Continuity & Access:

Applying the Clinic First Model in a Post-COVID World

Clinic First Miniseries Session 2, June 9, 2021

UCSF Center for Excellence in Primary Care

UCSF Department of Family & Community Medicine
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Welcome!

Reminders:

- Mute when not speaking
- Enter questions in the chat
- Session 1 recording and slides are available

https://cepc.ucsf.edu/

Poll: Intros & Icebreaker

1. Who's in the Room?

- Program directors/assistant program directors
- Faculty members
- Clinic directors
- Nursing leaders
- Front desk
- Residents
- Other?

2. Were you at the last webinar?

- Yes / No

3. How are you feeling about welcoming your new interns? (choose all that apply!)

- Excited!
- Terrified!
- Hopeful
- So tired
- Can I retire yet?

Agenda for Today

- Continuity improvement strategies/bright spot case studies
- Access improvement strategies/bright spot case studies
- The access/continuity balance
- Make an action plan on improving continuity of care and access in your residency clinic

Continuity Strategies

Review: Measuring Continuity of Care

Patient Perspective

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

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

- 2000 of these visits are with the patient's PCP
- Continuity is 2000/3000 = 67%

Clinician Perspective (resident, faculty, NP/PA)

Provider's visits with patients in their panel / # provider's visits

Example: A provider has 200 patient visits a month.

- 120 of these visits are with patients on the provider's panel
- 80 of these visits are with patients of other providers
- Continuity is 120/200 = 60%

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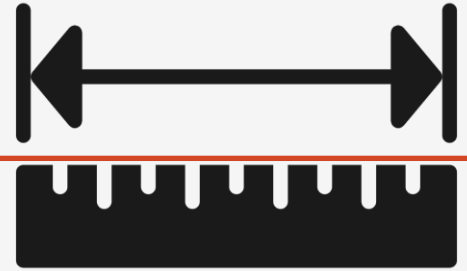
Review: Measuring Continuity



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/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%

The Challenges for Residency Clinics

How do you promote continuity with very part-time providers?

- Patients' continuity with their PCP
- Residents' continuity with their panel

Continuity of Care in Resident Outpatient Clinics: A Scoping Review of the Literature

Jeremey Walker, MD
Brittany Payne, MD
B. Lee Clemans-Taylor, MLS
Erin Dunn Snyder, MD

ABSTRACT

Background Continuity between patients and physicians is a core principle of primary care and an accreditation requirement. Resident continuity clinics face challenges in nurturing continuity for their patients and trainees.

Objective We undertook a scoping review of the literature to better understand published benchmarks for resident continuity; the effectiveness of interventions to improve continuity; and the impact of continuity on resident and patient satisfaction, patient outcomes, and resident career choice.

Methods We developed a MEDLINE search strategy to identify articles that defined continuity in residency programs in internal medicine, family medicine, and pediatrics published prior to December 31, 2015, and used a quality evaluation tool to assess included studies.

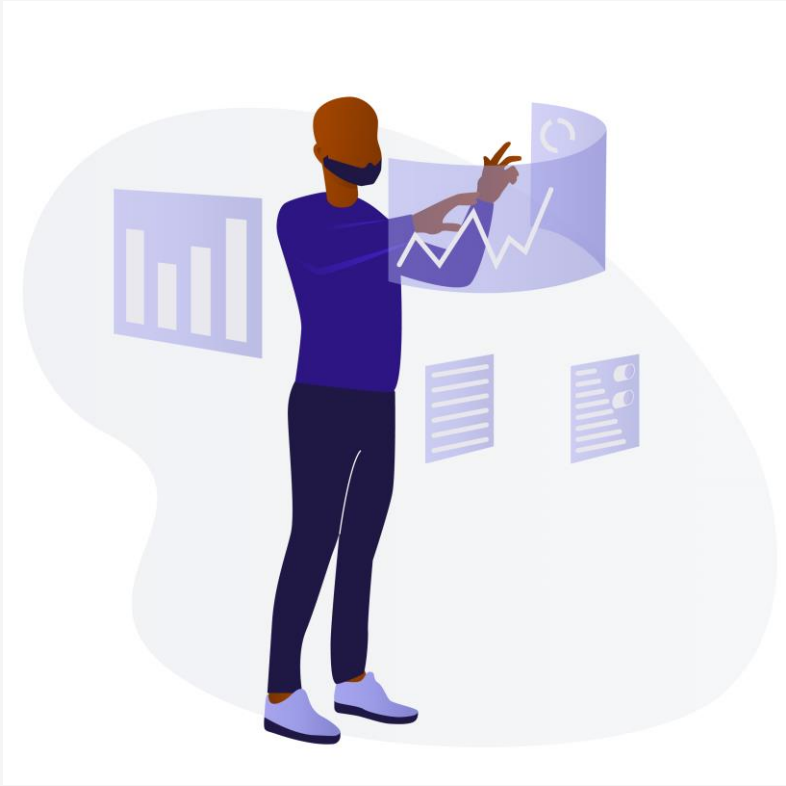
Results The review includes 34 articles describing 12 different measures of continuity. The usual provider of care and continuity for physician formulas were most commonly utilized, and mean baseline continuity was 56 and 55, respectively (out of a total possible score of 100). Clinic and residency program redesign innovations (eg, advanced access scheduling, team-based care, and block scheduling) were studied and had mixed impact on continuity. Continuity in resident clinics is lower than published continuity rates for independently practicing physicians.

