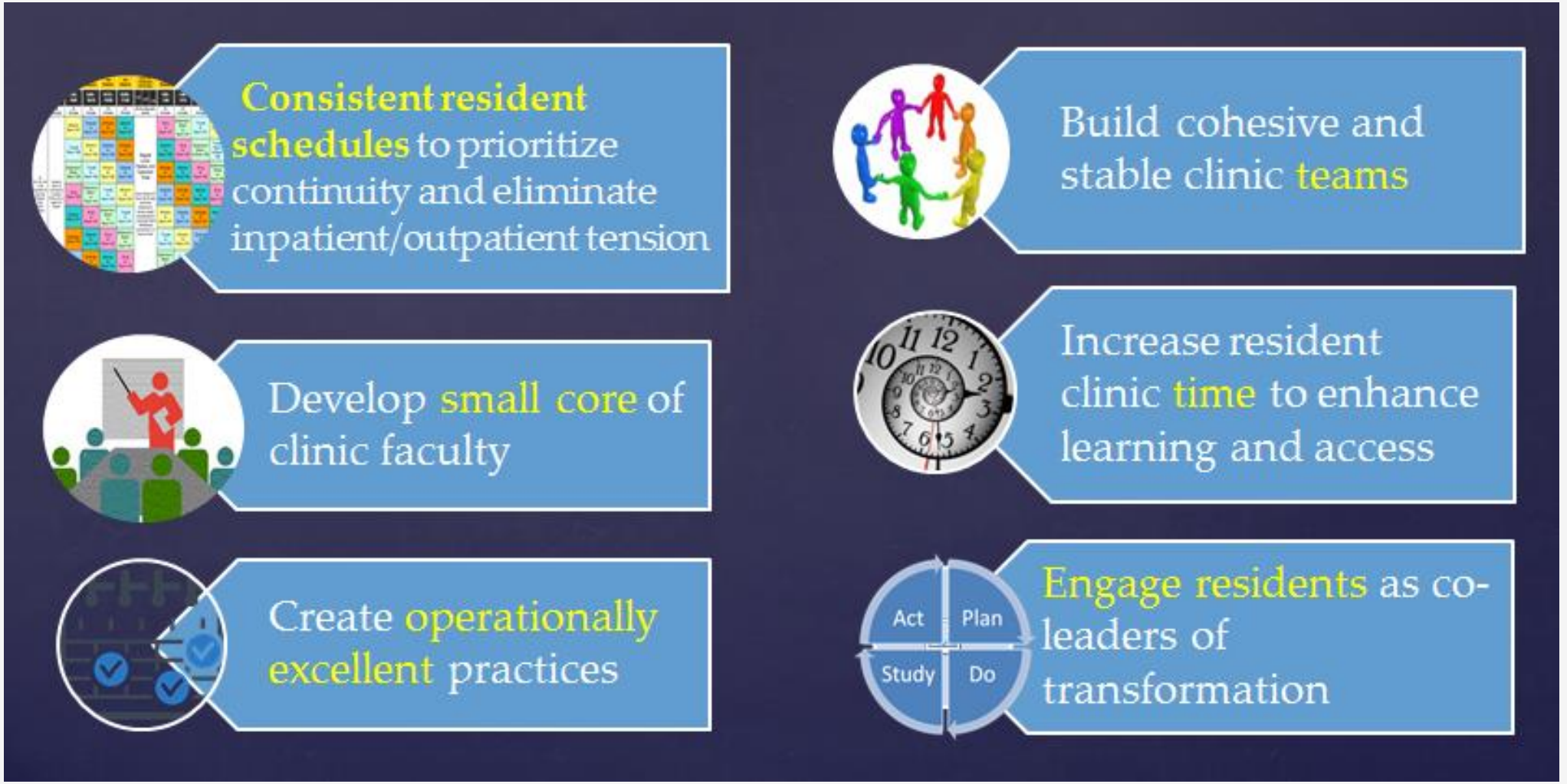
- Referred to curriculum changes that supported continuity and outpatient clinical excellence
- Published positive effects in 2001
  (Neher, Kelsberg, & Oliveira. Improving continuity by increasing clinic frequency in a residency setting. Fam Med. 2001 Nov-Dec.)

Idea spread in WWAMI Regional Medical Education Program

Adapted to signify the philosophy of prioritizing the primary care clinic in residency training

- Creating high-performing teaching clinics is essential
  (Gupta, Barnes & Bodenheimer. Clinic First: 6 actions to transform ambulatory residency training. JGME, 2016 Oct.)

Clinic First



The Hospital First – Clinic First Spectrum

Hospital first - clinic second

Clinic first

POLL: Where is my program on this spectrum?

- Red
- Orange/yellow
- Green
- Blue
- Purple

Continuity Fundamentals

Agenda

Session 1

- Define continuity and review fundamentals in the COVID/telehealth era
- Measurement and tracking

Session 2

- Improvement strategies/case studies
- The access/continuity relationship

What is Continuity of Care?

