

A Success Story...

IMPLEMENTING ADVANCED ACCESS

Access - Measuring and Shaping Demand and
Communicating Effectively with Patients

Franklin Street General Practice - SA

Franklin Street General Practice through the Change Principles changed their appointment system in May 2006 after a period of preparation for the patients, staff and doctors.

The practice applied the NPCC Change Principles to understand the profile of demand, shape the handling of demand, match the capacity of the team to the reshaped demand and communicate effectively with patients and across the team.

An Access study was undertaken by a lead GP who led the whole team into the concept and encouraged practice team building prior to it officially becoming a Collaboratives Change Principle.

A short term appointment (STA) concept was developed as part of PDSA cycles as the practice had found that “book on the day” appointments did not work well for part-time doctors.

This case study explains the STA system, the practice's successes and failures and their plans for further improvements in the appointment system.



Context

The Franklin St. General Practice is an independent association of five general practitioners providing a high quality health service to people who live, work or study in the city or nearby suburbs. Each of the five associates has worked for more than ten years in general practice in its various forms, in private general practices and/or community health centres in Adelaide and interstate. More than twelve months were spent in planning and preparing for the practice before opening in January 1999.

The practice is situated on the western side of the city of Adelaide. The Practice premises is an old stone villa. There are four large consulting rooms, a lunch room, allied health room, waiting room, front office, manager's office, kitchen, and scrub room. There are many back-packer hostels near the surgery which we service. There is also the interstate bus terminal situated next door and the Central Market is in the next street. There are many small and large businesses in the area, which are serviced by the surgery.

“It was essential to make a serious change
as the practice was at breaking point”

The Situation

Franklin Street had ten GP's which included eight women, six of whom worked part-time. It was essential to make a serious change as the practice was at 'breaking point'. Despite the large proportion of women who worked part-time, it was clear that the Access system was not working effectively. The system was not working effectively due to the in-consistent hours that were worked, and the major cross over during peak periods. As a practice we found the GPs preferred to work between 9am and 3pm and were quite reluctant to work either before or after these times, due to personal family commitments.

As a result, the lead GP undertook addressing access issues more closely. During the beginning stages of engagement in NPCC, she noted the following issues needed to be addressed: 'crisis' at the front desk; poor triaging; difficult patients as a result of long waiting periods; DNA's; stressed GPs; no Practice Nurse and an ineffective team.

The Change

With the assistance of the CPM, the lead GP began to promote the NPCC and the Collaborative methodology within the practice and encouraged each practice member to become involved with the process. The lead GP and PM organised the following:

- Engagement of the practice as a whole – including GPs and practice staff to ensure that all were aware of the proposed changes that may affect their job roles.
- Constant information flow was sought to be provided at staff and clinical meetings and associate meetings.
- Each meeting was facilitated by the Practice manager whom lead the process and could adequately provide all relevant information and ease the potential stress.

The Intra-mail was set up to provide staff with daily information in regards to the process of the Short Term Appointment System; it was also a useful tool for any staff member to post questions anonymously to promote thoughts and further questions. Data charts on staff notice board and seeing change happen gets people involved. The Data charts, as sent through by the CPM, were posted by the lead GP, this allowed all staff to see the change in progress.

The information that was produced actually eased the staff's initial concerns about the process, by seeing the physical change made all staff members feel good about themselves and allowed them to take ownership of the practice. Previously reception staff felt under-valued with having no say in how the practice could evolve, but having seen the charts and by offering suggestions it improved the moral of the whole practice.

Once up-to-date on the processes, staff then had the opportunity to have lengthy discussions with the practice as a whole. This included discussions about the positives and the negatives of the changes. Staff discussed concern about how the change would go, lengthy process of information provision and consultation and long lead time to inform patients

The most dramatic change that the practice faced was the Short Term Appointment (STA) concept. The STA concept was required as many patients were attending the practice required scripts only, this meant patients were booking fifteen minute time slots for a two minute procedure. The fifteen minute time slots were then reduced to five minutes per patient for script only.

The longer appointments resulted in the GPs constantly running late, overloaded and increasing the stress levels. The practice as a business, was also missing out on thousands of dollars as they were not claiming the appropriate Item Numbers and were not utilising the Diabetic SIPs.