Conclusions Interventions to enhance continuity in resident clinics have mixed effects. More research is needed to understand how changes in continuity affect resident and patient satisfaction, patient outcomes, and resident career choice. A major challenge to research in this area is the lack of empanelment of residents' patients, creating difficulties in scheduling and measuring continuity visits.

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.

Improving Continuity: Measure It, Track It, Share It

- Calculate chosen metric consistently
- Drill down to clinician and team level
- Track it regularly
- Share and discuss with everyone in the clinic



1. Do you get regular continuity data from the EMR?

- Yes
- Yes, but it's sporadic and not each month
- No

2. Is it for patient-centered continuity, clinician-centered continuity, or both?

- Patient-centered
- Clinician-centered
- Both
- N/A – no data available

3. Is it drilled down to the clinician (faculty & residents) level or is it only for the entire clinic?

- Drilled down
- Only for the entire clinic
- N/A – no data available

4. Do you discuss the data at team meetings or resident conferences?

- Yes at team meetings
- Yes at resident conferences
- Yes both
- No
- N/A – no data available

University of North Carolina: Culture of Continuity

"Continuity is King"

- Patient centered continuity averages **71%**
- Metrics for clinicians and teams reported monthly, reviewed and discussed for improvement strategies
- Appointment template and resident rotations reorganized to prioritize continuity and access
- Appointment slots reserved for patients assigned to that clinician until day of appointment
- Up to date continuity data is displayed on clinic walls and discussed at team meetings

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UCSF CEPC, Association of American Medical Colleges, Profiles of Three High-Performing Primary Care Residency Clinics. May 2018. https://cepc.ucsf.edu/residency-teaching-clinics

Strategy: Culture of Continuity

Prioritize with all members of clinic:

- Clinicians
- Clinical staff
- Frontline office staff
- Schedulers
- Patients

Everyone should be aware of the value and how to promote it

Share the data, discuss regularly ways to improve

Strategy: Culture of Continuity

Build continuity-promoting scheduling algorithms

Example: If PCP not available on day requested:

- Sees PCP on different day
- Sees different resident on same team (R1 > R2 > R3)
- Sees faculty member on same team
- Sees resident on different team
- Sees faculty on different team
- Sees urgent care

Create patient-friendly scripts

Train call center/front desk/scheduling staff

Continuity Starts at the Front Desk

In the chat: Share what things front desk personnel/call centers can do or say to optimize both access and continuity when patients call for appointments

Continuity Starts at the Front Desk

Create a front desk script allowing patients to choose continuity or access as their priority

Patient: I need to see a doctor

Front Desk: Your PCP, Dr. Bueno's next appointment is in 5 days, next Tuesday. Is that OK?

Patient: That's too late. Could I see someone else?

Front Desk: Sure. Dr. Goode is on Dr. Bueno's team. You could see her tomorrow at 9 a.m.

Patient: That would be great.

Front Desk: We'll see you tomorrow morning

- The script prioritizes continuity, offering a visit with the PCP.
- The patient prioritizes access, which the front desk provides

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Strategy: Culture of Continuity

Patient messaging/education

- Who is on their empaneled team
- Importance of continuity

"Scrub" schedules for patients scheduled with non-continuity clinicians

Continuity Starts at the Front Desk

In the chat: What might your clinic do to promote a culture of continuity?

Strategy: Resident Scheduling

- Increase **overall clinic time** throughout residency
- **Frequent clinics per week** during clinic-heavy blocks (set minimum half days)
- **Reduce the duration of the intervals between** clinic-heavy blocks
  - Short “mini-blocks”
- Schedule residents’ **clinic predictably and far in advance**, with some slots saved for same/next-day appointments

Strategy: Team-Based Continuity

- **Practice partners**
  - Shared panels within a team
- **Team continuity anchor**
  - A full-time faculty physician/NP/PA, or other team member, mainly sees team's patients when resident PCP not available

UMMS Baystate: Continuity Anchor

- 10 teams, each with 5-6 residents
- One full-time advanced practice clinician (NP/PA) per two teams
- NP/PA's main role to see resident-assigned patients when the resident is away from clinic
- Patient-centered continuity increased from **64% to 71%**

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Summary of Continuity Strategies

Culture of Continuity

- ✓ Measure it, track it, share it
- ✓ Prioritize with all clinic members
- ✓ Scheduling algorithms/scripts
- ✓ Patient messaging/education
- ✓ Scrubbing schedules