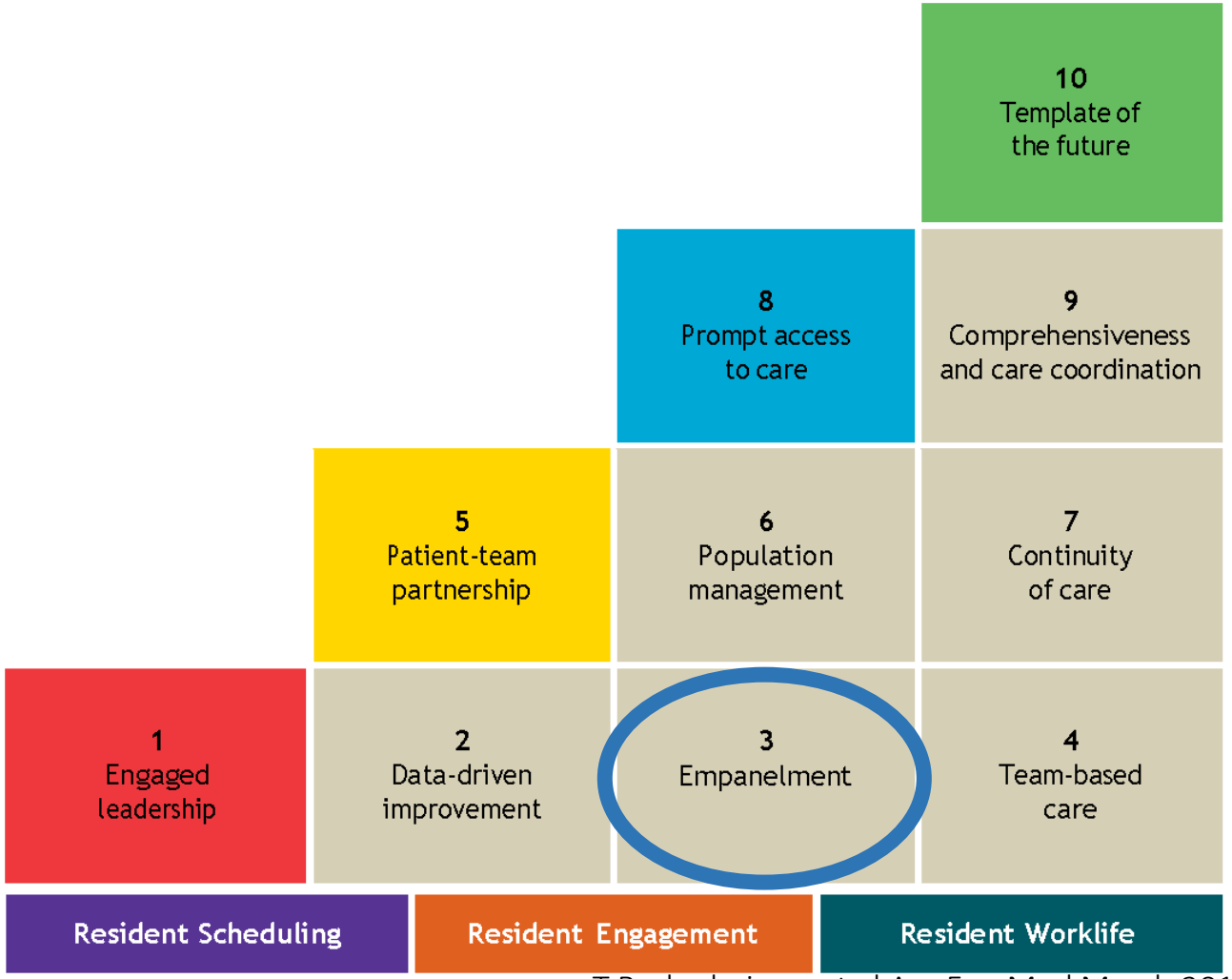
In the chat, write a definition for continuity of care

Continuity – Short Definition

Continuity of care means that patients/families are empaneled to a clinician and see that clinician every time they need care.

Pop Quiz!

What building block has to be in place to have CONTINUITY?



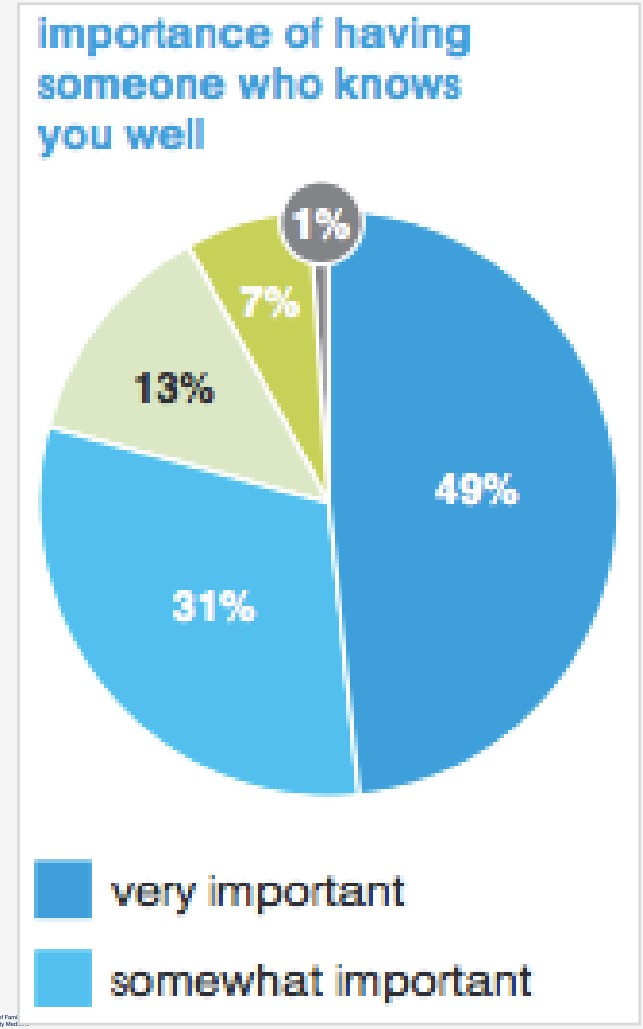
T Bodenheimer et al AnnFamMed March 2014

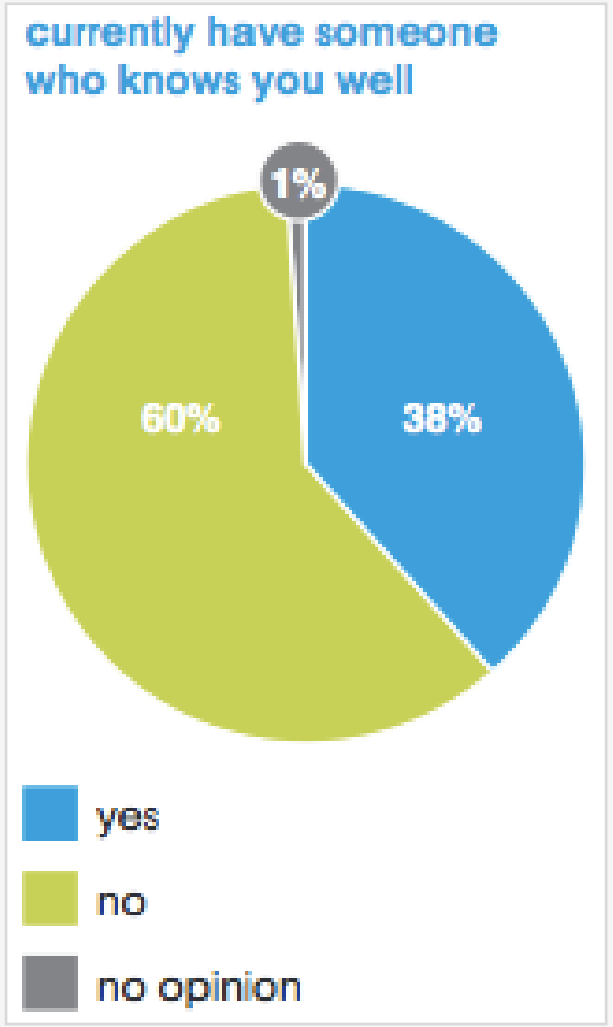
Why Does Continuity Matter?

