Longitudinal Access Study

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Better Access to Primary Care is one of the three topic areas in the Australian Primary Care Collaboratives Program. Better Access to Primary Care (Access) represents a novel approach in improving patients' access to their primary healthcare professional. The work conducted on Access to date has proven to be exciting yet challenging. Although there have been tremendous achievements for many practices, Access on the whole has not produced the level of outcomes achieved in the other Australian Primary Care Collaboratives Program (the Program) topic areas, which are shown in Attachment 1.

However, as the program has developed, the great potential for Access work to improve the experience of Australian patients and general practice has been identified. The Longitudinal Access Study (the Study) has been designed to analyse the uptake of the Access topic and provide a set of recommendations for the future implementation of the Access topic in Australia.

This report provides a brief background to the introduction of Access in Australia. Through the Program three core Waves have done work on the Access topic. Their achievements in this area will be analysed, along with an identification of the key barriers that have inhibited further success in this topic. The design of the Study will be outlined before moving into a discussion of the key findings. This report will conclude with recommendations for the future design of the Access topic, in particular considering the topic aim, measurement system and Change Principles.

Background

In the 1990s, Dr. Mark Murray, a family physician in the United States of America (USA) developed a set of ideas to improve the access situation of general practices in the USA. Drawing upon the success of these ideas, Sir John Oldham and the National Primary Care Development Team (NPDT) in the United Kingdom (UK) further refined them into a set of principles called "Advanced Access". The successful use of these principles in the USA and UK has shown that they are adaptable to several healthcare systems.

In 2004, the Australian Department of Health and Ageing announced that they would fund the Australian Primary Care Collaborative Program. Along with the clinical topic areas of Coronary Heart Disease (CHD) and Diabetes, Access was chosen as an integral topic for the program. However, it was apparent that the Access topic would need to be refined for the Australian health care system, which is unique, and different from both the USA and UK health systems.

The process of refining the Access topic to a model suitable for the Australian context began with the convening of an Expert Reference Panel (ERP). Members of the ERP were chosen to contribute a wide cross-section of experience. Individuals included those who had been familiar with the UK approach to Access along with early adopters of the topic in the Australian system. These early adopters had implemented Access in their general practices prior to the introduction of this topic in Australia. Other members of the ERP included representatives from Divisions of General Practice and other key peak agencies. The main task for the ERP was to ensure that the Access topic was suitable for the Australian context.

The ERP undertook work to refine the approaches to Access used in the UK, based on the NPDT handbook, experience and advice. The topic aim was set along with the

measures that would be collected. Change Principles[1] and Change Ideas were reviewed and refined to guide practices through their work on the Access topic. The topic was entitled "Better Access to Primary Care" and this content was written into the Access section in the Australian Primary Care Collaboratives handbook. This handbook has been a fundamental resource for the Program. It has also been a key resource for practices in all three Waves. Finally, Collaborative Program Managers (CPMs) were trained in Access by the UK team.

Access in Phase Two of the Program

Better Access to Primary Care was a mandatory topic area in phase two (the implementation phase) of the Program, which involved Core Waves one to three. The rationale for including Access was that it was considered to be an important area for improvement that fundamentally linked with the clinical topic areas. Practice's work in the Access topic increases efficiency at the practice level, which frees up time and resources. This enables General Practitioners (GPs) to focus on improving clinical care in the other two topic areas. However, Access was not a mandatory topic area in the Spread and Sustainability strategy, as the Local and Virtual Waves focused on the clinical topic areas of Coronary Heart Disease and Diabetes.

Access is a novel approach in Australia and the initial Waves were a period of learning for everyone involved. It was clear early into the Program that the work being done in the Access topic could be improved. Consequently, three strategies were devised to improve the delivery of the Access topic. Firstly, it became evident that the effectiveness of the practice team was critical to the success that a practice would have in the program. Drawing on this knowledge, a supplementary section to the handbook was developed to train practices in team building. Due to the significance of team building, this concept was added to each of the topic areas as the first Change Principle.

Secondly, it was clear that the Access topic represented a fundamental shift in thinking not only for practices but also for CPMs. To ensure that CPMs had sufficient knowledge and resources to successfully guide practices through this topic area, the critical success factors for the topic were distilled and written into an 'Access Recipe'. The 'Access Recipe' was used to provide further training to CPMs on the Better Access topic.

Finally, the strategic potential of the Access topic for improving efficiency in the primary care sector was recognised. It was realised that further work needed to be done on Access and an agreement was reached with the Department of Health and Ageing to undertake the present study on the topic. Before presenting this study, a brief review of the outcomes and learnings of the Access topic in phase two of the Program will be discussed.

Access Outcomes in Phase Two

Access Measures

Through the first three Waves of the Program, extensive data have been collected on the Access topic. This includes data regarding the Access measures as well as data on the Plan Do Study Act (PDSA) cycle submission rates. The key measures for the Access topic are: 'Percentage of Patients seen by the practice on their Day of Choice' ('Day of Choice') and 'Number of days until General Practitioner Third

[1] Change Principles are a series of principles that are based on current best practice and guide practices through the improvement work in a topic.

Available Appointment' (3AA). The number of days until Practice Nurse Third Available Appointment is also collected for practices that utilise a Practice Nurse to take routine appointments. The national aggregated results for the 'Day of Choice', General Practitioner 3AA and Practice Nurse 3AA from baseline to August 2007 are shown for each Wave in Attachment 2

These measures show a number of trends. Interestingly, the 'Day of Choice' has been consistently high throughout the program, irrespective of the measures recorded in General Practitioner and Practice Nurse 3AA. All Waves have shown an improvement in the 'Day of Choice' measure, however, the improvement has consistently reached a plateau in the mid 80% range. This may reflect the maximum level possible that can be achieved on a national basis.

In contrast to the 'Day of Choice', the results for General Practitioner 3AA have been more variable. Wave 1 practices exhibited the greatest improvement in this measure with an average reduction in General Practitioner 3AA of 0.52 days. However, the collection of Access measures was new to everyone involved in Wave 1. Consequently, the potential for inaccuracies and inconsistencies in the initial data may have impacted upon the reliability of this measure nationally in the first Wave of the Program.

In contrast, Wave 2 increased their General Practitioner 3AA by 0.11 days and Wave 3 increased in this measure by 0.86 days. These results were contrary to expectations and to the UK results, and demonstrate the limited improvement in the General Practitioner 3AA measure overall in phase two of the Program. Furthermore, although the General Practitioner 3AA does not rise above three days on the attached national graphs, it is important to acknowledge that the graphs represent a national average. Consequently, the graphs conceal the high General Practitioner 3AA found in some areas, particularly for rural and remote practices.

The Practice Nurse 3AA has been below one day for all Waves. However, it is important to note that the Practice Nurse 3AA has shown wide variation in the measure month to month. Anecdotally, many practices state that having a routine appointment for their Practice Nurse is a relatively new idea and, therefore, the measure is not collected consistently on a national basis. This may account for the variation seen in this measure.

The Access measures can also be considered with respect to the rurality of practices. Attachment 3 provides an overview of the national Access measures as a function of the Rural, Remote and Metropolitan Index (RRMA). Interestingly, the remote practices made the greatest improvement on the General Practitioner 3AA measure. Conversely, the Practice Nurse 3AA measure increased for both metropolitan and remote practices.

Plan-Do-Study-Act cycles

In addition to the above measures, practices submit monthly Plan-Do-Study-Act (PDSA) cycles which outline the changes that the practice is making in each of the topic areas. Attachment 4 provides a graph detailing the PDSA submission for Access in each Wave compared with the other topic areas. This graph shows that there was an equal amount of activity on Access compared to Coronary Heart Disease and Diabetes, with an Access PDSA submission range of 29-32% across the three Waves. This indicates that interest in the Access topic has been substantial in each Wave of the Program.

The PDSA data can be examined further to look at the proportion of PDSA cycles submitted for each Change Principle in the Access topic. This information is provided in Attachment 5. These data clearly indicate that across all of the Waves, practices tend to focus on the early Change Principles of 'understanding the profile of demand' and 'shaping the handling of demand'. It should be noted that the Change Principle on building the practice team was introduced at the beginning of Wave 3 and this indicates the variability in uptake of this Change Principle across all of the Waves. Furthermore, Change Principle 6 'communicating effectively with patients and across the practice team', has been utilised by practices to show the work that they are doing on team building in the absence of the Change Principle on 'building the practice team'. It is notable that very few practices have progressed through all of the Change Principles to establish full implementation of the Better Access model.

The first three Waves have taught us a great deal about the Access topic. In particular, they have identified areas of the topic that require further development to facilitate greater uptake and enhanced outcomes. The key learnings of the Access topic in phase two of the Program are discussed below. These learnings have been further examined during the course of the Longitudinal Access Study and will provide the basis for recommendations for the future of Access.

Key Learnings in Phase Two

The practices that have embraced Access in phase two of the Program can be seen as early adopters on Rogers' diffusion of innovation curve[2]. They represent the enthusiastic minority who are willing to implement transformational change in their practices. Their experiences in the Program have led to the development of key insights in the Access topic.

The most significant insights have related to the way that Access is conceptualised and the way in which the topic is delivered. The early outcomes have also highlighted the challenges posed by the measurement system used to gauge improvements in the Access topic. The key learnings from phase two of the Program are:

- The Scope of Access extends beyond an appointment system

The enthusiastic and significant early adopters of the Better Access model have taught us that the topic extends far beyond the initial focus on appointment systems. Fundamentally, Access is about connecting patients with their healthcare professionals. To do this effectively involves the whole practice team and consequently team building is a crucial prerequisite for the achievement of significant outcomes in this topic area. Furthermore, Access incorporates broader issues, including the effective and efficient use of practice resources. Many early adopters have commented that the word "Access" does not convey the full scope of the topic in an intuitive way.

- Access is a qualitatively different topic requiring a different approach

We have learnt that improving Access requires a different approach compared with the clinical topics areas. CHD and Diabetes are familiar problems with high recognition, agreed treatments and established policy frameworks. Access does not have the same level of established and agreed knowledge. There are relatively few Australian exemplars in this topic area, limiting the sharing of information on practice initiatives on this topic. Furthermore, the drivers and barriers to successful work on

[2] Rogers, E. *Diffusion of Innovations 5th Ed.*, Free Press, New York, 1995, p. 281.

the Access topic are distinct from those in the clinical topic areas. Consequently, practices have needed more time and training to confidently handle Access concepts and appreciate their importance. Moreover, CPMs have also required further training to be able to guide practices in their Access journey.

- We know some critical success factors for Access in the Australian context

The early work done on the Access topic has provided extensive information on the implementation of Access in Australia. This information has been distilled into a set of critical success factors for achieving Better Access, which have been captured in the 'Access Recipe' provided in Attachment 6.

- The measures need further consideration

Unlike the clinical topics, the measures for Access are new to most healthcare professionals. Consequently, they require significant work to understand. This is compounded by the fact that the Access measures are not as easy to collect as the measurements used in the clinical topic areas.

Furthermore, there is concern that the measures are not robustly detecting improvements made in Access. In particular, there is uncertainty about the ability of the Access measures to detect improvements in the early Change Principles. Despite the fact that a third of the work done in the Program has been on the Access topic, this has been associated with relatively little change in 3AA. Importantly, it needs to be ascertained whether 3AA is a sensitive measure or whether there are important improvements being made in efficiency that are not picked up by 3AA.

Finally, there is also concern about the validity of the Day of Choice measure. There is a high ceiling effect with this measure. Many practices have expressed that their high baseline scores did not accurately reflect their patients' experience. Interestingly, in the case study for Practice A (see Attachment 10), the dramatic improvements that were made to the 3AA measure (from a baseline of 7.33 days down to zero days), were analogous to the improvements made in the 'Day of Choice' measure, which reached 100%.

Overall, the Access measures have been novel and not as conceptually robust as the clinical measures. This has posed a challenge to the Access topic.

The Longitudinal Access Study

The significant knowledge and experience gained in the Access topic in the first three years of the Program has resulted in a realisation that further work needs to be done on the Access topic. To improve the Access topic, an agreement was reached with the Department of Health and Aging to undertake a formal study. The aim of the Study is to investigate the impact of the Access topic on four selected general practices. The Study will document these case studies and use the insights gained through them to provide recommendations on changes to the Access topic aim, measurement system and Change Principles.

<u>Longitudinal Access Study Governance</u>

Under the direction of the steering group, the Manager Virtual and Access is responsible for the conduct of the Study. A small working party (Access Study Group) has been formed to comment on the Study findings and provide final recommendations with regards to the consideration of the Access topic aim, measurement system and Change Principles. The members of the Access Study

Group have been strategically chosen to chosen to bring a range of knowledge and practical expertise to the Study. Overall, members of the Access Study Group have provided a theoretical and practical background, which has added to the robustness of the Study. Members of the steering group and Access Study Group have been listed in Attachment 7.

Longitudinal Access Study Design

To harvest the practical knowledge that has been gained in the Access topic, this Study will utilise case studies of four general practices. Each practice participating in the Study has submitted a range of data that provide information on four key areas: operational efficiency, financial data, patient population, workforce culture and patient experience.

A practice staff survey has been designed to elicit the impact of the Access work on practice staff. This survey has been included in Attachment 8. A patient satisfaction survey has also been completed by all practices. This has been done with a validated tool used widely in the UK and managed by Client Focussed Evaluations Program (CFEP). Specific questions were chosen from this tool, based on their relevance to the Study, for further analysis. Results of these questions are shown in Attachment 9. The data for each practice has been compiled and is supplemented by qualitative information outlining each practice's journey through the Access topic. Each practice's case study has been attached as Attachments 10-13. Each case study also includes information on the Access measures of Day of Choice, GP and Practice Nurse 3AA (where applicable).

Finally, a financial consultant has been contracted to advise on the Study. The main purpose of the consultant is twofold: to design a business case to assess the financial impact of the Access topic; and advise on new measures to gauge improvements in Access. The Financial Consultant's report is included in Attachment 14. Recommendations made by the financial consultant have been considered by the Access Study Group and the key recommendations have been incorporated in the discussion below.

Longitudinal Access Study Discussion

The quantitative and qualitative data gathered through the Longitudinal Access Study has provided important information that feeds into the key recommendations of the Study. The case studies show a journey of four practices that have all done varying amounts of work on the Access topic. However, a few trends can be seen, related to the various data collected.

Financial and Operational Efficiency

Some trends can be observed with regards to the financial and efficiency data submitted by practices participating in the Study. However, due to the fact that external factors, outside the scope of this Study, may have influenced the financial data for a given practice, caution must be applied in forming conclusive statements based on these trends:

- All practices reported a consistent 15% increase in practice overheads in a 12 month period. This was regardless of the level of income or practice activity.
- The majority of practices reported an increase in practice fees, of varying amounts, as a result of improving their appointment systems. Generally, the General Practitioners' clinical contact hours also increased.
- All practices reported a reduction in the number of items billed; however, they also reported an increase in hourly rates.

- Practices that had a higher hourly rate at the onset experienced a reduction in their rates. Consequently, their overheads increased higher than those with a lower hourly rate at the onset. The reverse trend occurred for those with a lower hourly rate at the onset of the study.
- For the majority of practices, the billing rate per item appears to have slightly decreased even though the billing rate per contact has slightly increased. This may suggest that more patients are being seen and fewer items claimed.
- The majority of practices have either had a slight increase or a stable number of patients seen in the last 18 months. In other words, patient numbers have not reduced as a result of the improvement work done on the Access topic. In fact, even the reduction in consulting hours by one day (see Case Study C, Attachment 12) was not associated with a decrease in patient population.