Resident Scheduling

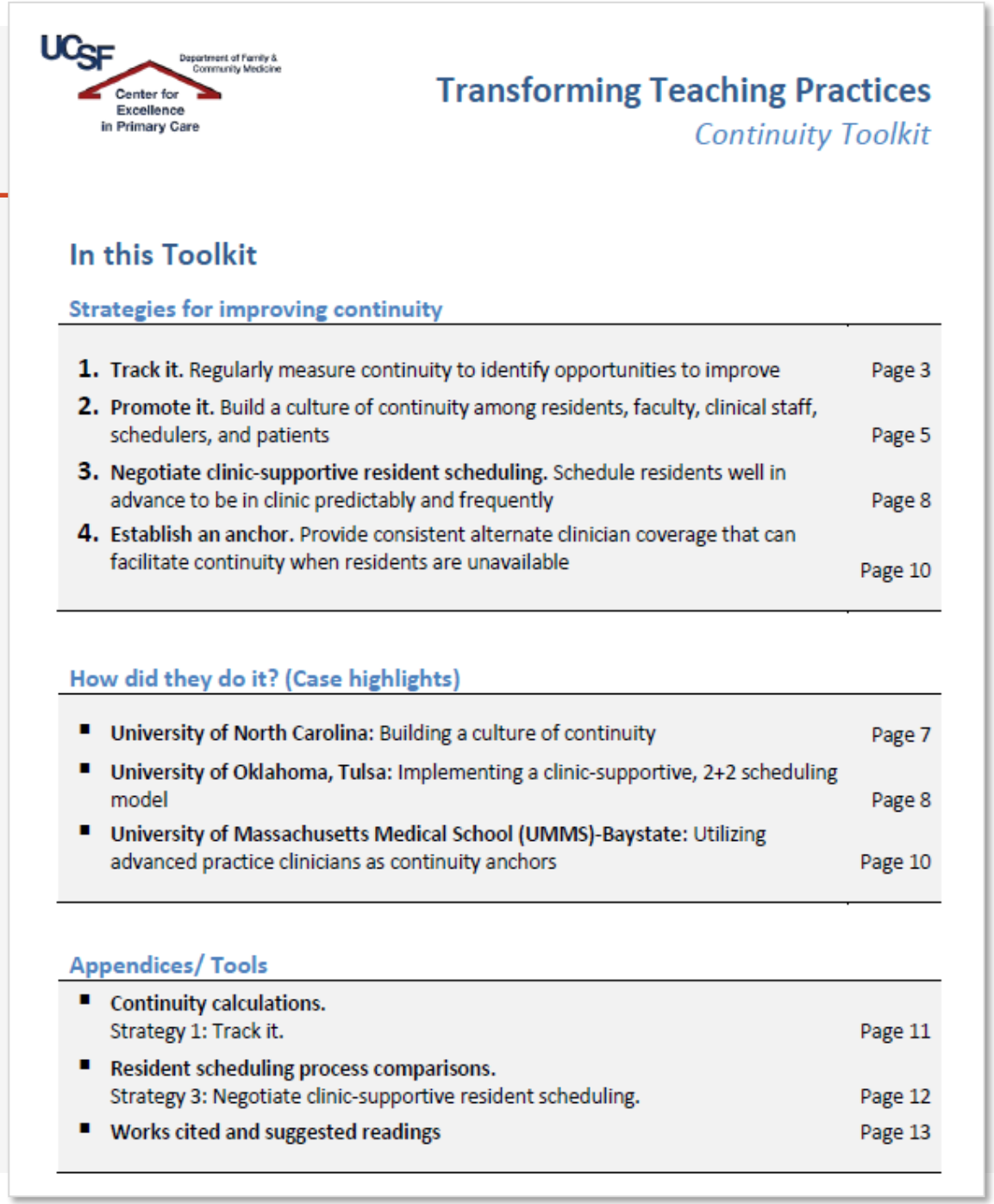
- ✓ Frequency of clinic blocks / clinics per week
- ✓ Overall clinic time
- ✓ Predictable/advance scheduling

Team-Based

- ✓ Continuity anchor
- ✓ Practice partners

Continuity Toolkit

https://cepc.ucsf.edu/residency-teaching-clinics



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Transforming Teaching Practices

Continuity Toolkit

In this Toolkit

Strategies for improving continuity

How did they do it? (Case highlights)

Appendices/ Tools

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Access Strategies

Review: 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

Review: Access Types

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

Structure for Improving Access

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?

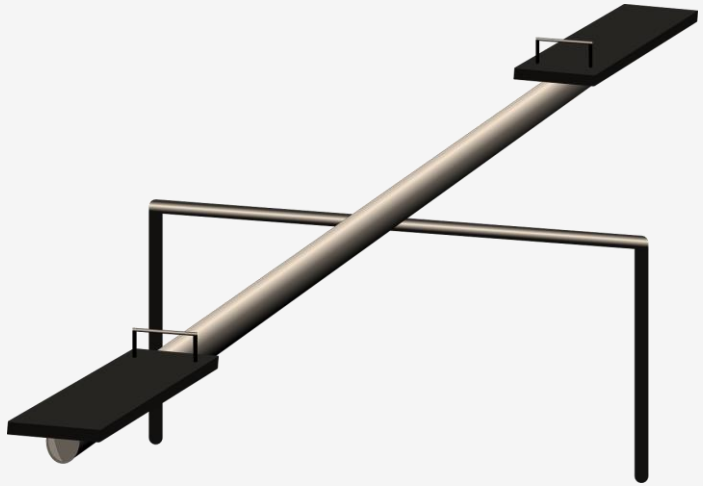
- Are all team members (front desk staff, nursing, providers, management, etc.) involved in discussing these together?
- How are these ideas discussed and refined to pilot?
- How do we examine what's going well with teamlets with better access data to learn possible best practices to spread?