- Low-income patients who say someone at their facility knows them well: care they receive is excellent or very good 65% (vs. 38%)
- More likely to feel very informed about their health (64% vs. 37%)
- More apt to be highly comfortable asking questions about their care
- More likely to be very confident in their ability to make healthcare decisions

Connectedness and Continuity: Patient-Provider Relationships Among Low-Income Californians, June 2012, BSCF.
http://www.blueshieldcafoundation.org/sites/default/files/u14/BSCF_Patient_Provider_web.pdf

Patients Want to Feel Connected





Two-thirds of low-income patients say they don't see the same care provider every time they visit their facility.

Connectedness and Continuity: Patient-Provider Relationships Among Low-Income Californians, June 2012, BSCF. http://www.blueshieldcafoundation.org/sites/default/files/u14/BSCF_Patient_Provider_web.pdf

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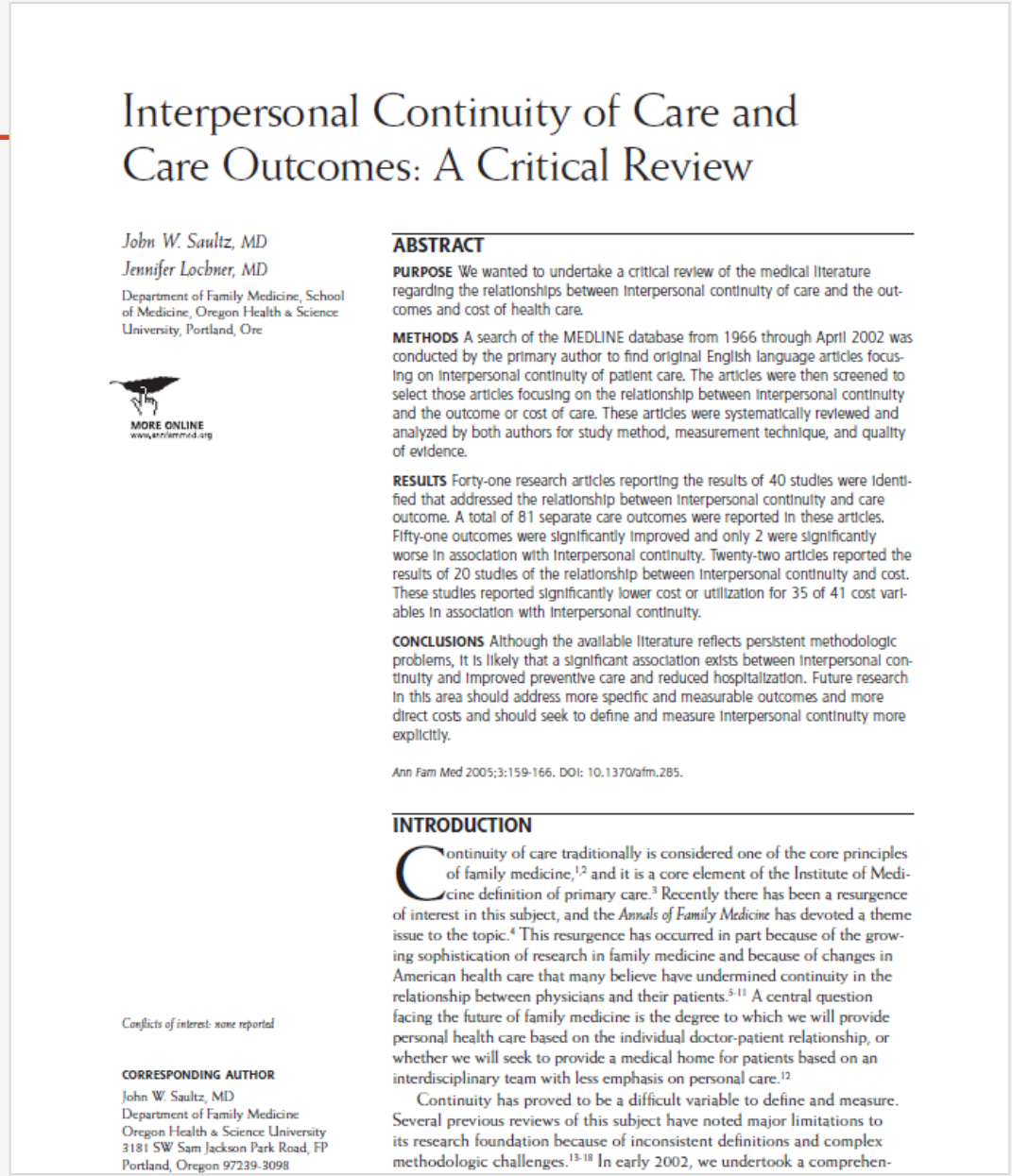
Why Continuity?

Associated with

- Improved preventive and chronic care
- Higher patient and clinician satisfaction
- Lower costs

Basis for the patient-clinician relationship



Interpersonal Continuity of Care and Care Outcomes: A Critical Review

John W. Saultz, MD
Jennifer Lochner, MD
Department of Family Medicine, School of Medicine, Oregon Health & Science University, Portland, Ore

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ABSTRACT

PURPOSE We wanted to undertake a critical review of the medical literature regarding the relationships between interpersonal continuity of care and the outcomes and cost of health care.

METHODS A search of the MEDLINE database from 1966 through April 2002 was conducted by the primary author to find original English language articles focusing on interpersonal continuity of patient care. The articles were then screened to select those articles focusing on the relationship between interpersonal continuity and the outcome or cost of care. These articles were systematically reviewed and analyzed by both authors for study method, measurement technique, and quality of evidence.

RESULTS Forty-one research articles reporting the results of 40 studies were identified that addressed the relationship between interpersonal continuity and care outcome. A total of 81 separate care outcomes were reported in these articles. Fifty-one outcomes were significantly improved and only 2 were significantly worse in association with interpersonal continuity. Twenty-two articles reported the results of 20 studies of the relationship between interpersonal continuity and cost. These studies reported significantly lower cost or utilization for 35 of 41 cost variables in association with interpersonal continuity.

CONCLUSIONS Although the available literature reflects persistent methodologic problems, it is likely that a significant association exists between interpersonal continuity and improved preventive care and reduced hospitalization. Future research in this area should address more specific and measurable outcomes and more direct costs and should seek to define and measure interpersonal continuity more explicitly.

Ann Fam Med 2005;3:159-166. DOI: 10.1370/afm.285.