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The Change *continued...*

The STAs could be booked on the day, or pre-booked – to assist their patients who had transport difficulties. The STAs were also designed to be available for any GP and patients could not request a particular GP. Two mornings a week were set out to cater for STAs that were pre-booked with blocks set out for those patients who rang and required an appointment for that day.

The reception staff were the most uncomfortable with this process and implementation of the new system as they were the ones who would bear the brunt of the unhappy and aggressive

Receptionists and the GPs took approximately a three month period in order to inform patients of what the practice's plan was, this allowed patients to be informed and to ask questions. Posters were put within the waiting room, with an easy to understand example (no longer available due to move of premises), emails were sent to those patients who had access to the Internet and an article was written within the practice newsletter.

The practice also put together a questionnaire / survey as used by AGPAL to gauge the overall practice performance as a baseline, and sent out the same survey months later as the change had occurred.

Reception staff answered questions and concerns over the phone with the use of a prompt placed next to the phone.

The practice organised for a two week period with no patient bookings in advance of the change over date. The change over went very smoothly without 'meltdown' as the practice had predicted and had been prepared for. The practice had put in a contingency plan as was recommended by another practice that had been through the process.

With the use of weekly meetings all staff had the opportunity to put together a 'case' of all the potential pitfalls that could happen, and planned a way forward to overcome each suggestion.

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The Outcome

The change process had a huge impact upon the practice and through the NPCC process they had the opportunity to meet peers in the collaborative framework, learn from peers, share experiences, reflect on work, reduce isolation and be part of a catalyst for change.

Through the Collaboratives the lead GP and Practice Manager had the opportunity to learn from other practices on how they had dealt with such a large system change. This allowed the practice to be prepared for any 'glitches' that may occur - in regards to difficult patients and ensuring reception staff are confident in explaining the concept; keeping in mind the different environmental factors between the practices experience.

As a practice they needed to collect relevant data in order to justify the need for change. As a result they took six weeks worth of data collection in regards to DNA's. The practice also collected data snapshot as complete as possible and school holiday details.

The Baseline data collected for the snap shot were the requests for appointments recorded against the Doctor requested and the numbers of new patients were recorded. The practice required this data to prove there was a need for change, as the 'stress level's were a physical factor, the 'hard data' supported what was being felt. As a result the Practice discovered that 50 to 68% of appointments available were requested on the day. The weekly pattern, new patient and overall numbers were predictable week to week. The snapshot also highlighted that Monday, Tuesday and Thursdays were the highest in demand and three doctors had a higher request for appointments.

The Outcome *continued...*

GPs had on average 120 appointments per week. By focusing on the Did Not Attend (DNA) and the costs financially the practice discovered a DNA rate of 5.5% from data collection and that there was no pattern to old/new patient, time of day, which Dr, or how long ago the appointment was booked. 5.5% DNA equated to approximately 6.6 appointments per week.

As a practice they discussed strategies (contingency planning) to put in-place for the DNA patients. As a result the following strategies were implemented: ringing new patients on day of appointments and reminder calls for certain appointments.

After a further three month data collection on DNAs the practice DNA rate was still up at the 5% mark. They concluded that they needed to make tougher measures in order for use to be financially viable. A policy of cancellations with at least two hours notice was implemented, with the intention of filling in the gaps. Warning letters or a phone call, as a 'First Strike' by an account of a second offence, was also implemented. Reception staff became strict on those patients who turned up late and as a result the DNA rate dropped to 3.2%, which equated to approximately 3.84 appointments per week.

The practice felt that from a basic PDSA the 'flow on effect' was huge and they discovered how many more PDSAs could be developed and pursued further. The process allowed each member of staff to offer their opinions and advice for continuing quality improvement.

For example the usage of each room and the possibility to employ a practice nurse, should there be a regular room that was free at a regular time each week. Through the practice meetings discussion around the change of appointment system further – short sessions, late starts, early finishes and teaching sessions may also be incorporated. Alternative methods of scheduling the appointment systems and the possibility of employing a reception coordinator to ensure the smooth running of the appointment system were further PDSAs that could be developed and analysed further.

Support Resources

The practice developed an Access manual that assisted everyone involved to understand the concept, when, where and why. The manual also had measurement and recordings to access to assist, especially reception staff when recording. Signs were posted around the practice, educating the patients on the whole process and what the practice hoped to achieve. Franklin Street also advertised on their website, newsletter and the 'on hold' message.

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