Overall, the financial and efficiency data suggest that changes made to improve Access in the participating practices were achieved without damaging the financial profitability of the majority of practices or a loss in patient numbers.

Staff Satisfaction Survey

Responses to the staff survey are included in the case studies (see Attachments 10-13). The low numbers of responses for this survey require caution to be applied in making conclusive statements; however, some trends can be noted. Interestingly, improvements in staff satisfaction seem to be correlated with the extent of changes made in the Access topic. The practices that have made the greatest level of change and achieved the greatest improvements in the Access topic, feel that the work has resulted in an increase in the perception of empowerment by staff, decrease in the stress felt by staff in dealing with patients and an increase in the overall efficiency of the practice. All practices have felt that the work done on the Access topic has been beneficial and resulted in improvements for staff satisfaction at some level.

Patient Satisfaction Survey

The results of the patient satisfaction survey (see Attachment 9) also show some useful insights. When examining the “Excellent” category, it is interesting that the practice that has made the most extensive Access changes, Practice A, does not have the highest rating. Instead, Practice B tends to rate the highest. Although this practice has implemented some changes towards achieving Better Access, it continues to have a high General Practitioner 3AA, generally in the two to three day range. The graphs indicate that Practice A is experiencing a tension as a result of changes made in implementing Better Access. Whilst patients are satisfied with their experience of making an appointment, they do indicate that the length of time waiting and actual time spent during the visit could be improved. This highlights the important interplay of several variables with regards to Access.

Overall, the case studies show that the most significant improvement in Access measures was achieved by Practice A, which has implemented the full Better Access model. This improvement was reflected in a decrease in General Practitioner 3AA to zero and a reciprocal increase in the ‘Day of Choice’ survey to 100%. These effects were sustained over the period of measurement. Interestingly, however, Practice D had a high General Practitioner 3AA but also a high ‘Day of Choice’ survey score. This reflects the deficiencies in this latter measure, which will be discussed in further detail below.

The complexity of measuring in general practice indicates that no single measure ultimately reflects the changes that are made throughout a practice’s work on the Access topic. Consequently, a suite of measures is needed.

However, when it comes to implementation, all practices in the Study agree that the following actions are vital: clear communication, a commitment by the practice and strong leadership by the practice owners.
The following sections outline the final recommendations with regards to the topic aim, measurement system and Change Principles. However, before each of these sections are provided, it is important to mention that a significant learning in the first two phases of the Program, which is endorsed in the Study, is that the scope of Access extends beyond simply looking at appointment systems. Importantly, Access is about practice efficiency and connecting patients with their healthcare practitioner. Consequently, an examination of Access requires a consideration of the entire practice system. This will be taken into account in each of the sections below.

Access Topic Aim

The Access aim developed for the first three years of the NPCC was:

“90% of patients should be able to access their health care professional routinely the next working day”

In reviewing the aim for the Access topic, the Access Study Group established specific criteria that the aim will need to fulfil. Specifically, the aim needs to be aspirational but focused, defined and measurable. Furthermore, the aim needs to take into account the two primary purposes of the Access topic: connecting patients and improving practice efficiency.

It is also acknowledged that although we want to encourage use of the practice team to meet patient demand, the importance of continuity has been well established and is vital to delivering high-quality patient outcomes. Consequently, there needs to be a balance between services provided by a multidisciplinary team and individual patient continuity. This balance has been a significant consideration in all aspects of the Study.

Two important deficiencies were identified with the initial Access aim:

- Not all patients want to have an appointment on the same working day. Consequently, patient choice regarding the time of their appointment is a significant factor that needs to be acknowledged.
- There are difficulties with measuring the current aim. To address this limitation, the following section on the measurement system puts forth some recommendations.

Bearing in mind the above considerations, the final recommendation on the Better Access topic aim manages the first deficiency by adding another variable. The recommended aim is:

“90% of patients should be able to access their healthcare professional of choice **on the day of their choice”**

However, it is important to acknowledge that this aim does not consider the efficiency of the connection between the healthcare practitioner and the patient. Although improving efficiency is a significant objective for the Access topic, the Study has not been able to put forth a measurement that effectively gauges efficiency within the aforementioned criteria. This tension between continuity of care and efficiency of connection (or timely access) represents a significant challenge that requires further work.

Access Measurement System

An extensive review has been undertaken on the measurement system for the Access topic. To clarify thinking on the measurement system, a framework has been utilised[3], which outlines three categories of measures: outcome measures, process measures and balancing measures. A definition of each category will be provided in turn, along with proposed measures for each category. After considerable evaluation, the list provided in each category outlines the measures through to be useful and some areas that require further attention.

Proposed Outcome Measures:

Outcomes measures indicate whether the changes being made within a topic area are resulting in an improvement towards the started aim.

- Third Available Appointment

This measure was identified by the working party as continuing to be the best reflection of patient access to care. It is internationally recognised. However, there is concern that this measure has never been 'real' to clinicians; it lacks meaning. Consequently, it has been suggested that the following variation, 'Queue to the Third Available Appointment', is further examined.

- Queue to the Third Available Appointment

This measure looks at the number of patients in the queue until the Third Available Appointment slot. Essentially, it is the 3AA measure expressed in terms of patient numbers. As this measure looks at actual patient numbers, it is suggested that it holds more meaning for clinicians as well as the rest of the practice team.

The possibility of measuring the number of patients in the queue to the first available appointment was considered. However, counting to the Third Available Appointment is more robust as it significantly reduces the impact that unexpected events, such as last minute cancellations, have on the calculation of appointment availability.

It is recommended that this measure needs further exploring as it could be a more meaningful outcome measure. Further work needs to be done to ascertain the best way to calculate the measure. For example, is it best calculated through determining the Third Available Appointment and then multiplying by the number of appointment slots, or is there an easier method?

- Number of 'fit-ins' combined with the number of empty slots in the appointment system.

The number of 'fit-ins' represents those patients that were 'squeezed' into the system as they needed to be seen on the day but did not have an appointment. This measure, combined with the number of empty slots, could be utilised as an outcome measure. However, this measure would also be an effective process measure that can be used to monitor the Better Access Model when it is fully implemented.

[3] Institute for Healthcare Improvement, Measures: Primary Care Access, (online), Undated, Available: http://www.ihi.org/IHI/Topics/OfficePractices/Access/Measures

- Number of deferred patients

This measures the number of patients turned away each day; i.e. those that could not receive an appointment on the day of their choice. This is an outcome measure that is very closely related to Third Available Appointment.

- Patient Accessibility Score

Currently, the Access topic reports on the 'Day of Choice' survey. There is concern about the validity and reliability of this patient survey. Furthermore, although it is acknowledged that the 'Day of Choice' survey is relatively easy to collect, there is uncertainty about whether collection of this measure is actually being used to guide change at the practice level.

Due to the problems with the current survey, this Study recommends a more comprehensive survey. Drawing on the patient satisfaction survey administered by CFEP, five questions have been distilled based on their relevance to the Access topic. When combined, these questions form a survey which provides a 'Patient Accessibility Score' for the practice. This score can be used to gauge improvements towards the recommended topic aim.

	Poor	Fair	Good	Very Good	Excellent
Your level of satisfaction when making an appointment (e.g. prompt service)	1	2	3	4	5
Your level of satisfaction with getting an appointment on the day of your choice	1	2	3	4	5
Your level of satisfaction with the opportunity to get an appointment with the healthcare practitioner of your choice	1	2	3	4	5
Your level of satisfaction with the length of time waiting to see the doctor	1	2	3	4	5
Your overall satisfaction with your access to the practice's services	1	2	3	4	5

It is acknowledged that although the inclusion of a patient survey adds value and that the brief survey proposed assesses more thoroughly a practice's improvements towards achieving Better Access, further pilot work needs to be conducted to ensure that any survey used is valid and reliable.

Other important variables to consider when doing a patient survey include: when the patient is surveyed (e.g. upon entry to the system, upon exit, day of the week, etc.) and the degree of anonymity that the patient has when answering the survey. Both of these variables have the potential to significantly alter the survey response.

- Cycle time

Cycle time is the amount of time that the patient spends in a practice visit. The cycle begins when a patient arrives at the practice and ends when the patient leaves the practice. This was identified as a useful outcome measure for open access practices. However, it requires further exploration to determine the most effective way of implementing this measure. For example, should practices measure cycle time from patient entry to patient exit? Such a measurement does not take into account the fact that time spent in the consulting room is variable depending on the patient's needs.

Alternatively, practices could measure cycle time from patient entry to the practice until the time that the patient is seen by the healthcare professional of choice.

Proposed Process Measures:

Process measures are used to gauge the success of a specific process change. Generally, a number of process measures are used during the course of a change effort with the assumption that when combined, the results of several process measures will ultimately impact upon the outcome measure(s).

- Relationship of demand to capacity

This is a process measure analysing the difference between demand and capacity. When the demand to capacity is 1:1, this means that demand and capacity are in equilibrium. However, if the ratio is greater than one, this indicates that demand is higher than capacity. A ratio of less than one indicates that capacity is higher than demand. This is a useful process measure to gauge whether the practice is able to balance demand and capacity, which is fundamental to the Better Access model.

There are a few limitations to this ratio that need to be acknowledged. Firstly, this ratio does not take into consideration the issue of backlog. Furthermore, practices that have utilised this ratio have commented that it does not always work out on a daily basis due to variables such as an increased demand during flu season. However, it does tend to work out over two to three days.

However, this measure is crucial for changing the psychology of the practice team to undertake work on Access. Being able to prove that demand and capacity are in balance is an essential pre-requisite for the practice’s journey towards achieving Better Access.

- Efficiency measures

It has been identified that improving efficiency within practices is a fundamental part of the Access topic. As such, various measures were considered to gauge improvements in a practice’s efficiency. Importantly, no single measure indicates efficiency by itself; instead use of a selection of measures is ideal. The following were identified as being useful process measures:

  - Patients seen per hour per full time equivalent (FTE) practitioner
  - Patients seen per hour per FTE support staff
  - Staff to doctor ratio. Analysis of existing practices suggests that a ratio of one or less is typical of more efficient practices. Efficient, computerised practices have been able to aim for a lower ratio, for example 0.8. However, if the ratio is higher than one, this may indicate that the practice needs to analyse its systems and the roles of all staff to maximise efficiency.

Use of efficiency measures is also advantageous in terms of selling the topic to practices. Regardless of their current access situation, all practices can benefit from improvements in efficiency.

Proposed Balancing Measures:

Balancing measures are used to ensure that changes to improve one part of a system do not cause adverse effects on other parts of the system.

- Team Perception Score

This measure provides a balance to the 'Patient Accessibility Score' by measuring practice staffs' perception of whether patients' needs were met. To obtain the score, a survey is carried out asking a number of staff to rate their satisfaction with meeting patients' access to the practice's services. Responses are captured on a Liekert scale and aggregated for the practice. It is important that this survey is used across the whole practice team, capturing a representative cross section of disciplines. It is important that this measure is collected by the same group each time as not doing so may lead to reliability issues.

- Panel size

A doctor's 'panel' is the number of patients that the doctor serves. Panel size is an important balancing measure. It may not be desirable that a practice improves its access by severely limiting the population that it serves. Alternatively, a practice may have greatly improved its efficiency but have static Access measures because it has greatly increased the panel size through 'demand creep'. Demand creep refers to a situation in which a practice that has implemented the Better Access Model sees an increase in their patient population as a result of their improved access situation. In other words, increased numbers of patients visit the practice because they know that they can get an appointment quickly.

A proxy for the panel size is the number of individual patients served in the last 18 months. Another proxy measure can be Standard Whole Patient Equivalent (SWPE) indicated on the Practice Incentive Payment (PIP) statement.

- Revenue

Financial measures can also be used as balancing measures to gauge whether work being done on the Access topic has an impact on the practice's finances. The following measures examine the revenue and overheads for a practice:

  - Revenue per patient per hour: This involves calculating fee for Service Income plus Practice Incentive Payments per patient, multiplied by 'patients seen per hour'. The fee information can be collected from the practice's billing system. To collect the 'patients seen per hour', the practice can calculate the number of hours the practice is open for consultations and divide this by the total patients seen in the week. It is recommended that this information is assessed on a quarterly basis.
  - Overheads per patient per hour: This involves calculating the 'total overheads per patient', multiplied by 'patients seen per hour'. Fee information is collected from the practice's general ledger (for example, practice total costs in profit and loss statement). Then, overheads are deducted. Overheads include any payments to doctors and related on-costs including superannuation, professional indemnity and motor vehicles. To collect the 'patients seen per hour', the practice can calculate the number of hours the practice is open for consultations and divide this by the total patients seen in the week. It is recommended that this information is assessed on a quarterly basis.

The two ratios can be compared. If the 'overheads per patient per hour' is increasing compared to 'revenue per patient per hour', the practice may need to assess if there are any unusual factors such as once off costs or revenue items that may have affected the overall result. The use of a financial measure is valuable in ensuring that

changes being made in the Access topic are not having a negative impact on the financial profitability and viability of the practice.

Change Principles

As previously mentioned, the learnings in phase two of the Program and the work undertaken in the Study have demonstrated the need to re-examine the way in which Access is conceptualised. Importantly, the scope of Access is much broader than the narrow focus on appointment systems. Access involves an examination of the whole practice system and the way in which this system can be managed to improve the ability for patients to access the practice's services. This has led to a recommendation that the Access topic is viewed from two perspectives: efficiency and patient connection.

Furthermore, Access is about teams. It is not simply about the connection that patients have with their General Practitioner. Rather, it is about the connection they have with the healthcare professional of their choice and/or the most appropriate practitioner, which can include Practice Nurses and Aboriginal Health Workers. Consequently, the role of the whole practice team is crucial.

Based on these insights, the Access Study Group has endorsed a redesign of the Access section of the handbook conducted by the National Primary Care Collaboratives, which is included as Attachment 15. The redesigned Access section recognises the need for the widened scope of Access to be incorporated in the handbook. Moreover, it is acknowledged that not all practices may be in a position to move to the Better Access model. Consequently, the Access topic has been divided into two sections. The first section outlines the basic Change Principles which are central to improving practice efficiency. We recommend all practices are encouraged, at a minimum, to engage in these fundamental Change Principles to measure their status and provide the impetus for change, where necessary. These Change Principles measure and provide basic practice efficiency tools. As efficiency is relevant for all practices, regardless of their current access situation, a focus on this concept is also advantageous in terms of selling the topic to practices.

The second section builds on the first and involves the whole of practice changes required to implement Better Access. This section has been extensively revised and rewritten to create a more effective resource in the Australian context. In addition, Australian examples are included. Ultimately, improvements in these areas lead to improved clinical outcomes.

Conclusion

The first three years of the Australian Primary Care Collaborative Program has pioneered the application of Access in Australia. Australian experience has confirmed that the approach can achieve a significant improvement in the ability for patients to access their primary healthcare professional. Building upon the knowledge gained through phase two of the Program, the Longitudinal Access Study has taken an in depth look at the impact of Access on four practices. This intelligence has been distilled into a set of recommendations for the future implementation of the Access topic in Australia. Recommendations have been made on the Access topic, measurement system and Change Principles to ensure a better fit of each with the context of Australian general practice. These recommendations have been included in an extensive rewrite of the Access section of the Handbook.