INTRODUCTION

Continuity of care traditionally is considered one of the core principles of family medicine,[1,2] and it is a core element of the Institute of Medicine definition of primary care.[3] Recently there has been a resurgence of interest in this subject, and the *Annals of Family Medicine* has devoted a theme issue to the topic.[4] This resurgence has occurred in part because of the growing sophistication of research in family medicine and because of changes in American health care that many believe have undermined continuity in the relationship between physicians and their patients.[5-11] A central question facing the future of family medicine is the degree to which we will provide personal health care based on the individual doctor-patient relationship, or whether we will seek to provide a medical home for patients based on an interdisciplinary team with less emphasis on personal care.[12]

Continuity has proved to be a difficult variable to define and measure. Several previous reviews of this subject have noted major limitations to its research foundation because of inconsistent definitions and complex methodologic challenges.[13-18] In early 2002, we undertook a comprehen-

Conflicts of interest: none reported

CORRESPONDING AUTHOR
John W. Saultz, MD
Department of Family Medicine
Oregon Health & Science University
3181 SW Sam Jackson Park Road, FP
Portland, Oregon 97239-3098

Poll: Where Are We?

In our practice, having patients see their empaneled clinician and team is encouraged:

- Only at the patient's request
- By the practice team, but it not a priority in appointment scheduling
- By the practice team, and is a priority in appointment scheduling, but patients commonly see other clinicians
- By the practice team, is a priority in appointment scheduling, and patients usually see their own clinician or a continuity figure

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How Did COVID Impact Continuity of Care?

- Research is not available on whether the measures of continuity discussed here changed during COVID.
- Perhaps more telehealth visits are with the patient's own clinician, but that is not known
- One way in which COVID reduced continuity is that most people stopped addressing their non-COVID conditions so that the continuity over time for patients with chronic conditions who need regular monitoring dropped markedly

Khera A et al. Continuity of care and outpatient management for patients with and at high risk for cardiovascular disease during the COVID-19 pandemic. (Am J Prev Cardiol 2020;1:100009)

In the chat: What have you seen happen with continuity in your practice?

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Two Perspectives of Continuity

Patient Perspective

- Receiving care from the same clinician/team I know

Clinician/Team Perspective

- Providing care to someone/panel that I know

Continuity Measures

1. Patient perspective: Percent of time patients have a visit with their assigned provider or team

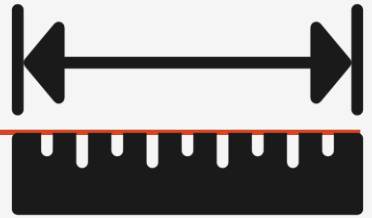
2. Clinician/team perspective: Percent of time providers have visits with their assigned patients

In the chat:

- Write a metric for patient-centered continuity of care
- Write a metric for clinician-centered continuity of care

(Hint: What is numerator? What is denominator?)

Measuring Continuity



Continuity of care from the patient perspective:

Patient visits to the patient's empaneled PCP/ # patient visits

Example: A panel of 1000 patients makes a total of 3000 visits per year.

2000 of these visits are with the patient's PCP.

Continuity is 2000/3000 = 67%

Continuity of care from the clinician (resident, faculty, NP/PA) perspective:

Clinician's visits that are visits with patients in their panel / # clinician's visits

Example: A resident has 200 patient visits in a month.

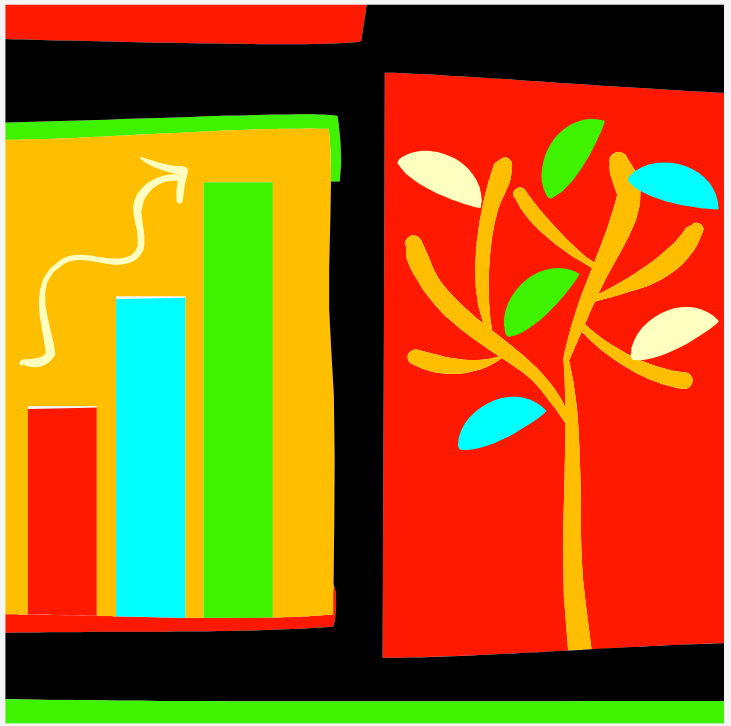
120 of these visits are with patients on the resident's panel

80 of the visits are with patients of other residents or faculty.

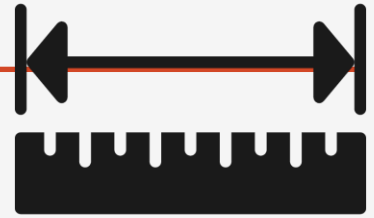
Continuity is 120/200 = 60%

“Team” Continuity

- Patient centered continuity with a team isn’t significant if the team is large (>3 clinicians)
- Patient centered continuity with a small team, or clinician pair, is more meaningful



Measuring Continuity



Patient centered continuity with a clinician pair

- Percentage of patient visits that take place with either the patient's assigned clinician OR one other clinician on the same team.

Example:

- A panel of 1000 patients makes 3000 visits per year.
- 1000 of these visits are with the patient's PCP
- 1400 of these visits are to the NP on the PCP's team
- 2-person team continuity is 2400/3000 = 80%

Other Ways to Consider Continuity

Kaiser Washington Family Medicine Residency:
"Longitudinal continuity"

- How often did a resident see one of his or her patients once, twice, three times, or >3 times during residency?

Poll:

Are you measuring patient-centered continuity?

- Yes/No

Are you measuring clinician-centered continuity?

- Yes/No

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How Much Continuity Do We Aim For?

- There are no official national benchmarks.
- Among published estimates from teaching clinics, median patient-centered continuity is 56% (range 43-75%) and median provider centered continuity is 55% (range 37-63%).
  (Walker J, Payne B, Clemans-Taylor BL, Snyder ED. Continuity of Care in Resident Outpatient Clinics: A scoping Review of the Literature. J Grad Med Educ. 2018;10(1): 16-25).
- In the teaching clinic visits made by the Center for Excellence in Primary Care, the highest patient-centered and clinician-centered continuity rates were around 70%.