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 PDSAs rolled out?

Does your clinic prioritize:

- ACCESS over continuity
- CONTINUITY over access
- BOTH equally



Good Access = Balancing Demand + Supply/Capacity

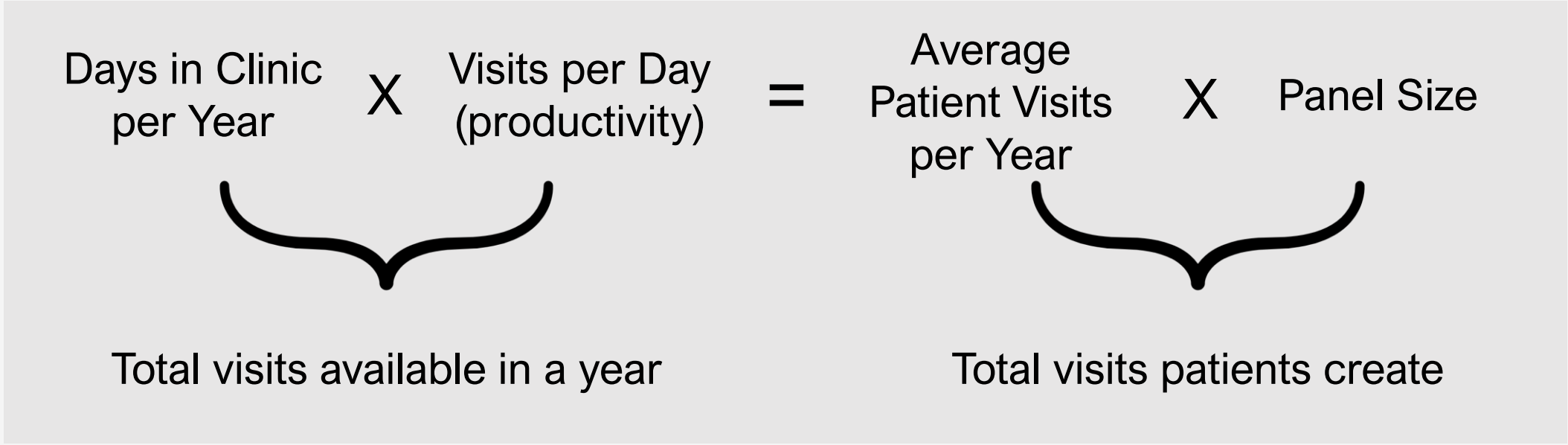
Demand

- Panel size
- Return intervals
- Seasonal
- Lab result availability
- Patient population needs (chronic & complex, acute, preventative)

Supply/Capacity

- Provider FTE
- # days open
- # appointment slots
- # of types
- Length of appointments
- Other services (i.e. Behavioral Health, RN Visits)

For Good Access, Capacity Should Equal Demand



To improve access, you can increase capacity and/or reduce demand

For more on calculating ideal panel size, see our Empanelment toolkit:
https://cepc.ucsf.edu/sites/cepc.ucsf.edu/files/Toolkit%20_Empanelment%2018-0829.pdf

For Good Access, Demand = Capacity

Reduce Demand:

- Reduce panel size
- Alternatives to visits
- Sign up patients for patient portal

Increase Capacity:

- More visits per day
- More days per year
- No-show reduction
- Other team members adding capacity

Increase Capacity with Resident Scheduling

- Increase **overall clinic time** throughout residency
- **Frequent clinics per week** during clinic-heavy blocks (set minimum half days)
- **Reduce the duration of intervals between** clinic-heavy blocks
  - Short “mini-blocks”
- Schedule residents’ **clinic predictably and far in advance**, with some slots saved for same/next-day appointments

Kaiser Permanente Washington FM

- Longitudinally integrated model. Residents are not absent from clinic for more than 7 days at a time. 1-2 week inpatient bursts, 3-4 OB shifts
- Residents care for panels of 400 patients from day one
- To make this possible, R1s are scheduled in clinic 4-5 half days a week, more frequently than R2s (3-4 half days a week), and R3s (2-3 half days a week).
- The schedule is designed to provide continuous access to larger patient panels and gives residents intensive primary care training at the beginning of residency, maximizing the experience of providing continuity care for patients over all three years of residency.