The exciting potential of Access to provide a more efficient and effective primary health care service has only just begun to be realised. By ensuring that the unique

contextual issues of the Australian healthcare system are considered, this Study forms the basis for the full potential of access to be attained in future phases of the Collaboratives program.

Attachment 1 - Australian Primary Care Collaborative Topic Outcomes

Program Outcomes for CHD, Diabetes and Access for Core Waves 1-3 as of October 2007 data submission (containing data inclusive of September 2007):

Coronary Heart Disease (CHD)

- 31% improvement in the percentage of patients with CHD recorded as being on aspirin medication
- 32% improvement in the percentage of patients with CHD recorded as being on a statin medication
- 45% improvement in the percentage of patients who have had a myocardial infarction in the last 12 months who are on a beta blocker medication
- 43% improvement in the percentage of patients with CHD whose last recorded blood pressure was below 140/90mmHg

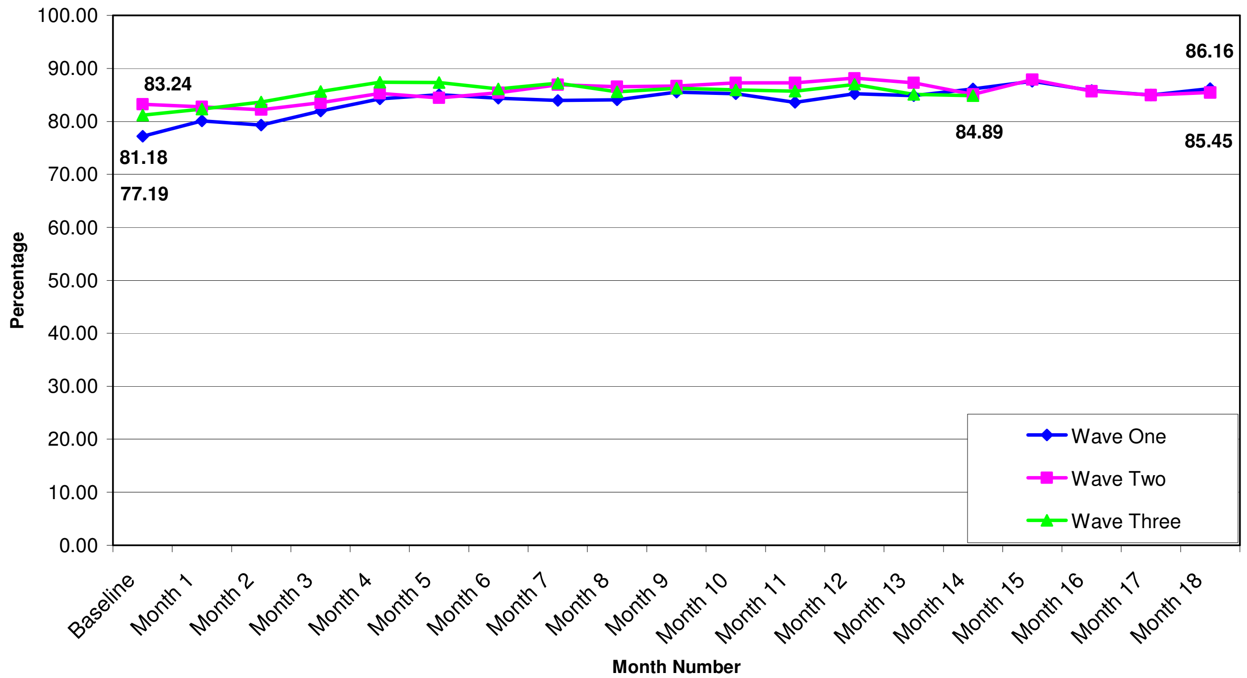
Diabetes

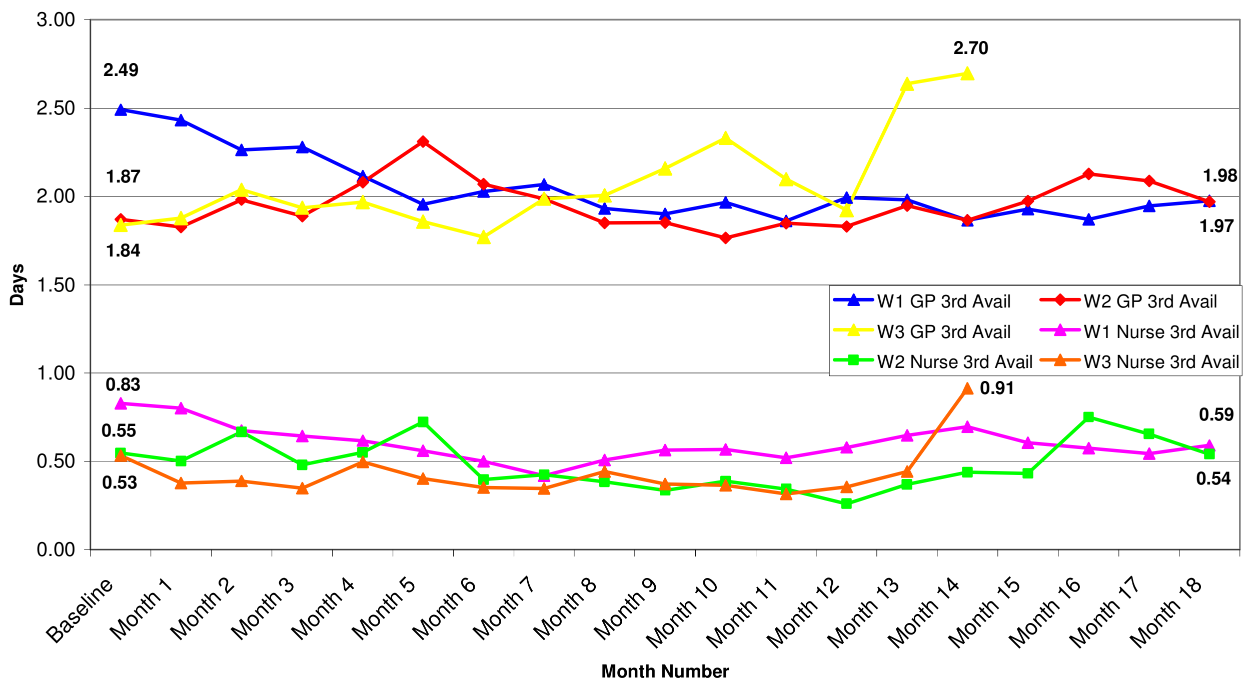
- 76% improvement in the percentage of patients with HbA1c levels equal to or below 7%
- 105% improvement in the percentage of patients with diabetes whose cholesterol was recorded below 4mmol/L
- 70% improvement in the percentage of patients with blood pressure equal to or below 130/80mmHg
- 82% improvement in the percentage of patients who have had a SIP claimed for them

Better Access to Primary Care

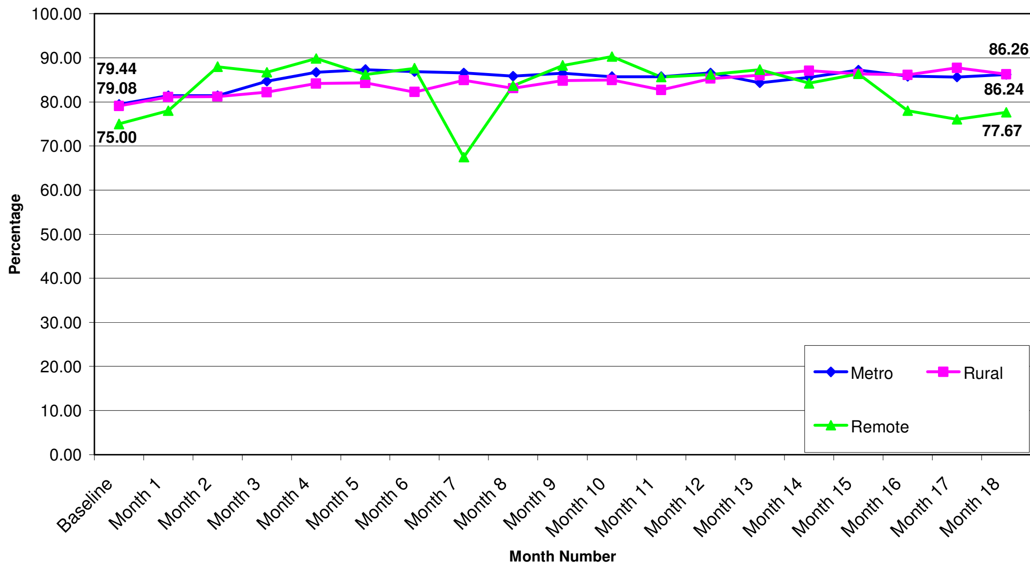
- 8% improvement in the percentage of patients seen by a GP on the day of their choice
- 8% improvement in the GP 3rd available appointment
- 15% improvement in the practice nurse 3rd available appointment

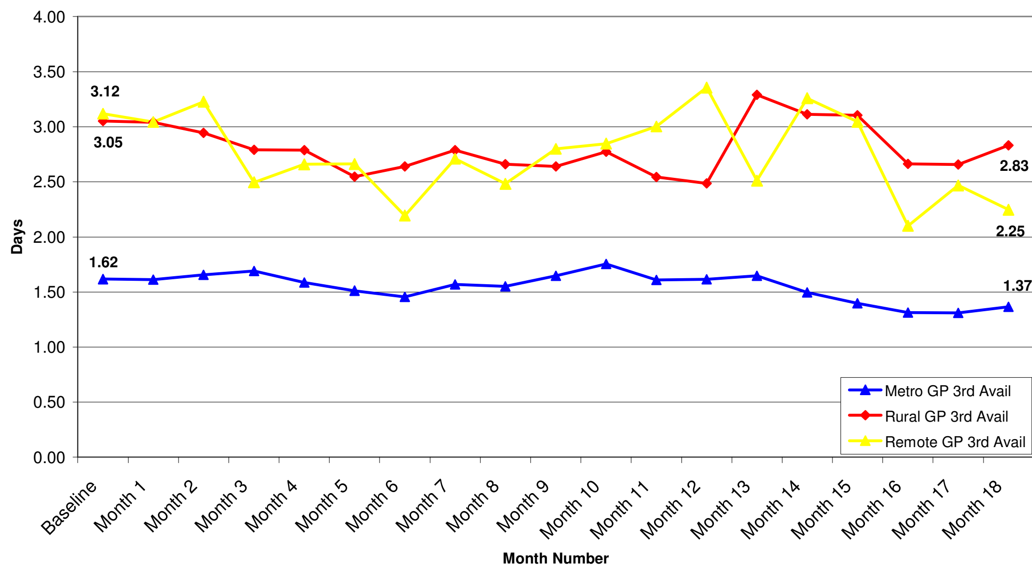
Attachment 2 – National Aggregated Access Measures for Waves 1-3

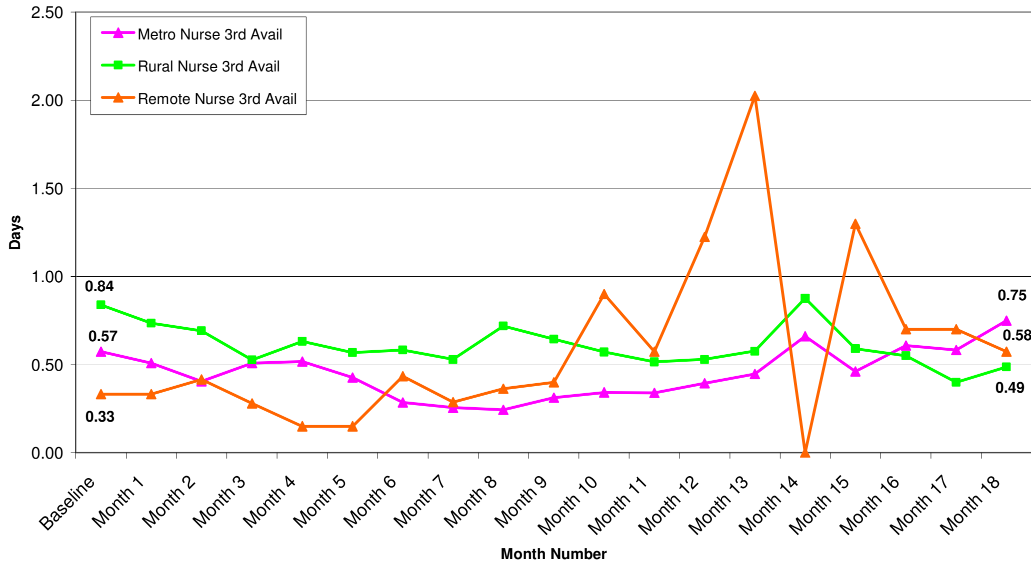




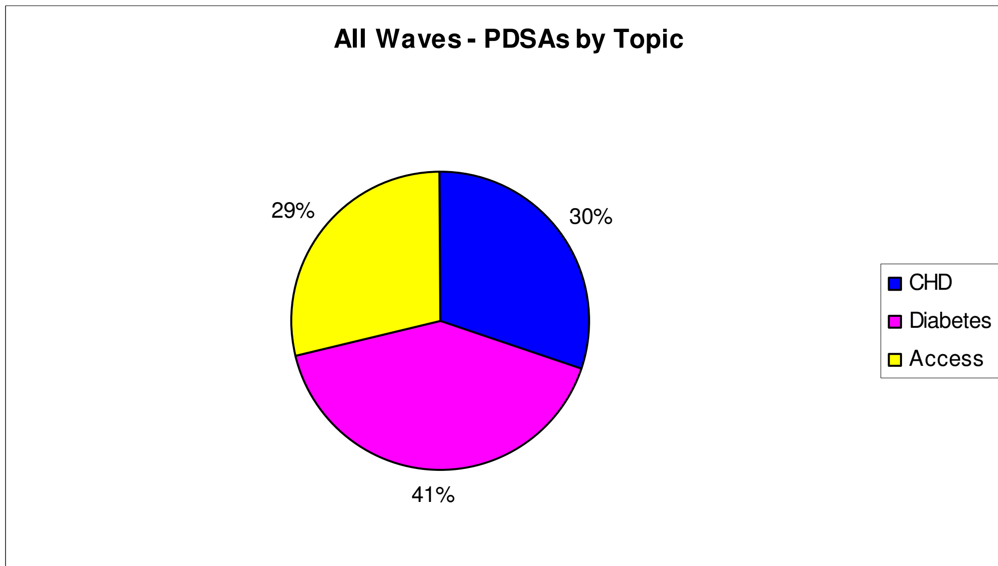
Attachment 3 – National Aggregated Access Measures as a function of the Rural, Remote & Metropolitan (RRMA) Index