Poll:

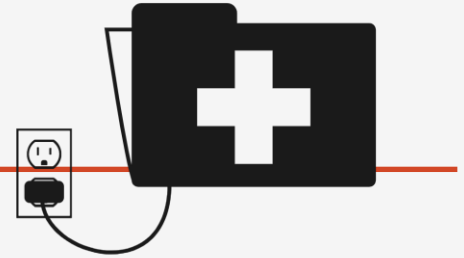
If you are <u>not</u> measuring continuity, do you think your EMR/IT team could provide and track this data?

- Yes / No

If you <u>are</u> measuring continuity, are you getting your data from the EMR?

- Yes, we get it every month
- Yes, but only rarely
- Yes, but we don't trust the data
- Actually, we aren't getting the data in a useful way that allows us to improve

Getting Started Measuring Continuity



From your EMR, have your IT support people collect and track for each resident and faculty person:

A. Total number of visits made each month by your patient panel
B. Number of those visits that are visits to you
Patient-centered continuity is B/A

C. Total number of visits you provide each month
D. Number of those visits that are with patients on your panel
Clinician-centered continuity is D/C

Spot Checks If You Are Unable to Get Data from the EMR

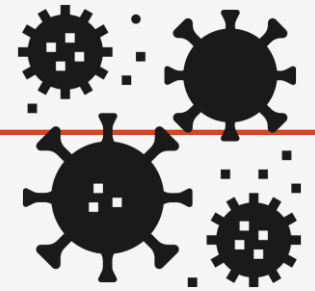
Spot check patient-centered continuity by reviewing the appointment records for about 10 patients scheduled today.

- For each patient, how many of his or her appointments in the past year took place with his or her assigned clinician?

Spot check clinician-centered continuity by reviewing the list of patients scheduled for each clinician today.

- For each clinician, what percent of the appointments are for patients assigned to that clinician?

Measuring Continuity in the Time of COVID



- The metrics don’t change except that visits include both face-to-face and telehealth.
- Generally patient portal communications are with the clinician’s own patients, so patient-centered and clinician-centered continuity are likely to be good.

In our session 2 discussion, we will discuss strategies to improve continuity

Access Fundamentals

Agenda

Session 1

- Define access and review fundamentals in the COVID/telehealth era
- Measurement and tracking

Session 2

- Improvement strategies/case studies
  Ways to decrease demand or increase supply
  Strategies when you can't change supply and demand
- The access/continuity relationship

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Access to Care Defined

In the chat…

Big picture: What is access?

Access to Care Defined

Patients can get care WHEN, WHERE, and HOW they need it.

= Care with timeliness, proximity, and appropriate to best meet needs.

Good Access = Balancing Demand with Supply/Capacity

Demand

- Panel size
- Return Intervals
- Seasonal
- Lab Result Availability
- Patient population needs (chronic and complex, acute, preventive)

Supply/Capacity: e.g. appointment slots

- Provider FTE
- # days open
- # appt slots
- # of types
- length of appts
- Other services: (i.e. Behavioral Health, RN Visits)

Poll:

In general, how is your access currently compared to pre-COVID times?

- Better
- Worse
- Same

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Whiteboard: How has COVID-19 Affected Access in Primary Care?

Increased capacity	Reduced capacity	Increased demand	Reduced demand

Whiteboard: How has COVID-19 Affected Access in Primary Care?

Increased capacity	Reduced capacity	Increased demand	Reduced demand
Telehealth has expanded available visit formats/flexibility	Social distancing reduces in-person capacity	Worsening of underlying/chronic disease due to stay-at-home and/or financial/social stressors	People avoiding care due to COVID related fears
	Providers/residents/staff deployed for COVID response	Increased mental health and substance use burden/exacerbations	
	Providers/staff lost to burnout, illness, COVID-related family care, etc.	Patients previously who couldn't access care in person may not be able to via telehealth	

Access and COVID-19

- Total outpatient visits declined during 2020, suggesting that there is pent-up demand with no increase in capacity in 2021 which would reduce access in 2021.
  [Patel SY, JAMA Intern Med 2021;181:388-391]
- In the first half of 2020, many primary care practices laid off staff and even closed, which may reduce access. [Krist AH, Ann Fam Med 2020;18:349-354]
- Thousands of physician practices closed under the stress of the pandemic. As revenues dropped, overhead remained the same or increased with the need for PPE and new workflows.
  [Rubin R. COVID-19's Crushing Effects on Medical Practices, Some of Which Might Not Survive. JAMA 2020;324:321-323]
- Many practices have become trained in telehealth and now have telehealth workflows, which could increase access especially for patients geographically distant from primary care, but could increase access disparities for patients without good internet coverage or those not comfortable with technology.
  [Schwann LH et al, Lancet Digital Health, June 1, 2020; Bashshur R et al, Telemed and e-Health 2020;26:571-573]

Primary Care Survey, 4/9-13/21 Larry Green Center

71% say level of burnout or mental exhaustion is at all-time highs

40% note practice levels of burnout have also reached new heights

40% say pandemic specific practice strain is the same as May 2020

23% report the strain is worse than last May, yet

27% have clinician positions they cannot fill

29% have had clinicians/staff out due to illness or quarantine

12% report pandemic-offered relief from loans and documentation is less available

These survey results are very likely to have negative implications for access

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What Now?

Opportunity to think more broadly about what constitutes good access, beyond in-person TNAA.

- What do patients really need?
- How do we address these needs in ways that use our available capacity strategically?

*However, in-person needs are ongoing, and health systems/payors may still be focusing on these metrics.

- How do we make sure in-person needs are adequately addressed and captured (while we advocate for updated payment systems long term)?

Access Types

- In person
- Phone visits
- Video visits
- Phone access (i.e., non-visit communication – ex. care coordination needs, refills, forms, etc.)
- Portal access

Poll:

Long term, how will your practice balance in-person vs telehealth visits?

- We'll go back to completely in-person access
- We'll do mostly in person visits with a small proportion of telehealth
- We'll do half in person and half telehealth visits
- We'll do mostly telehealth visits
- Who knows?