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Is your no-show rate usually:

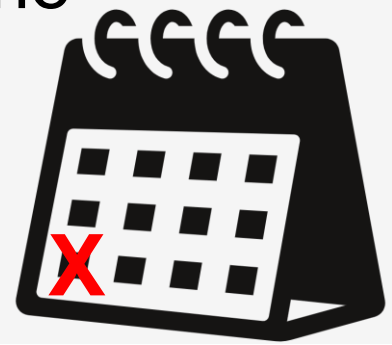
- Below 10%
- Between 10-20%
- Over 20%
- Not measuring no-show rate

When do you open your appointment books for patients?

- 2 weeks in advance
- 4 weeks in advance
- 2-3 months in advance
- More than 3 months in advance

Increase Capacity with No-show Reduction

- No shows reduce capacity, and that capacity is gone forever
- Many clinics try reminder calls, which are of some help
- The best way to reduce no-shows is to open appointment books only 2-3 weeks in advance
- No-show rate is proportional to the number of days between when a patient makes an appointment and the date of the appointment



Increase Capacity with a Powerful Extended Care Team

Capacity: Assume each clinician provides 4000 visits/year (200 days per year, 20 patients per day)

Demand: Assume panel of 2000, average patient has 3 visits per year, creating 6000 visits per year

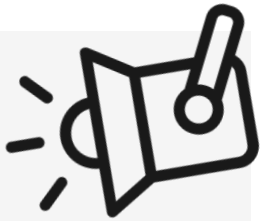
- 1000 visits by patients with diabetes
- 1000 visits by patients with hypertension
- 1000 visits for uncomplicated low-back, knee, shoulder pain

Assume RNs, pharmacist, PTs can independently care for 2/3 of these visits (no practitioner needed)

- Total non-clinician visits = 2000

Demand-capacity gap closes (6000 total visits), and burnout drops because clinicians share the care with other team members

University of Colorado Family Medicine Residency



Increase capacity with a powerful core team:

The clinic now has 2.5 medical assistants per clinician

MAs are in the visit taking the history, closing chronic and preventative care gaps, performing all the documentation on the EMR

Because clinician work is reduced, clinicians see more patients per day, increasing capacity

Access for new and established patients is excellent

The additional visits pay for the extra staff

Assuming You Cannot Make Capacity = Demand

- In most primary care practices, demand > capacity
- What to do about demand right now?
- **Rearrange your capacity** to increase immediate availability
  - Open appointment templates only 2-3 weeks in advance
  - Have one “provider of the day” with open slots
  - Freeze some slots of all providers until the day before

Note: Fixed capacity is zero-sum

Change How Far in Advance You Open Appointment Templates to Patients

- Rather than allow patients to make appointments 3 months from now, allow them to make appointments only 2 weeks from now
- Third next available appointment will be 14 days or less
- No-show rates will go down (also increases capacity)
- When a patient needs/wants an appointment in 6 weeks, front desk has reminder system
- Helps patients who want same-day care
- Hurts patients who want to schedule their next appointment in advance, like older patients with chronic conditions

Discussion…

Would you consider opening your appointment books only 2-3 weeks in advance to cut down no-shows and reduce your TNAA?

In the chat: Share why or why not?

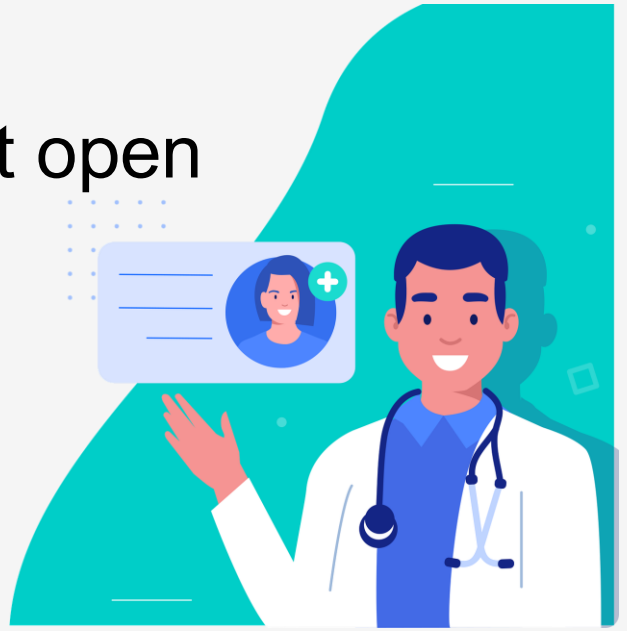
Banner/Univ of Arizona Family Medicine Residency

- In 2003, patients could not make appointments in advance. Appointment books were opened the same morning. All physicians' slots were open when the day began. TNAA was zero.

- Some patients loved open access; others wanted to make appointments in advance. The clinic began to open appointment slots one week in advance. Now, TNAA is no more than 7 days. No-show rate is low. When patients need follow-up appointment, front desk makes a reminder call to the patient one week before that date.