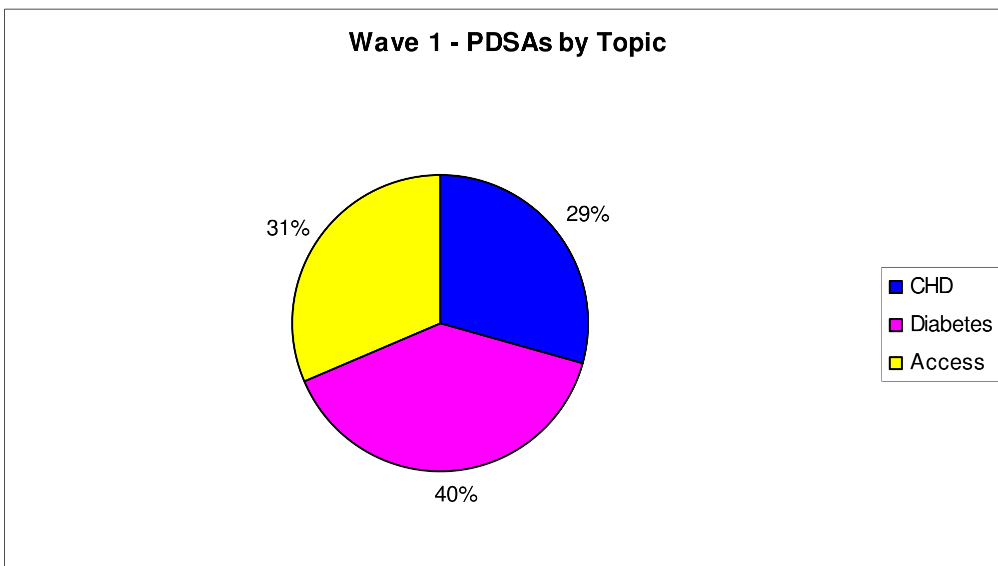




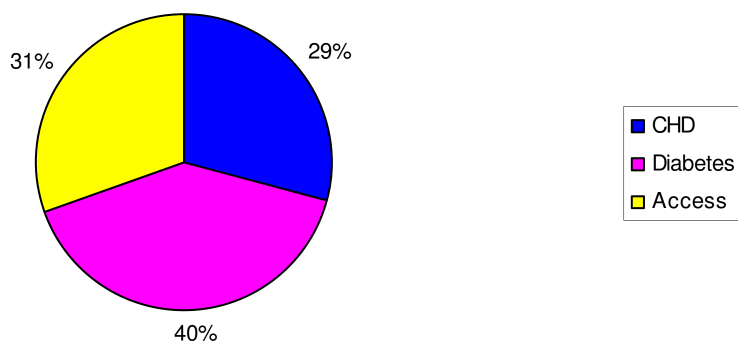

3rd Available Appointment: Trend of Mean Days by Month Number,
Comparison of Waves: August 2007
Metro Nurse 3rd Avail
Rural Nurse 3rd Avail
Remote Nurse 3rd Avail
Days
2.50
2.00
1.50
1.00
0.50
0.00
0.84
0.57
0.33
0.75
0.58
0.49
Baseline
Month 1
Month 2
Month 3
Month 4
Month 5
Month 6
Month 7
Month 8
Month 9
Month 10
Month 11
Month 12
Month 13
Month 14
Month 15
Month 16
Month 17
Month 18
Month Number

Attachment 4 - PDSA Submission for Access compared to CHD and Diabetes, for Waves 1-3

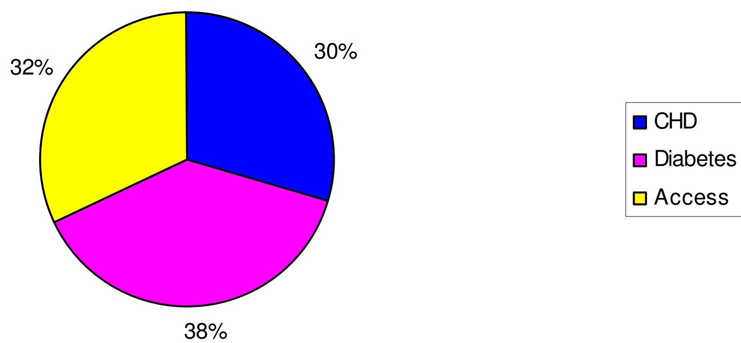




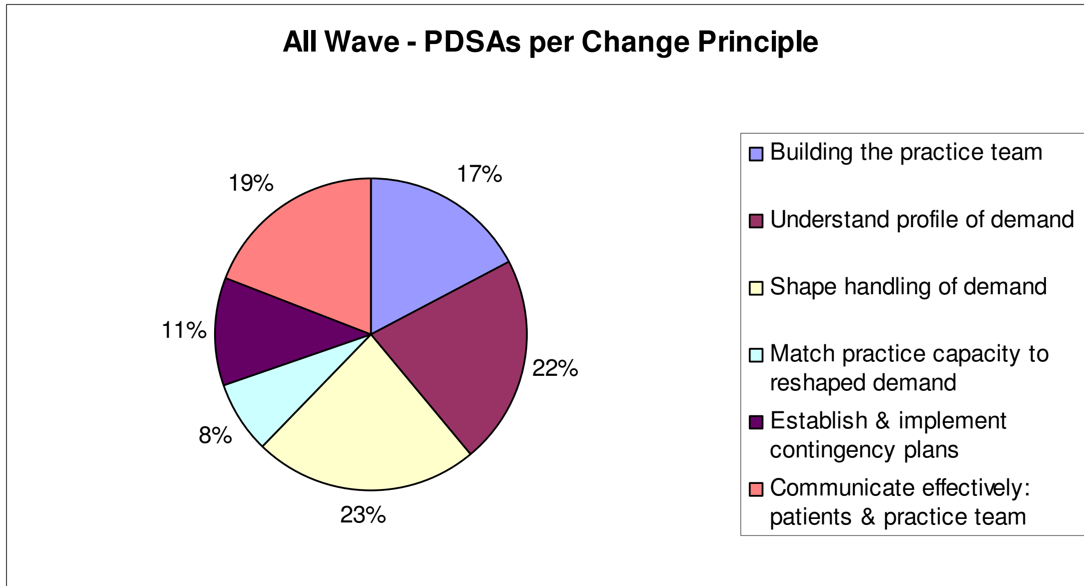
Wave 2 - PDSAs by Topic

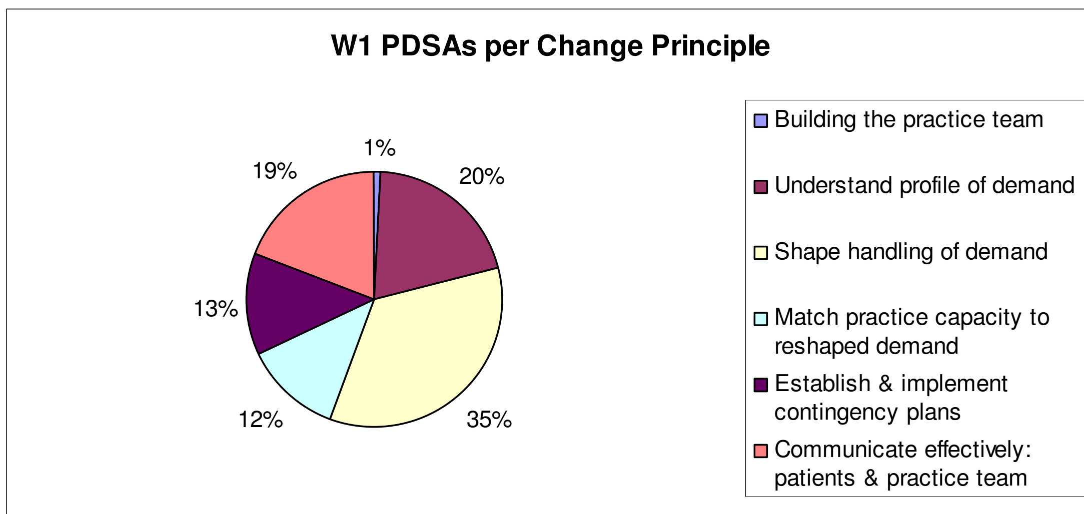


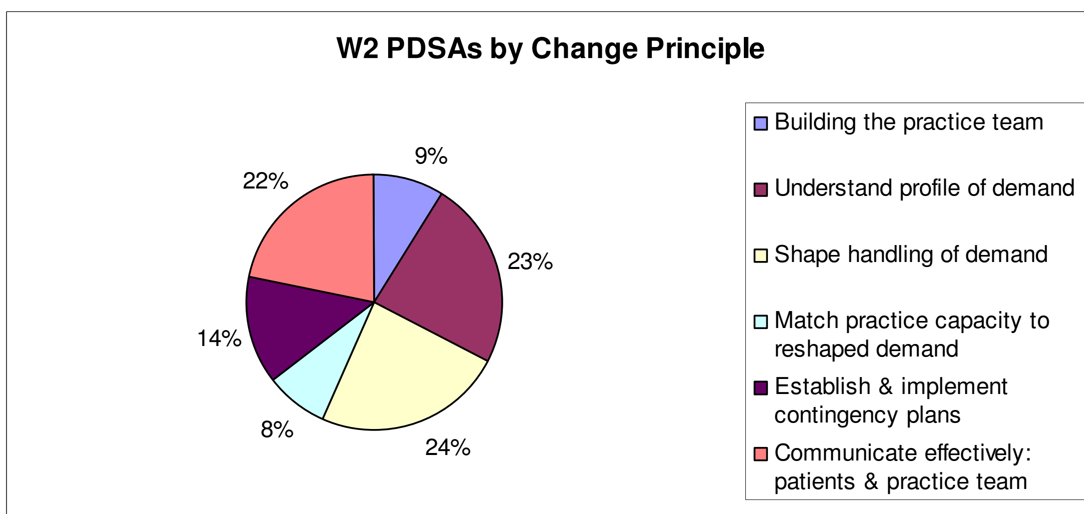
Wave 3 - PDSAs by Topic

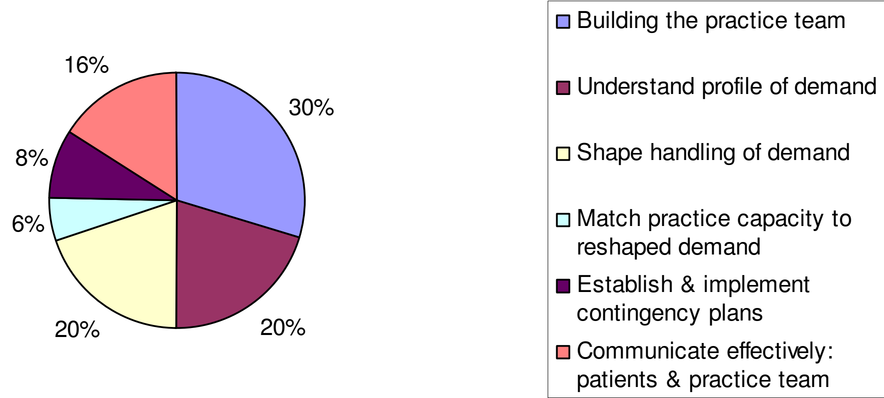


Attachment 5 – Access PDSA Submission per Change Principle








W3 PDSAs by Change Principle
30%
20%
20%
6%
8%
16%
Building the practice team
Understand profile of demand
Shape handling of demand
Match practice capacity to reshaped demand
Establish & implement contingency plans
Communicate effectively: patients & practice team

Attachment 6 – Better Access Recipe

Introduction
After two years we now have the experience of numerous practices in applying Better Access in Australia. Below are listed some of the practical tips that have led to success.

Preparation
Measure your demand

Ingredient	Why	Resources
explain to and get buy in from receptionists before measurement	It is extra work. If they are not committed to it they will either give up or do it badly. You cannot plan better access without good demand measurement.	READ THE MANUAL Waratah HC staff info sheet Kooringal staff info sheet
tally sheet by each phone	It must be simple and in front of them if they are to remember and do it. Keep checking on them during data collection. Encourage them – it is hard to remember to do it.	READ THE MANUAL Waratah HC tally sheet
confidence that you have enough capacity each week to meet demand	The practice team needs to believe they have the capacity to meet demand if they are to make changes keep measuring till you are convinced demand is finite and predictable	demand and capacity data

Shape handling of demand

- can be done without major changes in the appointment system and can make a big difference
- unique to practice – team approach wise and efficient, requires thinking and creativity

Ingredient	Why	Resources
shift work away from busy staff e.g. can practice nurse do pap smears or give normal results, can non clinical staff do sterilising, can less busy doctors take on the new patients	frees up capacity to deal with demand	Data on why patients are coming – part of demand measurement READ THE MANUAL read other PDSA's
rational follow up e.g. 6monthly for controlled hypertension, to nurse for BP or weight monitoring	this reduces future pressure on appointments	guidelines e.g. National Heart Foundation Hypertension Guidelines
follow ups and visits on low demand days e.g. excisions on Tue or Thu	to keep precious capacity to handle acute demand on those days	
discourage multiple bookings long into the future	blocks up future capacity	
today's work today e.g. repeat scripts	putting things off saves time now but puts pressure on the future	

try to match patient with their preferred doctor	access to usual doctor increases patient confidence to self manage and minimises need for repeat appointments for the same problem	
increase patient self management	reduces need for acute appts e.g. parents are confident to manage simple illnesses in their children, asthmatics can self manage acute exacerbation	GPMP's patient information sheets
target frequent flyers	explore why they come so often and try to find ways to safely decrease frequency of visits e.g. can they see the nurse? would a patient held calendar of care help them? would regular monthly visits prevent self presentation weekly?	Kingsley Pearson DVD

Match the team to the reshaped demand

- can be done without a major change in patient behaviour
- unique to practice – requires thinking and creativity – get the whole team thinking about the problem

Ingredient	Why	Resources
more staff on high demand days (move doctor/nurse shifts)	increases the chance meeting all demand on the day. Decreases deflection into the future and preserves future capacity.	daily demand data
staff development e.g. nurses trained to do well women's clinic	frees doctors capacity	data on type of appts patients need local training courses
More staff – decisions based on type of demand i.e. nurse? doctor? other?	If demand is greater than capacity despite being reshaped	data on type of appts patients need
creativity	your circumstances are unique – invent solutions for your situation	read other PDSA's

Going for better access

Better Access involves a significant change in thinking for patients and staff. Many practices in the US, UK and now Australia have found the benefits of doing it properly are enormous. Read the manual carefully over and over. Read anything else you can on the model. Listen to others who really understand it.

DO YOU WANT TO DO IT? WHY?

The following steps have been gleaned from successful implementers and may help you avoid some common mistakes.

Ingredient	Why	Resources
lead staff need to understand the model	It is a new idea for most of us. We cannot implement it well or explain it to others if we do not understand it.	READ THE MANUAL read the articles on the NPCC website e.g. by A Knight et al in MJA July 2005 Read articles by Mark Murray available on the internet

get "buy in" from the team Agreement on goals (today's work today, clinician of choice for patient) Commitment to try it	If the doctors don't understand it or want to do it they can undermine the changes because of patient pressure over the changes and they will not be willing to work down the back log. If reception staff don't understand it or want to do it they can undermine the changes in the face of pressure from patients or other work.	Use the team principle Data on demand and capacity to convince the team it will work. Data from accreditation surveys of access problems.
Calculate the backlog	When you know what your backlog is you will know how many extra appointments you need to provide each day and week to get rid of it. You have already shaped the demand to be as lean as possible and you have already matched the team to it. Demand and capacity are in balance or near to it. The reason for delay is backlog.	READ THE MANUAL on how to calculate backlog
Work down the backlog. E.g. doctors forgo half day off for a limited time, or work Saturdays or do longer days. Get some of the part time doctors to do more for a time.	So that the back log which is preventing you from giving an appointment to the patient ringing today is gone.	READ THE MANUAL read other PDSA's
Set a date. Make the date far enough in advance that there is time to educate patients about the changes. Some practices have set the date five months in advance. From that day you will have enough capacity each day to deal with all demand. For now in order to change behaviour do not allow patients to make an appointment beyond that date.	Setting a date allows every one to work towards a goal. After that date you will run on the better access system.	Calendar Calculator to work out how long it will take to get rid of your backlog.