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Access and Continuity in the COVID Era

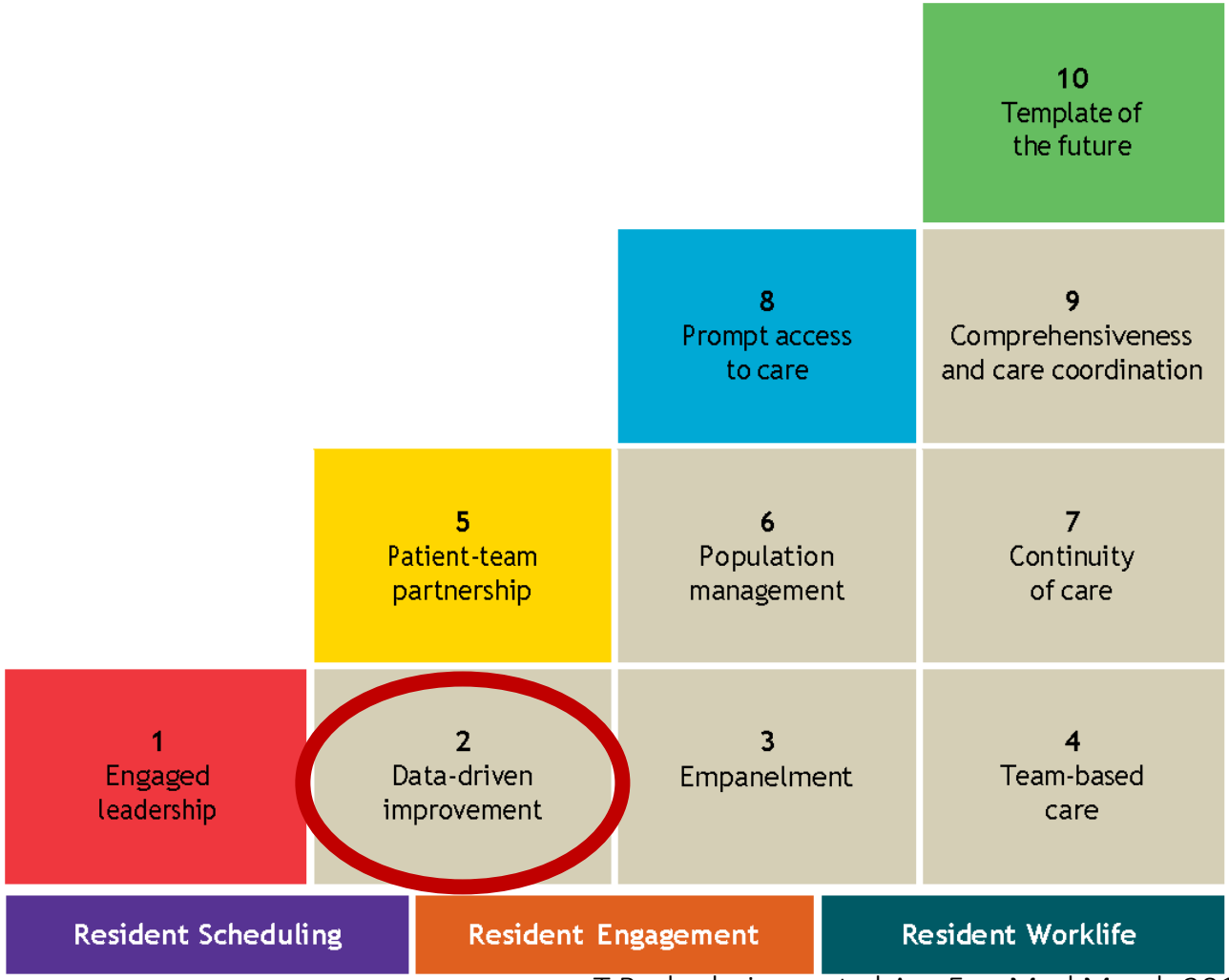
- There are now more access points for patients: patient portal, phone visits, video visits, and face-to-face visits
- In an informal survey of 29 family physicians, 24 felt that phone visits took less time or the same amount of time compared with face-to-face visits and 13 of the respondents felt that phone visits took less documentation time
- 17/29 wanted primary care to continue to use phone/video visits for at least 50% of all visits after the pandemic
- A number of primary care clinicians feel that continuity is even more important in the COVID era because it is more difficult to develop relationships through telehealth than in-person.

Telehealth Access Considerations

- Are there types of in person visits that are better/just as well handled by phone or video?
- Are telehealth visits more accessible for subpopulations of your patients?
- Are telehealth visits disadvantageous for certain patients/visit types?
- Do all of your patients have equal access to video visits? Are there disparities in access?

Measurement

To improve, we need to know where we are, and be able to know if we are improving.



T Bodenheimer et al AnnFamMed March 2014

Poll:

Do you measure TNAA? If so, what is your approximate clinic-wide TNAA?

- 0 – 5 days
- 6 – 10 days
- 11 – 20 days
- Greater than 20 days
- Don’t measure TNAA

Do you use a different access measure that is not TNAA?

- Yes/No

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Key Measures

Metric	Definition	What to Look For
% Same Day Appointments	# of appointments scheduled today or yesterday / # scheduled appointments	Set a goal (e.g. 30%) and see if you meeting the goal
% open capacity	# open slots / # appointments available	Are there enough appointments in the near future?
3rd Next Available	# days until 3rd open appointment	Ideally, less than 2

% of Same/Next Day Appointments

Clinic Schedule	Appointment Scheduled
1:00	PM HUDDLE
1:20	TODAY
1:40	2 weeks ago
2:00	2 weeks ago
2:20	1 month ago
2:40	TODAY
3:00	Yesterday
3:20	3 weeks ago

50% same/next day appointments

Future Open Capacity

- Identifies if the next 2-4 weeks have open slots
- Metric is number of open slots divided by total number of slots in a time period

Future Open Capacity

Week	This Week	Next Week	3 Weeks	4 Weeks
# Open	2	10	25	45
Total Appointments Available	50	50	50	50

2-week future open capacity: $\frac{12}{100}$ = 12%

4-week future open capacity: $\frac{82}{200}$ = 41%

Third Next Available Appointment

Day of the Week	Mon	Tues	Wed	Thur	Fri	Sat	Sun	Mon	Tues
Open/Scheduled Appointments	X	2	X	x					
	X	X	X	3					
	X	X	X	X					
	1	X	X	X	X	X			
3rd Next Available Measure	0	1	2	3	4	5	6	7	8

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Third Next Available Appointment

Day of the Week	Mon	Tues	Wed	Thur	Fri	Sat	Sun	Mon	Tues
Open/Scheduled Appointments	X	X	X	X	X	X	X	X	3
	1	X	X	X	X	X	X	X	
	X	X	X	X	X	X	X	X	
	X	X	X	X	X	X	X	2	
3rd Next Available Measure	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**

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Poll:

How does your clinic measure patient access?