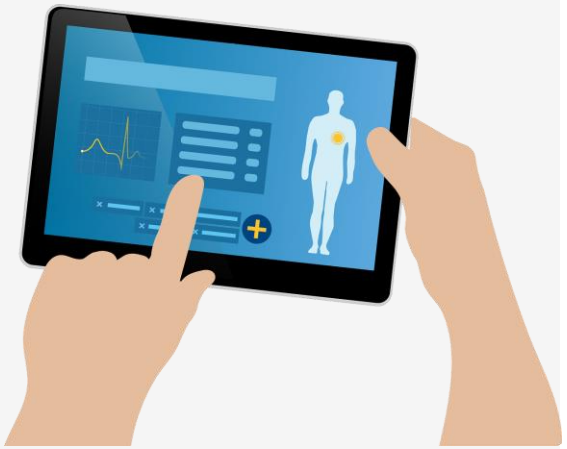
Have Access to “Provider of the Day” with Open Slots

- Patients calling the day before or same day will get an appointment with the provider of the day
- Clinic experiments with how many slots are need to satisfy next-day and same-day demand
- Clinic will decide about walk-ins if no slots are left open
- Continuity of care will go down



Freeze Some Slots of All Clinicians Until the Day Before

- At OHSU at Gabriel Park, the clinic's goal is TNAA under 7 days for new and established patients and to start the day with 30 slots open
- The clinic generally fills 50% of appointment slots in advance; 30% are opened 7 days prior to the appointment and 20% open the morning of the appointment
- The leadership team reviews TNAA metrics weekly



Freeze Some Slots of All Clinicians Until the Day Before with Continuity Priority

- To improve access without reducing continuity of care, all clinicians can have some slots “frozen” and only “thawed” the day before
- How many slots to free needs to be determined by data / experimentation
- Only patients of that clinician should be given those slots
- If after 8am there are clinicians who still have open slots, can be given to any patient

UNC: Strategies for Managing Supply/Demand

Managing individual clinician supply/demand

- 30% of appointments thaw <7 days in advance, are reserved for continuity patients until the day of
- Strategic template control allows practice to adjust access vs. continuity. Appointments can “thaw” at different times, and be reserved for continuity/released to other patients at different times
- Using patient centered scripts to promote continuity

Managing day to day appointment supply/demand practice-wide

- Co-located clerical staff
- Simplified appointment types (all 20 minutes)
- Flexibility and contingency planning (ex. for peak times of low access such as holidays/summers)
- Approving requests for schedule changes/time off depends on how clinic-wide supply will be impacted

Managing panel sizes

- Developed systems to track panel assignment and promote continuity
- Balance panel sizes for individual PCPs

Summary: Access

There are a variety of strategies to solve the access problem

- ✓ Reducing visit demand with patient portal
- ✓ Doc of the day or NP/PA without a panel, with empty slots
- ✓ Freezing slots for same day or next day access for all clinicians
- ✓ Reducing no-shows (which reduce capacity) by opening appointment books only 1-2 weeks early
- ✓ Adding capacity by hiring new providers or empowering MAs, RNs, pharmacists, behaviorists to see patients, thereby reducing clinician time and burnout

Adding capacity is ideal; other strategies have pros/cons

Balancing Continuity and Access

It is possible to improve both continuity and access – and this can be mutually beneficial (better continuity improves future access)

- UNC: Give same day appointments only to the patient's own clinician
- Baystate: Team NP/PA has open slots to see the team resident's patients same day

Patients may prioritize access over continuity, or vice versa depending on the situation