Prepare for A day

Ingredient	Why	Resources
Educate patients about the changes. Use flyers, posters in the waiting room, window. Put articles in the local paper. People who come often are the targets as they will have expectations of a need to book ahead.	Patients who need to go to the doctor regularly have learned they need to book ahead to get appointments. Many book every two weeks just in case. If you suddenly stop them without an effective education program they will get very nervous and put a lot of pressure on receptionists and doctors who in turn may lose their nerve. Get the patients on side by telling them the potential benefits i.e. you will be able to get in to see a doctor on the day you ring up. If you are sure of your figures you can guarantee them an appointment on the day. Experience suggests patients will want to help and be kind to you in the first days of the new system. The main change in better access is in patient behaviour – their willingness to trust that they can ring on the day and get an appointment.	Patient information Kooringal NPCC resources on the website
write and rehearse scripts for reception staff and clinicians What should a receptionist say when a patient wants an appointment two weeks after A day? What should a doctor say when a patient complains they cannot book a month in advance?	Staff and doctors will be nervous and stressed about dealing with patients who are stressed by change. Scripts will help them cope effectively.	Tony Lembke has written some scripts.
write and get agreement from clinicians on contingency plans planned eg holidays unplanned eg sickness, funerals	Once you have achieved the ability to meet all demand on the day the greatest threat to maintaining better access will be absence of clinicians: expected or unexpected. Practice managers will need to be able to implement contingency plans on their own authority if someone calls in sick. Clinicians will need to understand and agree to contingency plans in advance so there are no surprises.	READ THE MANUAL on contingency plans. Read PDSA's on contingency plans. e.g. all do three extra appts if someone calls in sick e.g. only one clinician on holidays at a time

On the day

Ingredient	Why	Resources
All clinicians and staff available on the first day prepared to see all patients	It is important, particularly in the early days, to fulfil the contract to see all patients on the day they want to be seen. Practices that have done this step have reported it easy to achieve.	

get rid of different appointment types	Since all can get in when they want, you do not need emergency appointments and you do not need staff triaging. The drop in DNA's due to patients booking on the day will free hidden capacity	

Running the system

Ingredient	Why	Resources
monitor the system Measure third available appt daily. Measure number of empty appts each day measure number of patients deflected from the day	To detect problems early and correct them before a backlog can re-accumulate.	
listen to staff and patient feedback		
learn to work the system	What are the appts that are hard to sell? Book them first if possible. Relax the "no book in advance" rules – once patients are confident they can get an appt whenever they ring they will not need to book in advance and so future capacity will be preserved. Those who definitely need appt at a certain time to accommodate work or transport requirements should be given one. They will not throw it out – they are part of the routine demand you have already measured. Keep tweaking to allow more efficient use of medicare/wider range of patient services e.g. EPC items	
train reception staff to run the system Monitor and advise if 3AA blowing out Train new staff.	So it becomes part of the system and self perpetuating without too much input from managers/clinicians.	

Attachment 7 – Members of the Steering Group, Access Study Group and NPCC Staff contributing to the Study

Steering Group

- Dr. Andrew Knight- Chair of the Access Expert Reference Panel
- Professor Liz Farmer- Director of Education, NPCC
- Ms. Judy Myers- Senior Program Manager, NPCC

Access Study Group

- Dr. Tony Lembke- Clinical Chair, NPC
- Professor Moyez Jiwa- Professor of Primary Care & Co-Director WA Centre for Cancer and Palliative Care, Curtin University of Technology
- Dr. Nicholas Stephens- General Practitioner, Daisy Hill Medical Centre
- Ms. Sandi Hill- CPM, Northern Rivers General Practice Network
- Ms. Debbie Buckley- CPM, Gold Coast Division of General Practice
- Ms. Liz Griffin- Practice Nurse/Manager, Alstonville Clinic
- Ms. Kim Gardner- Practice Manager, Daisy Hill Medical Centre

NPCC Staff

- Ms. Mini Dhillon- Manager Access & Virtuals, Regional Manager NT
- Edited by Ms. Linda Hein- Communications and Marketing Manager
- Ms Anne Bowdren – Former Regional Manager NSW

The NPCC would also like to acknowledge the four general practices that have spent tremendous time and effort contributing data for the Study.

Attachment 8 – Staff Satisfaction Survey Questionnaire

Please tick the title that most accurately reflects your position:
☐ General Practitioner ☐ Practice Nurse ☐ Practice Manager ☐ Practice staff member Other (please specify) ________________________________

The Access topic has empowered me to make changes at the practice.	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
	1	2	3	4	5
Please comment on the reasons for your rating:					

I have seen an improvement in the practice's business efficiency since commencing work on the Access topic.	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
	1	2	3	4	5
Please comment on the reasons for your rating:					

I think that the practice runs more efficiently since commencing work on the Access topic.	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
	1	2	3	4	5
Please comment on the reasons for your rating:					

The work undertaken on the Access topic has decreased the amount of stress I feel in dealing with patients.	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
	1	2	3	4	5
Please comment on the reasons for your rating:					

Since working on the Access topic, I feel happier at work.	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
	1	2	3	4	5
Please comment on the reasons for your rating:					

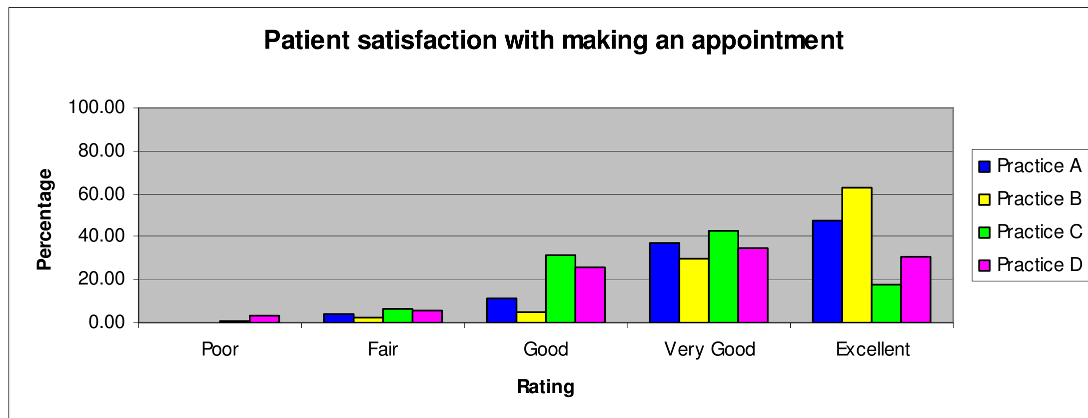
Our work on the Access topic has been worth the overall benefits.	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
	1	2	3	4	5
Please comment on the reasons for your rating:					

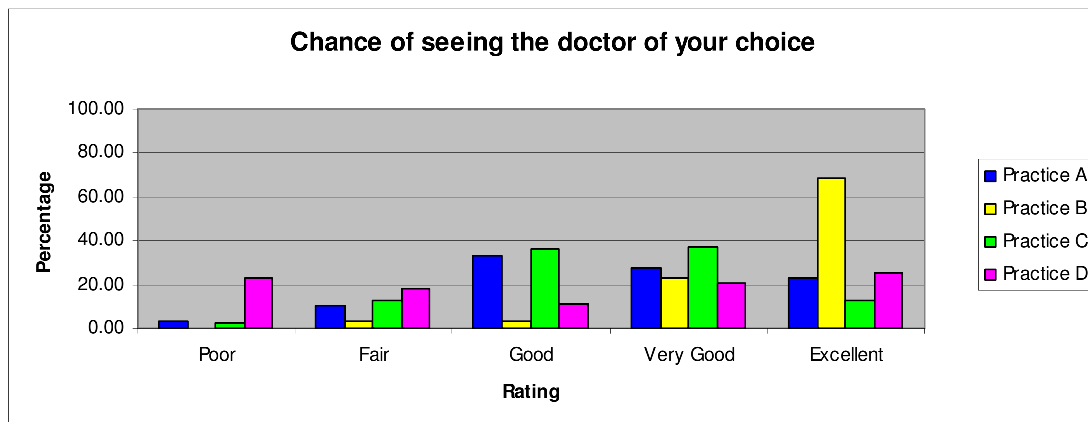
What have been the benefits of working on the Access topic?
What have been the best aspects of the work undertaken on the Access topic?

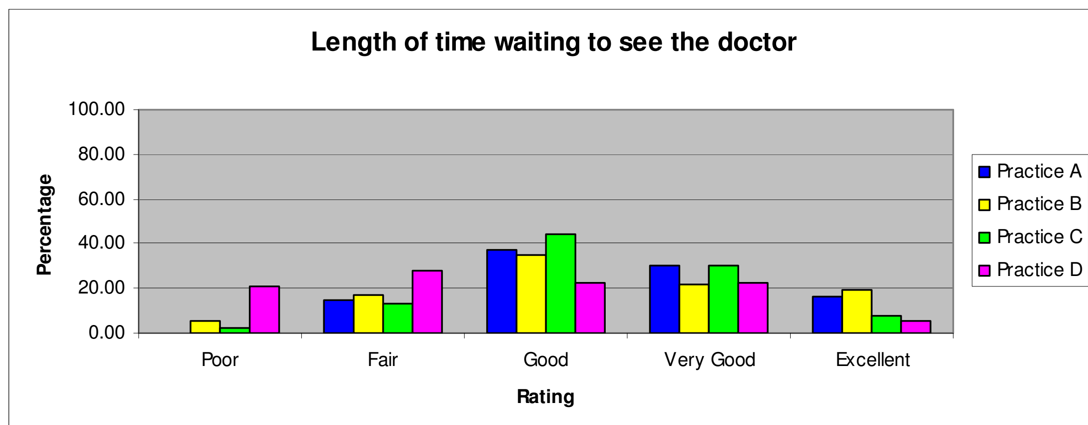
What has been the greatest challenge(s) of working on the Access topic?
What would you like to see NPCC do in the future in relation to the Access topic?
If you have any additional comments, please include them here:

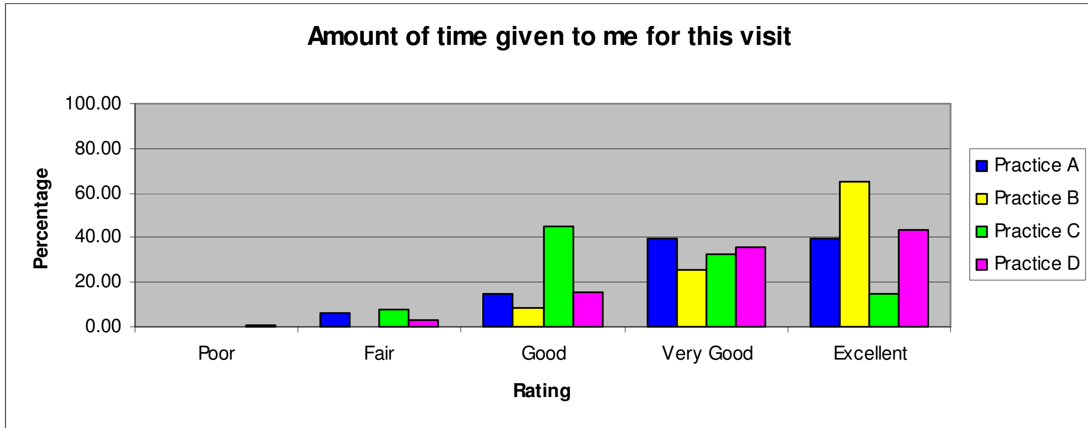
Thank you for taking the time to complete this questionnaire.

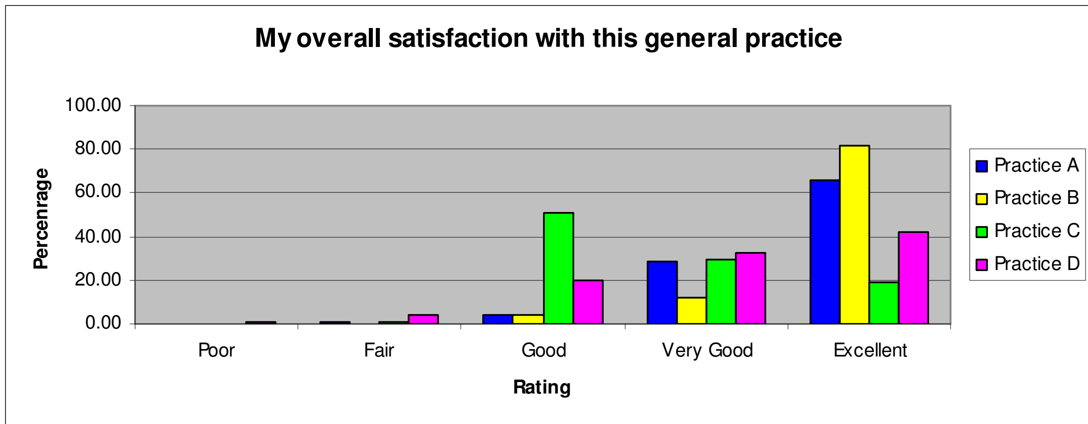
Attachment 9 – Results of CFEP Patient Survey








Amount of time given to me for this visit
100.00
80.00
60.00
40.00
20.00
0.00
Percentage
Poor
Fair
Good
Very Good
Excellent
Rating
Practice A
Practice B
Practice C
Practice D


My overall satisfaction with this general practice
100.00
80.00
60.00
40.00
20.00
0.00
Percenrage
Poor
Fair
Good
Very Good
Excellent
Rating
Practice A
Practice B
Practice C
Practice D

Attachment 10 – Case Study, Practice A

Practice A Profile

Practice A is a located in a rural village in New South Wales. It is situated 20 kilometres from the regional centre of Lismore in Northern NSW and 15 & 25 kilometres respectively from the coastal towns of Ballina and Bryon Bay. The nearest hospitals are located in Lismore and Ballina. Consequently, practice A provides a 24 hours on-call emergency service. At practice A, there are currently 6 General Practitioners. Four of these doctors are principals and the other two are part-time GPs making up a 4.8FTE general practitioner workforce. They also have 1 FTE registrar and are supported by 5 Practice Nurses (3.2 FTE), one of whom is also the Practice Manager. Additionally, there are 7 office staff (3 FTE) and several speciality staff including a chronic disease coordinator, an exercise physiologist, a diabetes educator and a dietician.

In terms of their population profile, practice A has an active patient population (based on patients seen in the last 24 months) of 7, 761 patients. 75% of the patients are older than 50 years of age. Finally, in terms of their chronic disease profile, they currently have a diabetic register of 330 patients and a CHD register of 310 patients.

The practice utilises Genie as their clinical and billing package.

Practice A's Access Journey

The practice was experiencing significant delays in the waiting times that patients had for routine appointments. This was not only a concern for patients but also for doctors and staff. Initially the practice tried taking a couple of steps to improve their access situation, including the addition of more doctors and nurses as well as restricting admission of new patients to those residing in the immediate postcode. However, the practice continued to have an access problem.

Practice A was running a 'jeopardy doctor' model, whereby one doctor for a given day would start the day unbooked and see all the emergency and urgent cases that present to the practice, regardless of who the patient's primary doctor was. The other doctors saw the patients who booked in for them. Although this appointment system ensured that acute patients were seen every day, the delay for patients requiring routine care was lengthy. In fact, at baseline practice A's access figures confirmed that they had an access problem with GP third available appointment sitting at 7.33 days and only 40% of patients stating that they received an appointment on the day of their choice.