- We don’t regularly/accurately measure access
- We have data on access for the clinic as a whole
- We have data on access for the clinic and individual PCPs/teams

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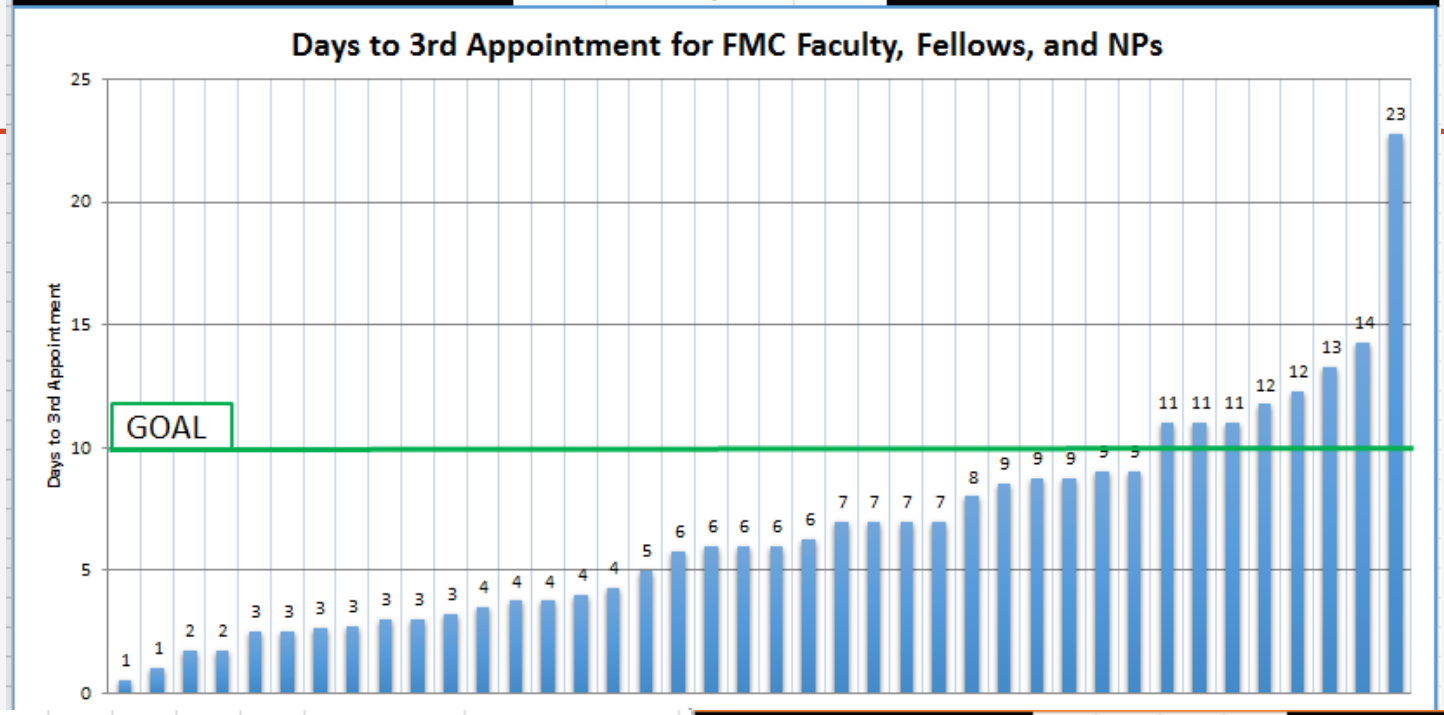
Examples of Detailed Access Data