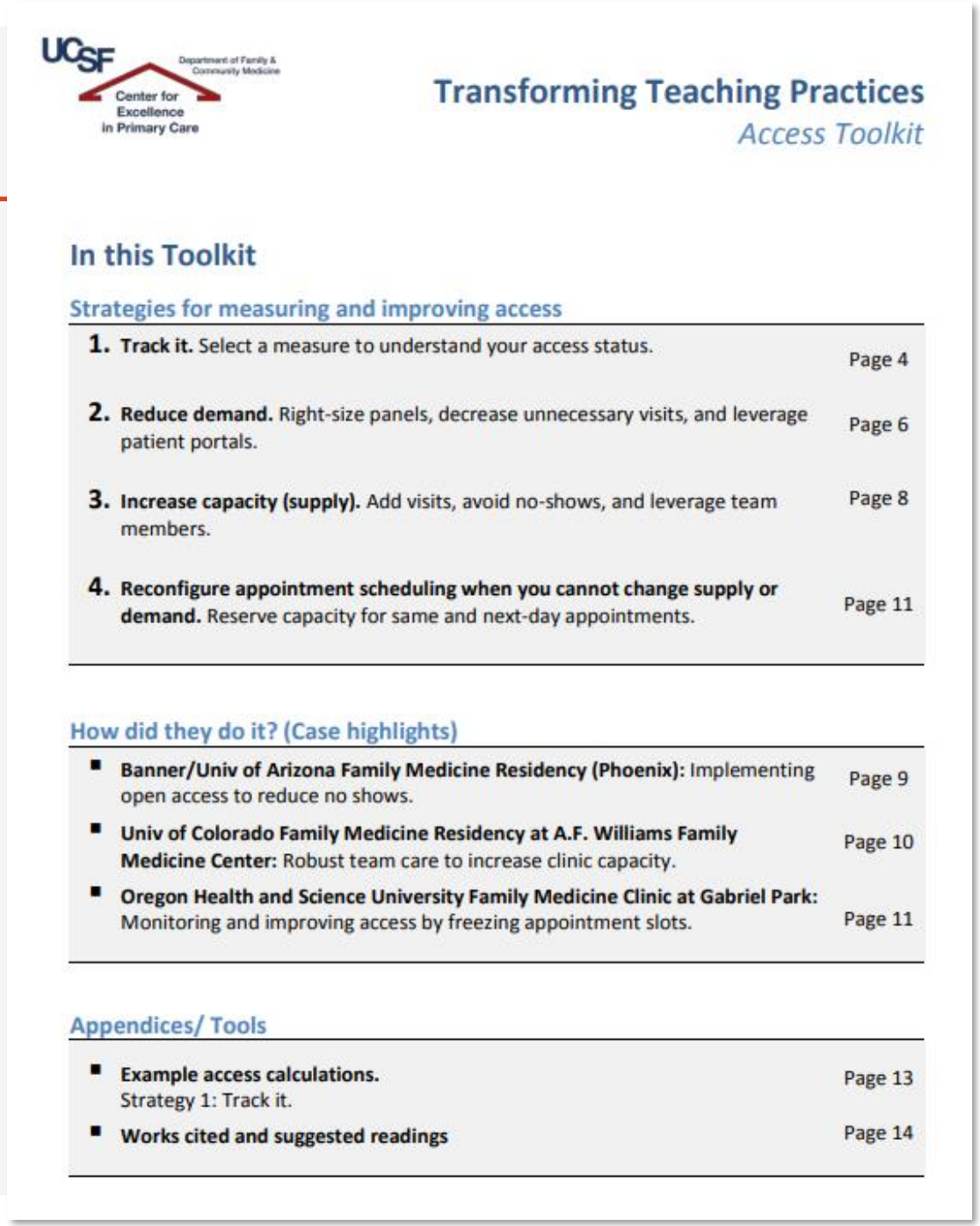
- Front desk/call center scripts allow patients options based on their priority

First steps to improve access and continuity:

- Choose a metric and regularly measure it
- Track it, ideally for each clinician
- Discuss the data with everyone in the clinic

Access Toolkit

https://cepc.ucsf.edu/residency-teaching-clinics



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Transforming Teaching Practices
Access Toolkit

In this Toolkit

Strategies for measuring and improving access

How did they do it? (Case highlights)

Appendices/ Tools

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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 Rooms: Discussion

You'll be split into breakout rooms for 15 minutes. Your facilitator will keep track of time and summarize your discussion when we come back to the main room.

- What might your program do to improve continuity and/or access?
- Share ideas and possible solutions!

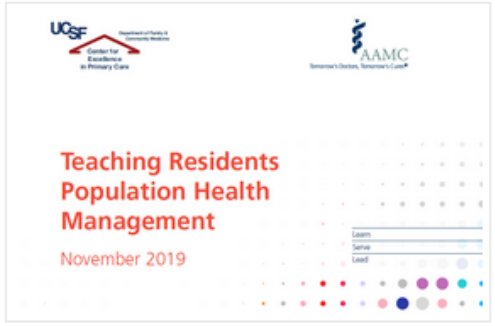
Debrief and Q&A

Resources https://cepc.ucsf.edu/residency-teaching-clinics

Residency Teaching Clinics

Print PDF

High functioning teaching clinics must meet the challenge of delivering both excellent clinical care for patients and comprehensive training for residents. Since 2013, CEPC has visited over 43 primary care teaching clinics and shared lessons learned through publications and national conferences. The projects below highlight selected CEPC work with primary care teaching clinics.



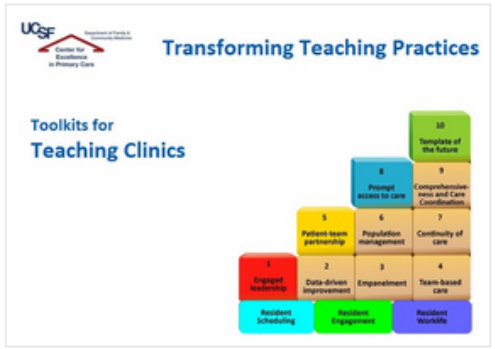
Population Health Report

In November 2019, CEPC published a report with the AAMC on **Teaching Residents Population Health Management**, a result of a national meeting between the CEPC, AAMC, CDC, and several bright spot residency programs in population management around the country. The report addresses population health using several domains, and includes bright spot case examples and checklist action steps for each area.

To read the free report, please visit: https://www.aamc.org/data-reports/report/teaching-residents-population-health-management

To download the report, please click the following:

Teaching Residents Population Health Management.pdf



Toolkits and Resources for Primary Care Teaching Clinics

CEPC is developing to a series of toolkits to guide primary care teaching clinics with implementing the Building Blocks of Primary Care.