Convinced by the success of the Better Access model overseas, the lead clinical staff member in the NPCC decided to trial the model at practice A. Hearing from other practices in Australia that had implemented the Better Access model, this GP decided to systematically follow the steps in the NPCC handbook. With the support of the Practice Manager, practice A commenced their Access journey in May 2006. It should be noted that the lead GP in the NPCC program is also a principal at the practice and therefore in a position to drive change.

Measurement of demand and capacity gave them a true picture of their Access situation. It also proved that the practice did not actually have an issue with capacity but that the problem was related to delay. Consequently, changes would need to be made within the practice to reduce this delay. The GP and PM convinced the practice team about the need to make the changes, as suggested in the NPCC handbook and, with some initial hesitancy, the practice team committed to supporting the trail. It was agreed that the Better Access model would commence in September 2006 and the model would be trailed until December 2006.

Patient Education

However, implementation of the Better Access model required a shift in thinking not only for the other GPs in the practice but also a fundamental shift in patient behaviour. The practice needed to educate patients about their new appointment system and the meaning of the go live day or “A day”. To do this, the practice produced a flyer explaining their new appointment system, the reasons for the change and what this would mean for their patients. This flyer was given to every patient that walked through the door commencing two months prior to “A day”. An article was also written in the practice’s newsletter. Furthermore, the practice ensured that patients were given the opportunity to ask questions, to ensure that they felt reassured about the change. As the practice is located in a rural village, news of the changes that Practice A was making to its appointment system spread rapidly throughout the village.

Backlog

Another big hurdle was backlog and the GPs found that the only way to deal with this was through a bit of hard work. After calculating the extent of backlog, the GPs committed to working it down before their go live date, which had been set for September 4th. The various GPs decided to do it in different ways; the majority of which required working extra sessions for a nominated period of time. Once the backlog was eliminated, the GPs started on “A day” with an empty slate.

Staff education

All of this work required commitment not only from the GPs but also the whole practice team. Consequently, everyone needed to be kept abreast of the changes that were happening at the practice. The main conduit for the provision of information was through staff meetings. The doctors were committed to the change and decided that it was important that all staff attend these meetings. Consequently, staff were provided lunch and paid for their attendance. At the beginning, meetings were held weekly. As staff became more comfortable with the change, meetings were reduced to fortnightly and are now held every three weeks. The main purpose of these meetings is to ensure all staff are kept informed of any changes and are also able to ask questions and voice concerns. These meetings have had the added benefit of creating a culture in which staff feel comfortable raising concerns at any point in time.

The Current Appointment System

Since moving to the Better Access model, practice A's current appointment system contains several features that are distinct from the old system. This includes the ability for patients to access same day care, whether it is for acute conditions or a routine appointment. Patients can also book an appointment up to one week in advance if they desire. The front desk staff utilise a flowchart to assist them in managing demand. This flowchart guides them in the way that they allocate patients to an appointment. For example, when a patient does not have a strong preference for an appointment time, s/he is assigned an appointment time that is known to be less popular. In this way, demand is constantly moulded.

Some doctors were concerned about the ability for their chronic disease patients to access care and consequently doctors are allowed to book up to three weeks ahead for patients that they think require this level of pre-booking. The practice continues to have an on-call doctor to ensure that all emergencies are promptly attended to; however, this doctor takes regular bookings throughout the day. The majority of doctors, however, they do not take long bookings when they are on-call.

The result is that since moving to the Better Access model, practice A's access picture looks much better. In September 2006, when they went live with the Better Access model, their GP third available appointment was 0 days. This was accompanied with a day of choice survey of 100%. Better yet, these figures have been maintained! This certainly indicates that patients are not experiencing the significant delays in accessing medical services that they were previously faced with.

It should be noted that the use of Practice Nurses is fundamental to practice A's access picture. Three Practice Nurses are used each day to primarily see acute patients. These Practice Nurses, along with the on-call doctor, manage the Accident and Emergency service. Furthermore, the practice has one nurse whose main role is chronic disease coordinator. Unfortunately, due to limited structural capacity, this nurse is only able to provide this service 15 hours per week. Although she takes routine appointments, the practice felt that that it was not necessary to collect a third available appointment measure for this nurse.

Access Study Data

Access Measures

See attached.

Staff Survey

Seven responses were received for the staff survey, the results of which show that the work undertaken on the Access topic has generally been positive. All respondents agreed that the work has resulted in an improvement in the practice's efficiency. Only 57% of respondents believed that it empowered them to make changes at the practice. 71% of respondents felt that it decreased the amount of stress they feel when dealing with patients. Overall, all respondents further felt that the work had resulted in dramatic improvements for their patients' ability to access care. Patients no longer experience lengthy delays to see their doctor and the majority of patients experience increased satisfaction. However, it was mentioned that several classes of patients

might be disadvantaged with the new approach including those with chronic conditions and the elderly. In addition, there was concern expressed that although the changes had been very beneficial for patients, they are not as positive for the practitioners with one practitioner stating that the less structured days are more stressful.

Patient Survey

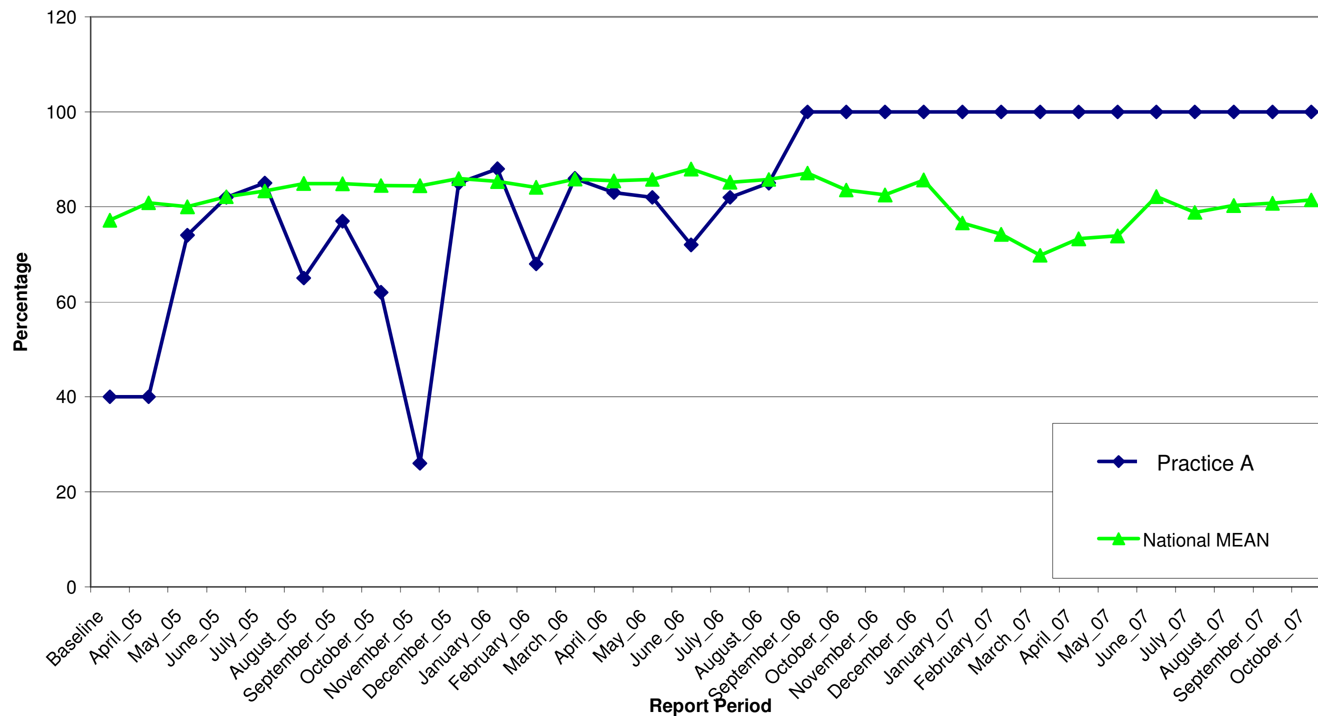
Collated results are shown in Attachment 9 of the report.

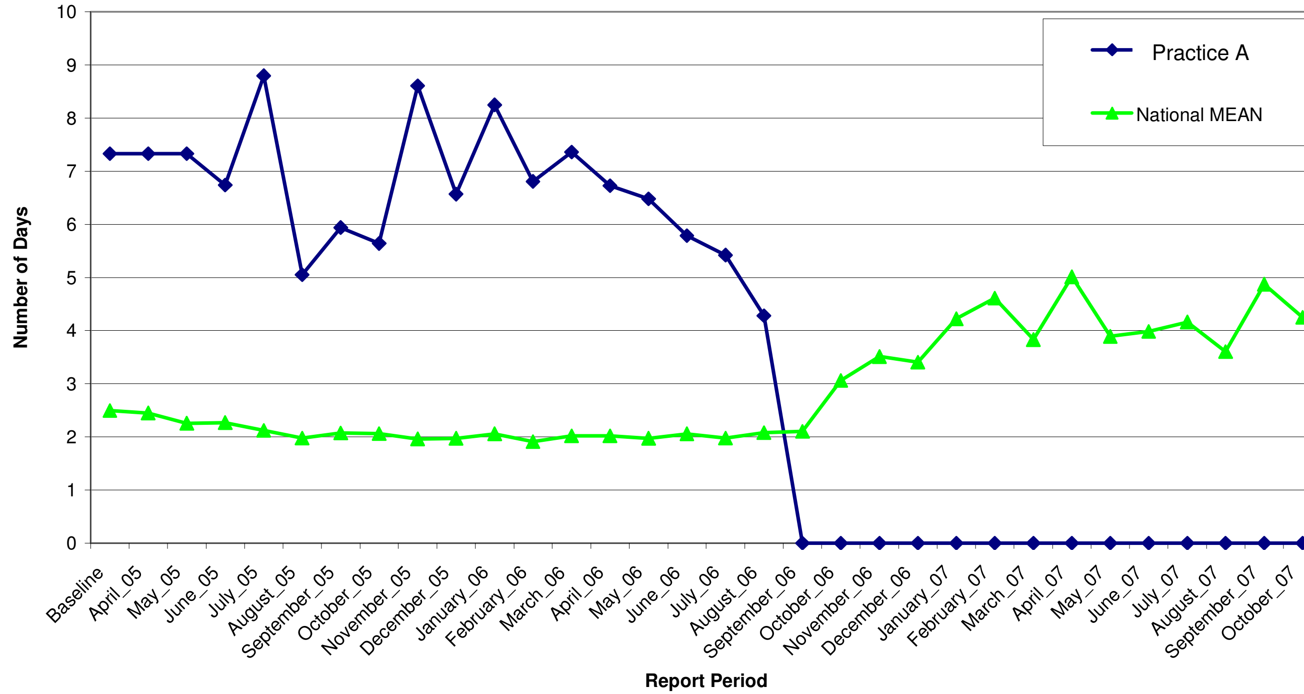
Lessons Learnt

Since implementing the Better Access model, the practice had made several reflections on the model. In particular, the importance of having leadership with a sound understanding of the model is paramount. As some people (patients and staff alike) are not comfortable with change, the practice has found that having knowledgeable people who are also committed and enthusiastic has been a major driving force.

In addition, the practice has emphasised that the system requires constant monitoring and refinement to ensure that it is continuously adapted to the patient's needs. It does not work as a once off change.

Practice A - Access Measures




Number of Days until the GP 3rd available appointment. Practice vs. National Mean
Trends of Remaining Practices. Wave 1 Month 31 (October 2007)
Practice A
National MEAN
Number of Days
Report Period
10
9
8
7
6
5
4
3
2
1
0
Baseline
April_05
May_05
June_05
July_05
August_05
September_05
October_05
November_05
December_05
January_06
February_06
March_06
April_06
May_06
June_06
July_06
August_06
September_06
October_06
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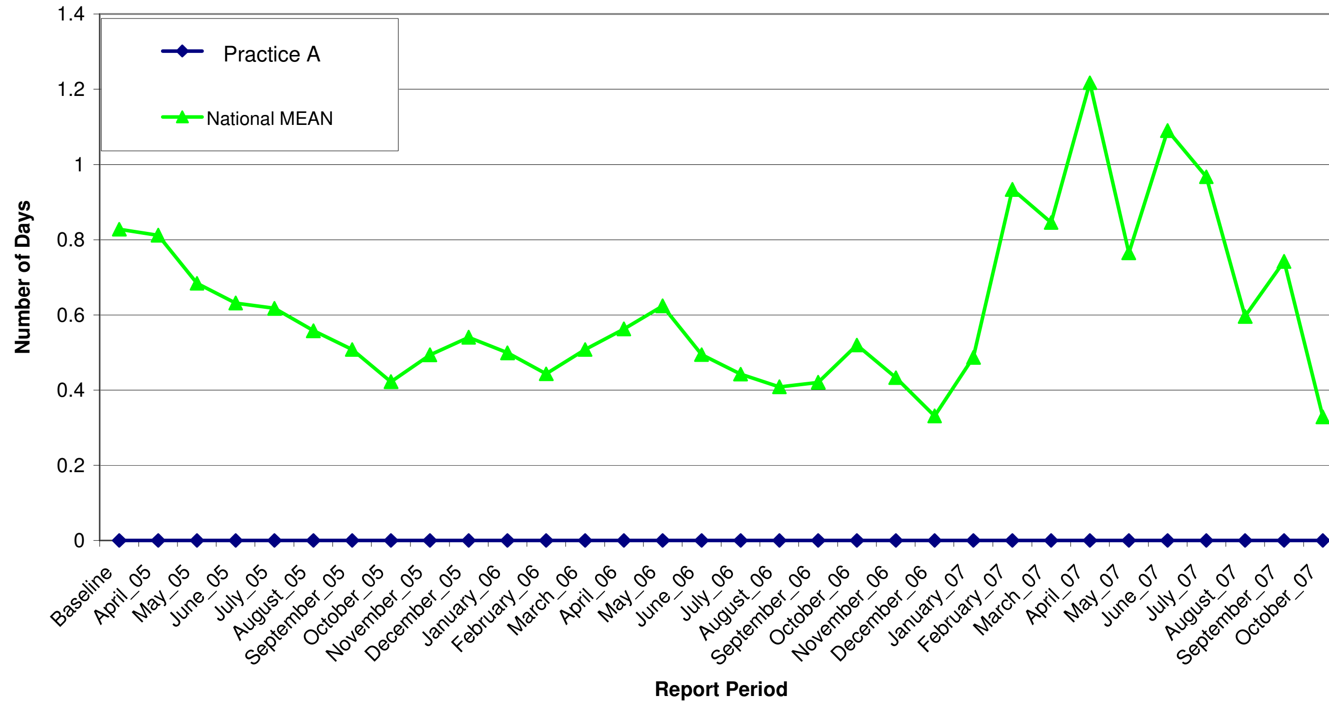
October_07



Number of Days until the Nurse 3rd available appointment. Practice vs.National Mean Trends of Remaining Practices. Wave 1 Month 31 (October 2007)
Practice A
National MEAN
Number of Days
1.4
1.2
1
0.8
0.6
0.4
0.2
0
Baseline
April_05
May_05
June_05
July_05
August_05
September_05
October_05
November_05
December_05
January_06
February_06
March_06
April_06
May_06
June_06
July_06
August_06
September_06
October_06
November_06
December_06
January_07
February_07
March_07
April_07
May_07
June_07
July_07
August_07
September_07
October_07
Report Period

Attachment 11 – Case Study, Practice B

Practice B Profile

Practice B is an established practice in an urban area of Queensland, which has been operating for 30 years and is now seeing third generation children! Practice B is a busy practice with 4 FTE GPs (7 GPs in total), who are supported by 2 part-time Practice Managers (1 FTE). In addition, there are 4 reception staff members (3 FTE) at the practice and 1 part-time Practice Nurse (0.8 FTE). Practice B provides a holistic service to their patients with the assistance of a mental health practitioners, podiatrist, musculoskeletal specialist and dietician available to patients. Practice B has been designated as a workplace shortage area as well as an area of need.