Faculty Average	6.7
Family Medicine Avg	7.2

FACULTY, FELLOWS, NPs
February 2017

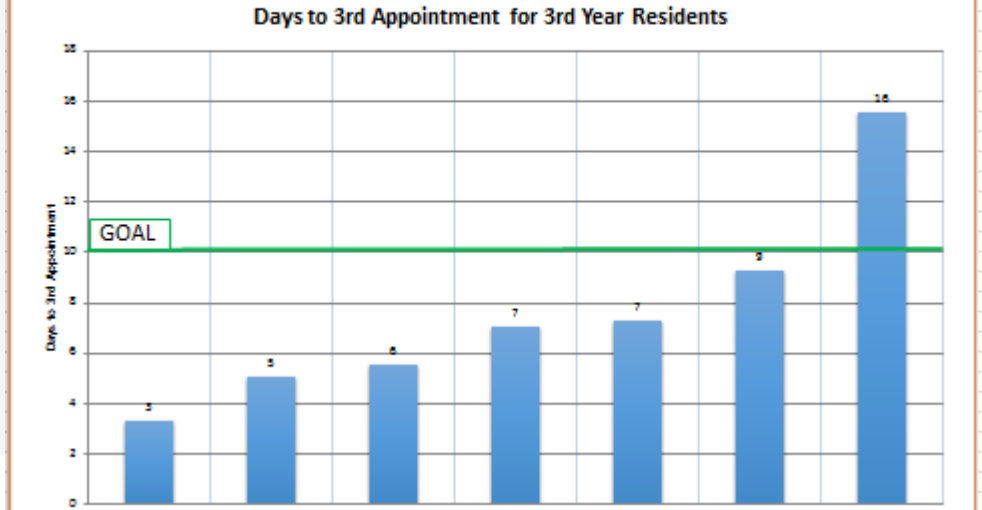
Faculty Below 10 Days	80.0%



3rd Year Resident Avg	7.5
All Resident Average	8.2
Family Medicine Average	7.2

3RD YEAR RESIDENTS
February 2017

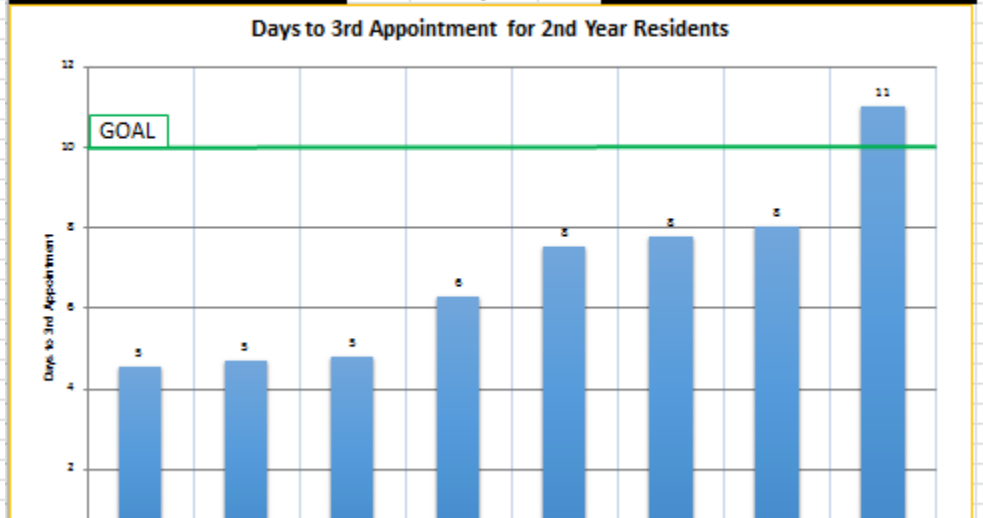
3rd Year Residents Below 10 Days	85.7%



2nd Year Resident Avg	6.8
All Resident Average	8.2
Family Medicine Average	7.2

2ND YEAR RESIDENTS
February 2017

2nd Year Residents Below 10 Days	87.5%



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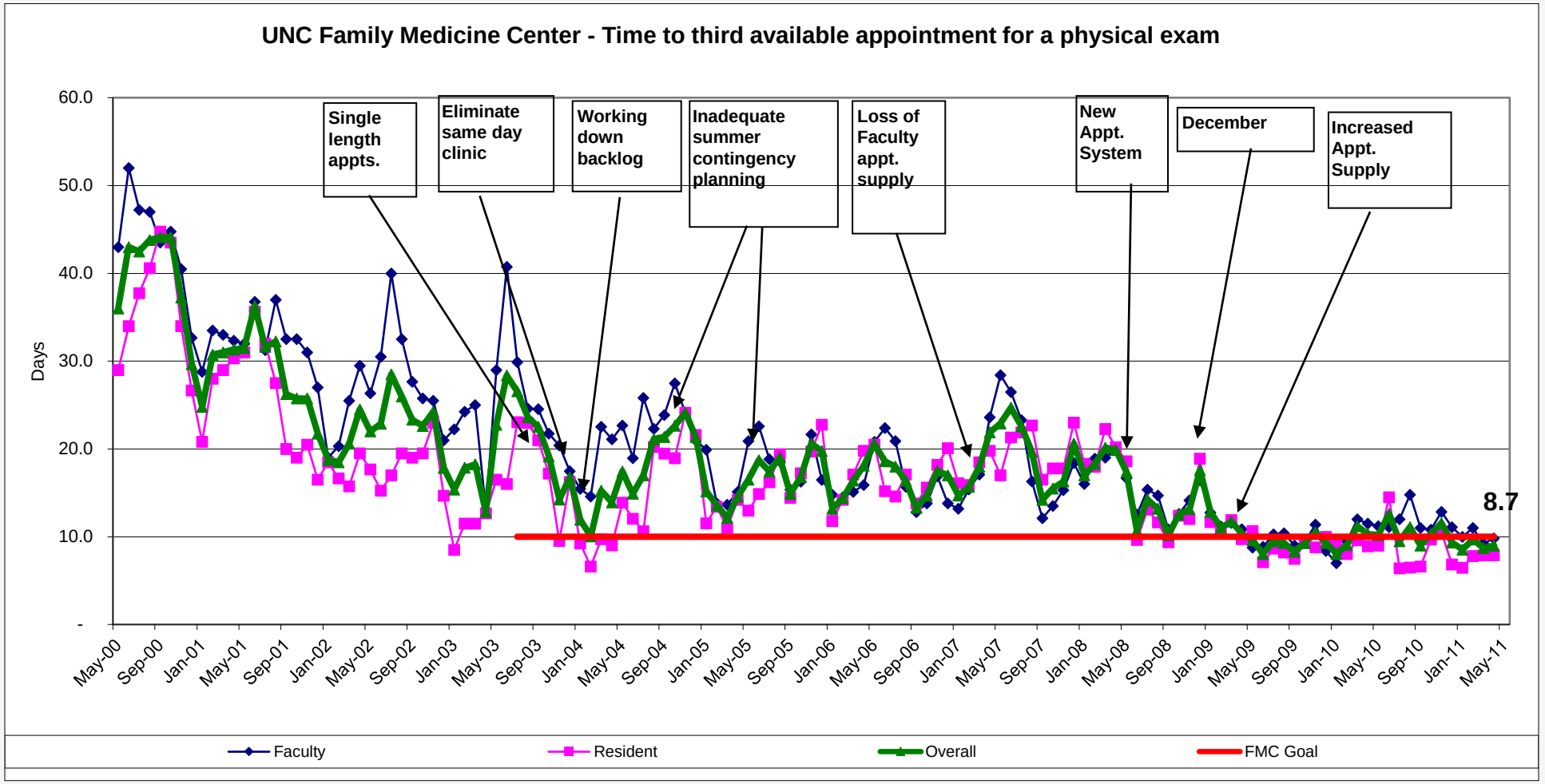
UNC Family Medicine: TTA for Routine Physical



Data shown prior to July 2003 indicates Time to 1st Available Appointment >=30 Minutes; July 2003 and later indicates Time to 3rd Available Appointment

Telehealth Access Considerations

Who is reviewing the data? When/how often?

- Is data accessible?
- Are team members asked to discuss their data and identify trends and possible root causes?

Who comes up with ideas for improvement?

- Are all team members (front desk staff, nursing, providers, management, etc.) involved in discussing these together?
- How are these ideas discussed and refined to pilot?
- How do we examine what's going well with teamlets with better access data to learn possible best practices to spread?

How are ideas for improvement piloted and monitored for improvement – i.e., PDSA'ed?

- When and how do PDSA outcomes get reviewed and discussed?
- How are successful PDSA's rolled out?

Action Planning

Action Planning

What are the goals of action planning?

Goals are broader and longer term (ex. reducing clinic-wide third next available appointment from 45 days to 10 days, or patients will see their own provider 70% of the time)

Action plans are small steps toward a goal (ex. talk with IT about getting continuity data drilled down by provider, or organize a multidisciplinary team to start reviewing access data)

Breakout Groups: Goals & Action Steps

- Everyone will be broken out in groups of 4 for 15 minutes.
- Choose one person to act as group facilitator and also keep track of time and report back when we reconvene.

Then each person in the group will have 2 minutes to:

- Introduce yourself: Name, role, and program
- Identify a GOAL you would like for your program to work towards in continuity or access (By June 2022, we will…)
- Identify one ACTION STEP toward this goal (In the next two weeks, we will…)

After everyone has had a chance to share, discuss how confident you are in achieving your action plan in the next few weeks (on a scale of 1-10) and discuss what would help you achieve it.

Group Debrief

In the chat, share one example of a GOAL and ACTION STEP

Next Time

- Continuity improvement strategies/case studies
- Access improvement strategies/case studies
  - Ways to decrease demand or increase supply
  - Strategies when you can't change supply and demand
- The access/continuity relationship