- Empanelment Toolkit
- Continuity Toolkit
- Access Toolkit

For additional resources including resident curricula and faculty development materials, please visit https://fcm.ucsf.edu/practice_transformation

High-Functioning Primary Care Residency Clinics Report

In October 2016, CEPC published a groundbreaking report, *High-Functioning Primary Care Residency Clinics* based on an initial wave of teaching clinic site visits. The 53-page report proposes a model to assist residency teaching clinics to transform themselves, using many case examples from well-organized teaching clinics around the country.

The free report is available here:

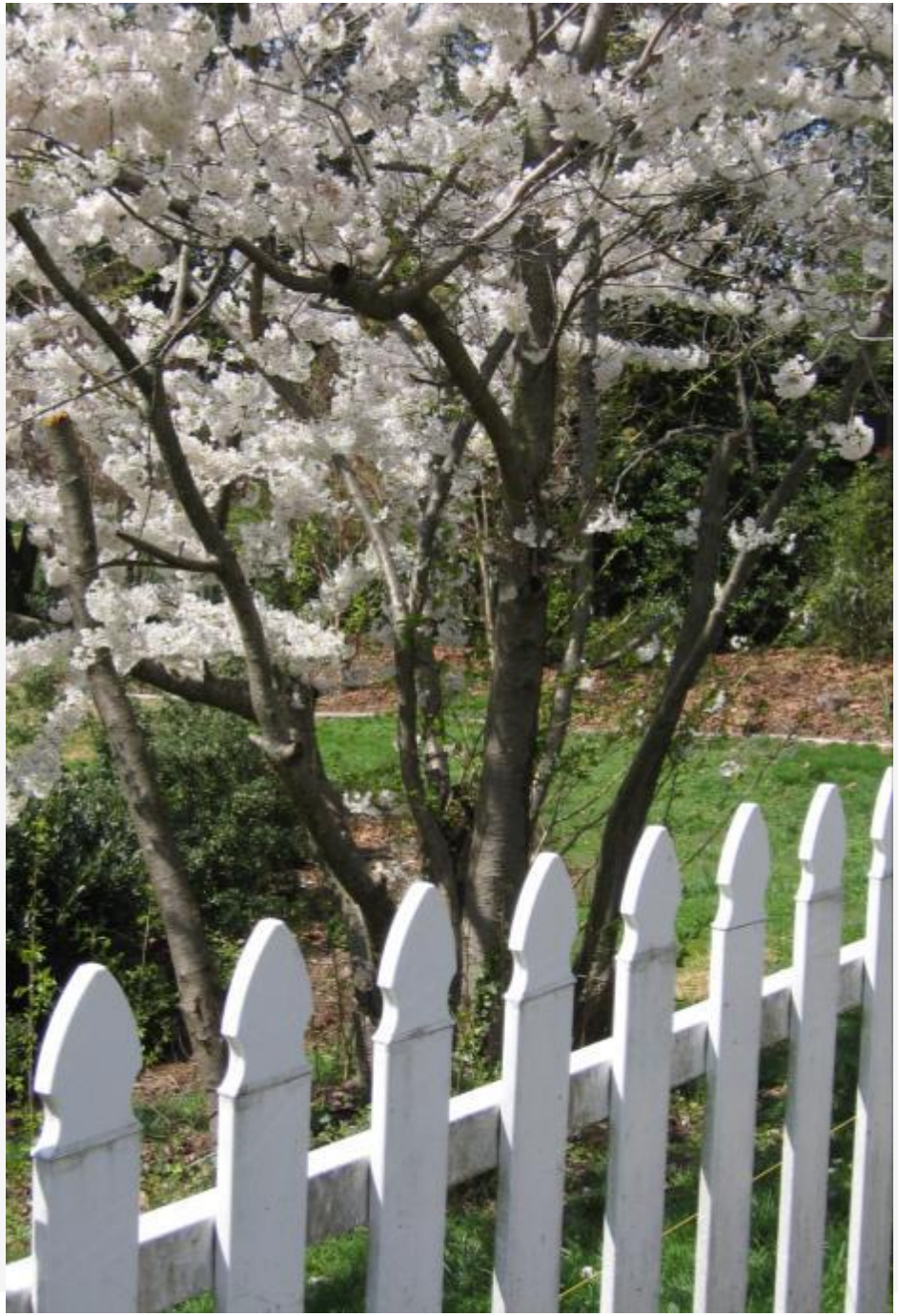
AAMC CEPC TeachingClinicsReport_ (002).pdf

See also:

In-depth profiles from three residency sites

Association of Family Medicine Residency Directors (AFMRD) *Clinic First* Collaborative

The AFMRD and CEPC are supporting a family medicine residency collaborative for 18 programs interested in moving toward a "Clinic First" residency paradigm. The collaborative launched with a 1½ day face to face meeting in Kansas City, Missouri on February 26-27, 2018. Each residency program selected up to 3 people to participate, typically a residency director, clinic medical director, and resident. The collaborative also involves 6 interactive video-conferences over 10 months after the kick-off meeting to continue to address practical steps and best practices examples for implementing the Building Blocks of High Performing Primary Care and Clinic First principles. Find more information at the AFMRD website.



Continuity of care and prompt access to care are beautiful things

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