Practice B has 13,633 active patients on its database at present (based on patients seen in the last 36 months) with good distribution across the age groups. The largest age group is 60-70 years with children coming in second. The average age of patients seen in the practice is 38.5. The practice has a cross section of mid to high income earners with a small group of lower income earners. The most common conditions treated within the practice are CHD, diabetes and lung diseases such as asthma.

The practice is currently using Medical Director 3 as their clinical software program and PracSoft as their billing package.

Practice B's Access Journey

As an established practice, several of the staff at practice B had been working there for some time. The principal GP has been there for 29 years and the Practice Manager has been working at the Centre for 10 years. Both were ready for a new challenge! Armed with the desire to face a challenge and with the goal of improving the quality of service provision in mind, the principal GP and Practice Manager joined the NPCC in 2005. Prior to entering the NPCC, the practice was aware that they had an access problem with patients facing lengthy waits to see their GP and the practice staff working long, stressful hours. This access problem was validated when the practice calculated their GP third available appointment, which was 4.25 days across the practice in April 2005. Furthermore, the Day of Choice survey indicated that only 58% of patients were seeing a GP on the day that they had ideally wanted.

Practice B recognised that their GPs were working increasingly long hours and that a more multidisciplinary approach was required in order to provide improved quality of services to their patients. In fact, in 2001 they had tried to recruit another GP but had no luck with this. The lead clinical general practitioner and Practice Manager attended NPCC workshops and heard from other practices about the value that a Practice Nurse could bring to the team and the ways in which these practices were successfully utilising their Practice Nurses. The GP and Practice Manager returned to their practice with the thought that engaging a Practice Nurse would be a positive move for the practice in terms of improving efficiency and freeing up the doctor's time. Armed with this knowledge, practice B wrote a PDSA focused on employing a Practice Nurse. Within a month, this PDSA came to fruition and the practice employed a Practice Nurse, who is now an integral part of their practice team. Interestingly, since doing work on the NPCC program, the practice has also attracted two doctors and a dietician.

With the addition of this staff member, practice B now had some extra capacity within their practice. They set off looking at the Access topic in a systematic way. They started with the measurement of their demand and capacity, which was done by the reception staff. Using this information, they began shaping the handling of their demand. They instigated the important measures of reducing the routine care on busy days and utilising the team more effectively. Monday was measured to be consistently the busiest day in the practice. Consequently, an early PDSA involved educating staff and patients that Mondays were not for routine care and thus routine appointments such as follow-ups should not be scheduled for a Monday.

The practice also began using the Practice Nurse, initially to take workload off of the GPs by performing 'non-essential procedures' such as wound dressings and vaccinations. These types of changes were partially successful, however, it was soon realised that the type of changes required to improve access required a behaviour change by patients. To effectively carry out patient education, it was important that initially the general practitioners and staff were kept abreast of any changes that were happening at the practice and the reasons for these changes. Information provision occurred mainly through practice meetings, which occur monthly. The Practice Manger had tried using memos to provide information to GPs, however, it was found that this approach did not work very well as the memos usually just ended up within the rest of the doctors paperwork.

Patient education was done with a number of approaches including the use of information cards that were handed to each patient and posters displayed in the waiting room. Education was also done verbally by the front desk staff and by the Practice Manager and this was found to be the most effective approach to patient education as it allowed patients the opportunity to ask questions and ensure that their concerns were immediately addressed.

<u>The Current Appointment System</u>

The majority of changes have been made to the lead GP's appointment system. This GP sees a high proportion of elderly patients, who had previously pre-booked monthly appointments for the entire year. These patients wanted to ensure that they were given the appointment of their choice, which was early in the day. The practice found that this was having a negative impact on their access picture. Interestingly, however, these appointments were not accompanied by a high level of DNAs as might be expected. The practice tried many approaches to get their access situation back into a manageable time frame. Initially, they started blocking off more appointments each session, which were then released on the day. Following on from this, they only allowed appointments to be made two weeks in advance. In the current system, this GP (who is the most senior and popular GP at the practice), has both pre-booked and same day appointments available. Appointments at 8:30 and 8:45 are held for quick scripts. There is also one appointment per hour held aside for same day care. This GP allows his patients to book for a maximum of one month in the future. The other GPs at the practice have varying levels of pre-booking, however, the majority have a GP third available appointment between 0-3 days. The addition of a Practice Nurse has been especially helpful to the practice's access as the PN is responsible for triaging patients and does the initial assessment on all emergency appointments.

The overall effect of these changes is evident in practice B's measures. Their GP third available appointment has fallen to 1.69 days in September 2006, accompanied by a Day of Choice survey percentage of 90%, indicating that patient's were certainly more satisfied with their ability to access a GP. And the GPs were, perhaps for the first time in a number of years, able to routinely have a lunch break.

Work on the Access topic has occurred concurrently with the work on the other clinical topic areas of CHD and diabetes. The result has been a shift in thinking away from reactive care to the provision of more proactive care. An example of this proactive thinking is a PDSA written by the practice in July 2005. The PDSA describes the plan to have the Practice Nurse undergo training to become a diabetic educator. This will provide the practice with the capacity to commence diabetic education clinics to provide effective, efficient care to their patients.

Initially some GPs were concerned that patients would find it difficult to change their established ways of accessing care and would consequently not be happy seeing a practice nurse. However, this was found not to be the case and ultimately the Practice Nurse has been positively received by patients and staff alike.

As indicated above, Practice B has made consistent improvements in Access. However, it is important to note that these improvements have occurred alongside improvements in the clinical areas of CHD and Diabetes, showing that there has not been a reduction in the quality of care provided to their patients.

Access Study Data

Access Measures

See attached.

Staff Survey

Two responses were received for the staff survey, the results of which show that the work undertaken on the Access topic has generally been positive. All respondents strongly agreed that the Access topic empowered them to make changes at the practice, especially as the workshops provided actually strategies to improve access. There was differing views on whether the Access topic had improved the practice's business efficiency as any improved outcomes were inconsistent, often due to season variations. However, respondents agreed that the practice runs more efficiently since commencing work on the Access topic. Stress was noted as an issue with all respondents agreeing that they still experienced some level of stress when dealing with patients. Overall, respondents felt that the work undertaken on Access had been beneficial, especially as it encouraged all staff to continually improve and challenge their thinking. Furthermore, staff have an improved level of knowledge on this subject. Networking and the opportunity to exchange ideas with peers were described as the best aspects of the work undertaken on the Access topic. The greatest challenge was convincing patients and staff of the need to instigate change. Time was also identified as a significant hurdle.

Patient Survey

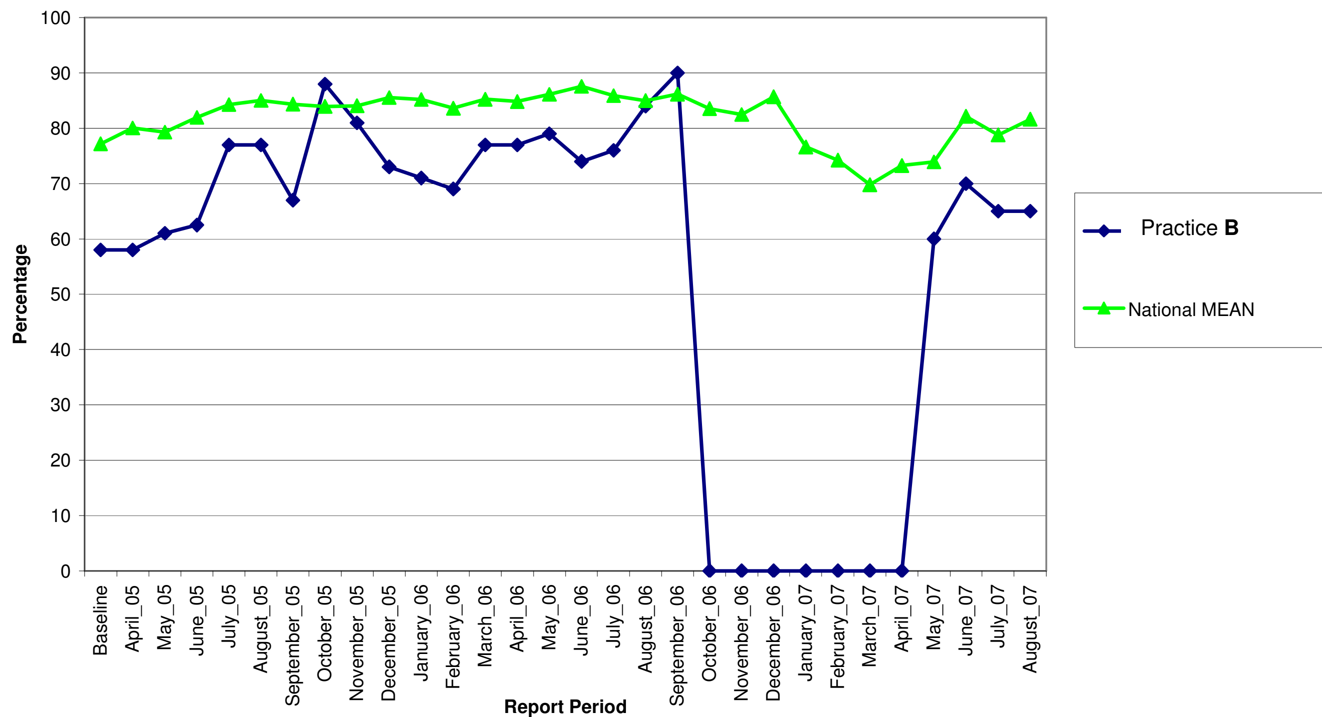
Collated results are shown in Attachment 9 of the report.

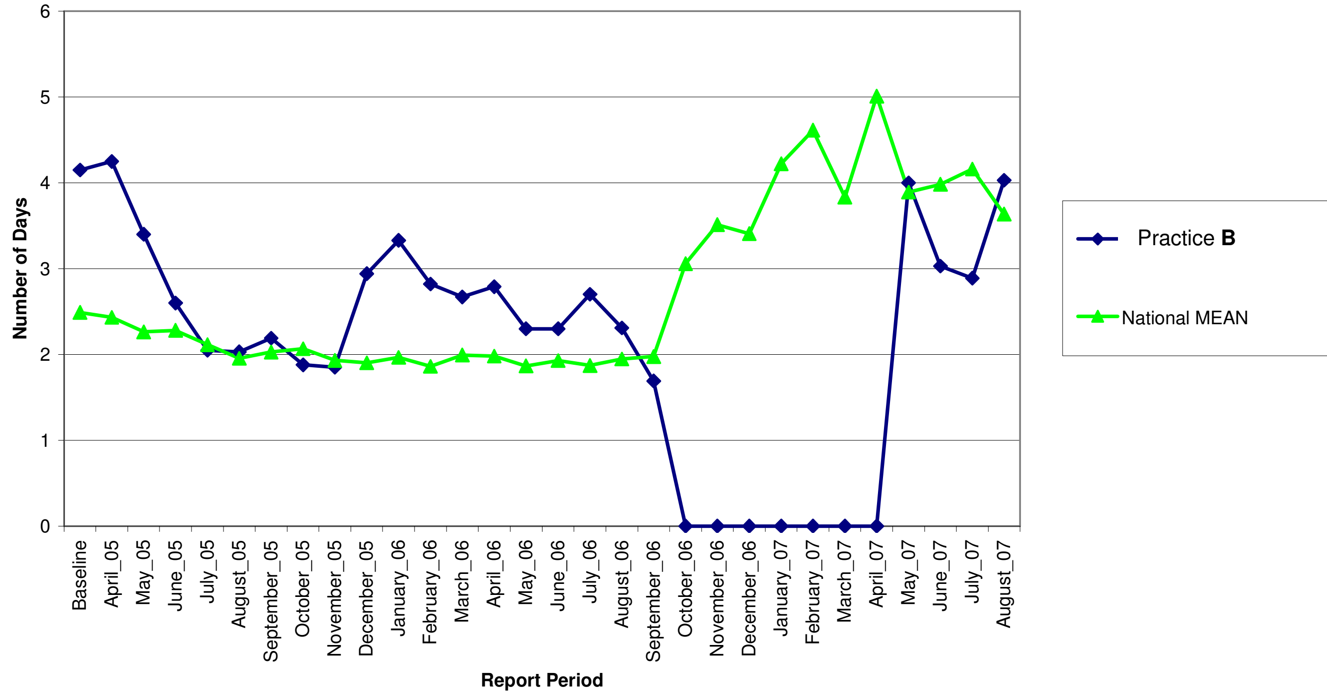
Lessons Learnt

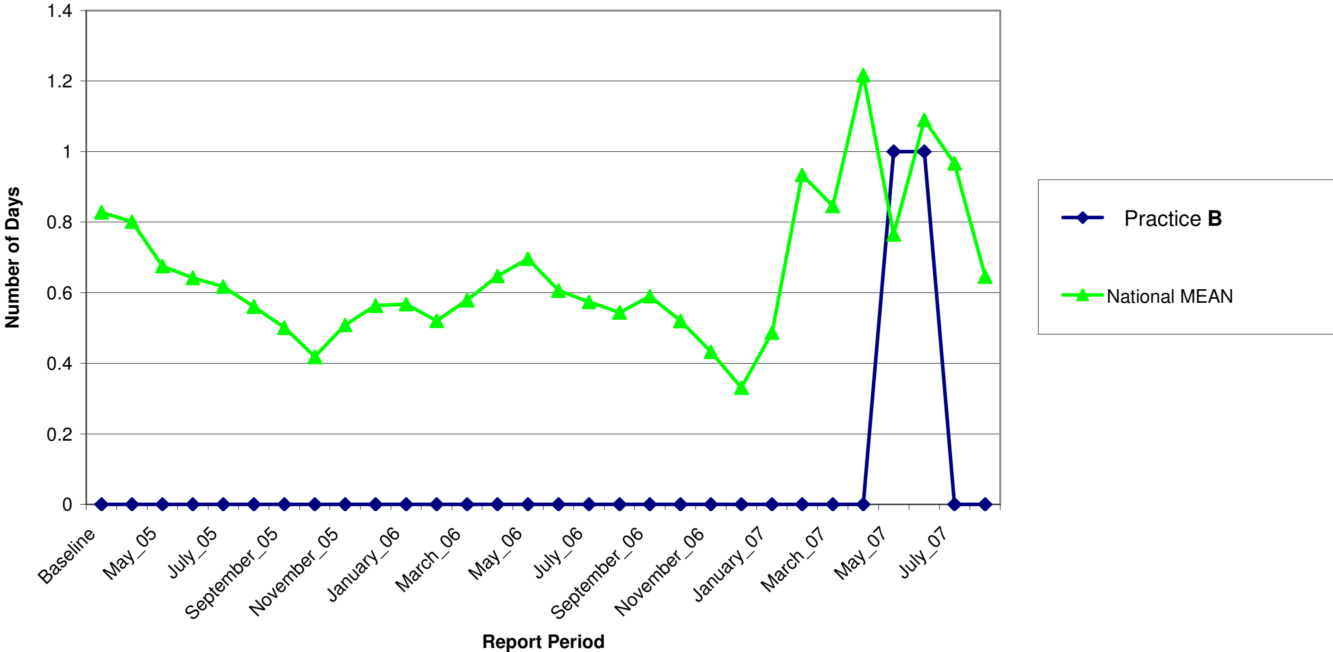
Throughout the course of their work on Access, this practice has made several reflections. The lead clinical and practice staff that were involved in the NPCC have always been open to change and willing to embrace new ideas. However, through the work on Access, they have come to realise how important it is to educate staff and patients thoroughly in the change that they are planning on bringing about in the practice. Ensuing that the team understands and is committed to the change is fundamental to its success. Just as important is ensuring patients understand the change and what it means to them.

The other crucial factor is time. The practice has realised the importance of ensuring that there is sufficient time, not only for people to ask questions and understand the change, but also time required to maintain the change and constantly improve. This involves setting aside time to record the measures and monitor the situation. Finally, ongoing commitment is required for any change to be maintained.

Practice B – Access Measures




Number of Days until the GP 3rd available appointment. Practice vs.
National Mean Trends of Remaining Practices. Wave 1 Month 29 (August 2007)
Number of Days
6
5
4
3
2
1
0
Baseline
April_05
May_05
June_05
July_05
August_05
September_05
October_05
November_05
December_05
January_06
February_06
March_06
April_06
May_06
June_06
July_06
August_06
September_06
October_06
November_06
December_06
January_07
February_07
March_07
April_07
May_07
June_07
July_07
August_07
Report Period
Practice B
National MEAN



Number of Days until the Nurse 3rd available appointment. Practice vs.National Mean Trends of Remaining Practices. Wave 1 Month 29 (August 2007)
Number of Days
1.4
1.2
1
0.8
0.6
0.4
0.2
0
Baseline
May_05
July_05
September_05
November_05
January_06
March_06
May_06
July_06
September_06
November_06
January_07
March_07
May_07
July_07
Report Period
Practice B
National MEAN

Attachment 12 – Case Study, Practice C

Practice C Profile

Practice C is located in Gladesville, an urban area of NSW. It is a medium sized practice with 4 FTE doctors (there are 5 doctors at the practice, one of whom is currently seconded to another organisation). They are supported by a FTE Practice Manager, 4 FTE practice receptionists and 1 FTE Practice Nurse. To provide a holistic service to their patients they are able to provide an immunisation service and home visits. The practice has a number of special areas of interest which are: family medicine, shared care (antenatal), cardiovascular risk management, diabetes care, paediatrics and minor skin surgery. Located adjacent to the practice is a physiotherapist which their patients can access.

The practice's active patient population (based on patients seen in the last 18 months), is 10, 196 patients. The practice sees a varied patient population; the following table presents a breakdown of the top patient age ranges seen:

Percentile	Patient Age Range
1	35-39 years
2	0-4 years
3	40-44 years
4	30-34 years

The practice sits in a medium area with regards to advantage. They are above the national & NSW average for advantage/ disadvantage, however, they are slightly below that of the division. Finally, the practice sees the following chronic disease profile (which is based on their 15 month patient population of 7425): asthma 338; cardiovascular disease 435; diabetes 141; mental health 149.

The practice is currently using Medical Director 2 as their clinical software program and Remedy as their billing package.

Practice C's Access Journey

The Access data presents a good picture for Practice C. The day of choice survey has been consistently at 100%. The GP third available appointment averages 1.01 days over the last eleven months, with a range of 0.9-1.2 days. It would appear from this data that their access situation has been consistently good since participating in the National Primary Care Collaboratives, which the practice joined in Wave 3 (June 2006). This practice was approached by their Collaborative Program Manager to participate in the Longitudinal Access Study. As their access situation had always been positive, it was felt that this practice could contribute to the learnings of the NPCC. Reciprocally, the practice felt that they could be a valuable asset to the study as they could share their understanding and experience in clinical and business systems.

Prior to being involved in the NPCC, practice C ran a hybrid appointment system. Their doctors ran standard 15 minute consults, with the exception of one doctor (GP) who ran an open access system. GP saw a largely ethnic population base, who was satisfied with the open access system and, on the whole, was not bothered with

waiting (sometimes lengthy periods) to see him. GP had been thinking of reducing his time at the practice due to a desire to shift focus to be more involved in the RACGP and in teaching. Through their involvement in the NPCC, practice C had a shift in thinking about their appointment system and combined with GP's intentions to decrease his hours, the practice decided that having an appointment system was actually a more effective and efficient way of seeing patients. This decision was reinforced through the NPCC hand book and from hearing other practices talk about their systems during NPCC workshops. The decision was made that GP, who ran an open access system, would move to an appointment based system. It was thought that the only way GP could manage his patient load was by having his appointments well managed, which was only possible in an appointment based system. Interestingly, this GP is the principle of the practice and therefore in a position to instigate such a change.

Along with the Practice Manager, GP decided that he would commence an appointment based system in January 2007. A staff meeting was held in October 2006, in which this decision was announced to the practice team along with an implementation plan. With the exception of one senior practice receptionist, the remainder of the team were happy with this decision. Patient education also commenced in October and patients were advised that they could begin booking appointments as of December 1 2006. On January 1 2007, as planned, GP began running an appointment based system.

The transition from an open access system to an appointment based system was difficult. Although GP was committed to this change, and therefore positive, the open access system was ingrained in his patient's behaviour. A large shift in patient behaviour was thus required to convert these patients to an appointment based system. Practice C decided that their approach to changing patient behaviour would not occur through information distribution on a large scale (e.g. mail-outs) but instead through individual patient education. As previously mentioned, the GP saw a largely ethnic patient population. Due to the relationship that GP had with his patients and the fact that some of his patients primarily spoke a foreign language, GP decided that it would be most appropriate if he did the initial patient education around the new appointment system and the reasons for this change. This education was reinforced by the reception staff when the patient went to the front desk.

GP was committed to his patients and ensured that every patient was seen during this transition period. Some patients had the appointment system explained to them and were satisfied with booking an appointment in the next available slot, whether today or another day. Other patients were seen on the day. The transition period from open access to an appointment system took approximately 3 months, and the initial phase was described by the Practice Manager as chaotic. He stated that staff, at times, had wondered whether they had done the right thing. However, in the end the Practice Manager has described the new system as a win-win situation where patients, doctors and the practice's staff are happy with the new, streamlined appointment system. It has been so successful, that it has allowed GP to decrease his consulting time by one day, while retaining the same patient load. When questioned about whether they felt that any patients had been lost during this transition, the Practice Manager thought that there might be the possibility that some patients had been lost, however, found

this difficult to determine due to the fact that a certain percentage of patients had always been transient. Any losses were thought to be of a non-significant proportion.

Another significant change to the practice as a result of their participation in the NPCC was the introduction of a Practice Nurse. The use of a Practice Nurse has been a prevalent topic during the workshops and the optimal use of a multidisciplinary team is a change principle in all of the NPCC topic areas. Practice C decided that they could effectively utilise a Practice Nurse and, in February, hired a Practice Nurse who would take regular bookings for generalist care. The 3AA for the Practice Nurse has been consistently under one day. Their multidisciplinary approach to care is being further expanded with the introduction of diabetes and cardiovascular clinics. Through the assistance of a pharmaceutical company, they will be implementing diabetes clinics in September.

The Current Appointment System

The changes to GPs appointment system has brought him in line with the appointment system used by the other doctors in the practice, which is based on a standard 15 minute consult. There are no variations in appointment types, however, a short or long appointment can be requested by the patient or GP. It has been eight months since this transition and the Practice Manager states that it is working successfully for both the practice and patients.

Study Data

Access Measures

See attached.

Staff Survey

Not completed.

Patient Survey

Collated results are shown in Attachment 9 of the report.

Lessons Learnt

The work that they have done on Access has certainly been beneficial for this practice. In terms of lessons learnt through the course of this work, the Practice Manager has noted the following areas of improvement and/or learning:

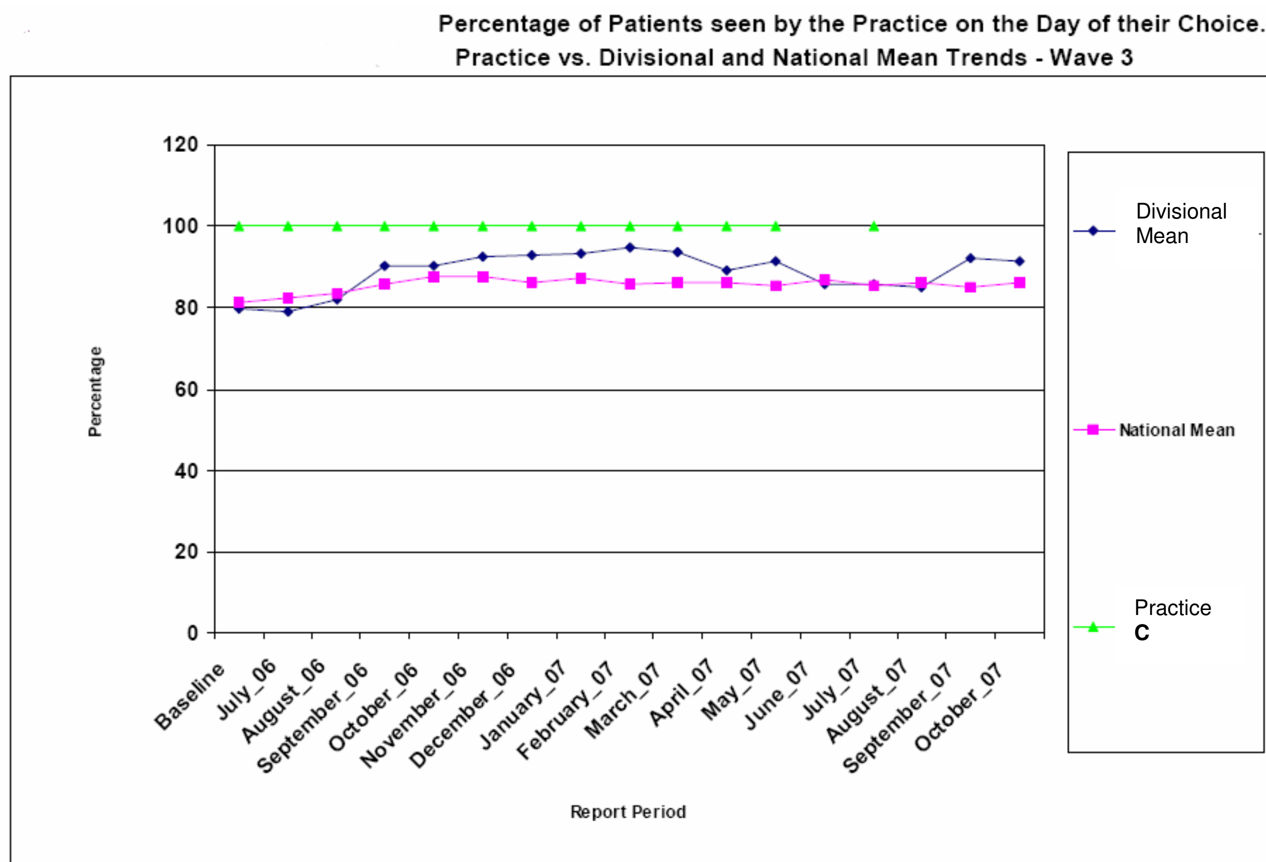
- Better management of both doctors time and staff time.
- Streamlining of patient management (throughput and health outcome).
- Ability to involve the Practice Nurse in patient management (without an appointment system, I think this would not be achievable)
- Peer group involvement with other NPCC members allowed us to define what system best suited our needs – take advantage of currently used practices by GP's
- NPCC showed the importance of health outcomes by providing better access to the patients needs and doctors need
- Patient number management – although I wonder how a practice can grow, without the cost of employing another doctor once access has achieved 100%

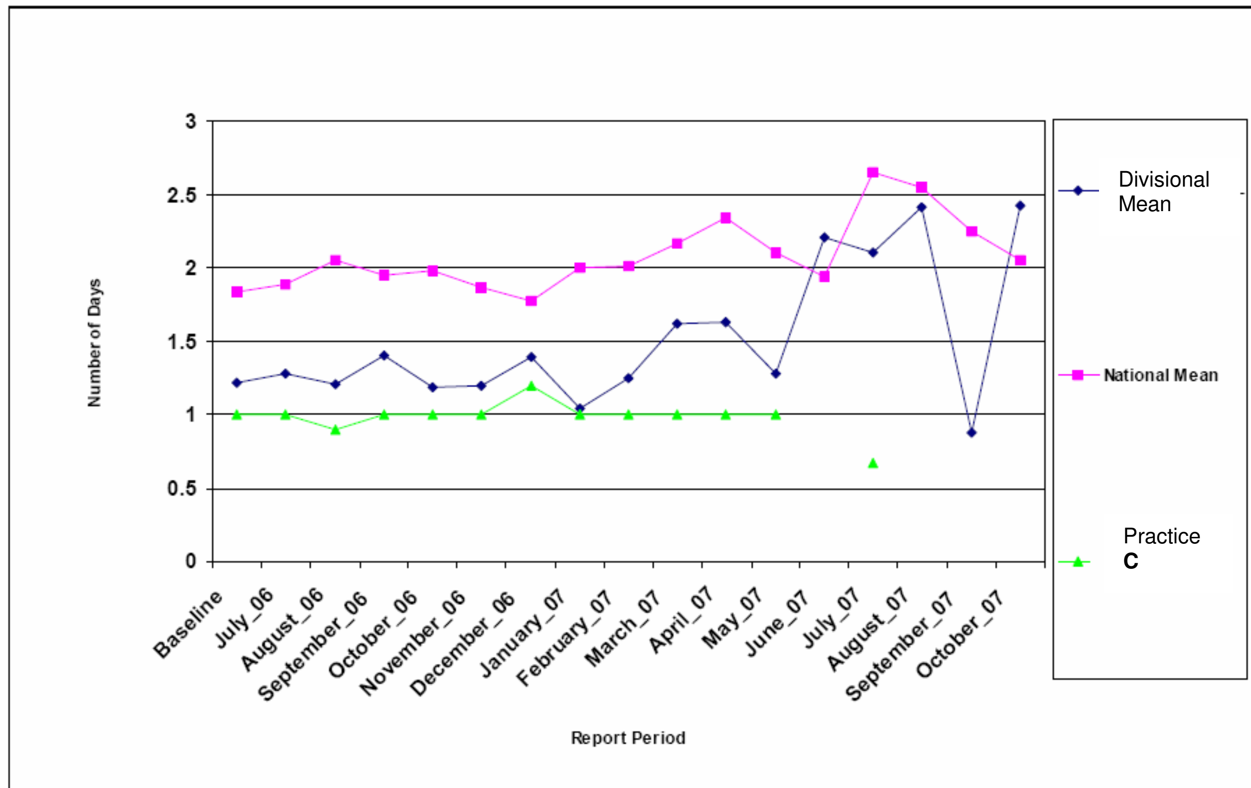
With regards to the Access Study data that was collected, the Practice Manager has found that extracting this data has allowed him to closely analyse both the doctor's time and the staff time and the financial return to the practice for that time. Further analysis will allow him to make both financial changes and clinical changes in the practice to achieve better outcomes overall.

Notes

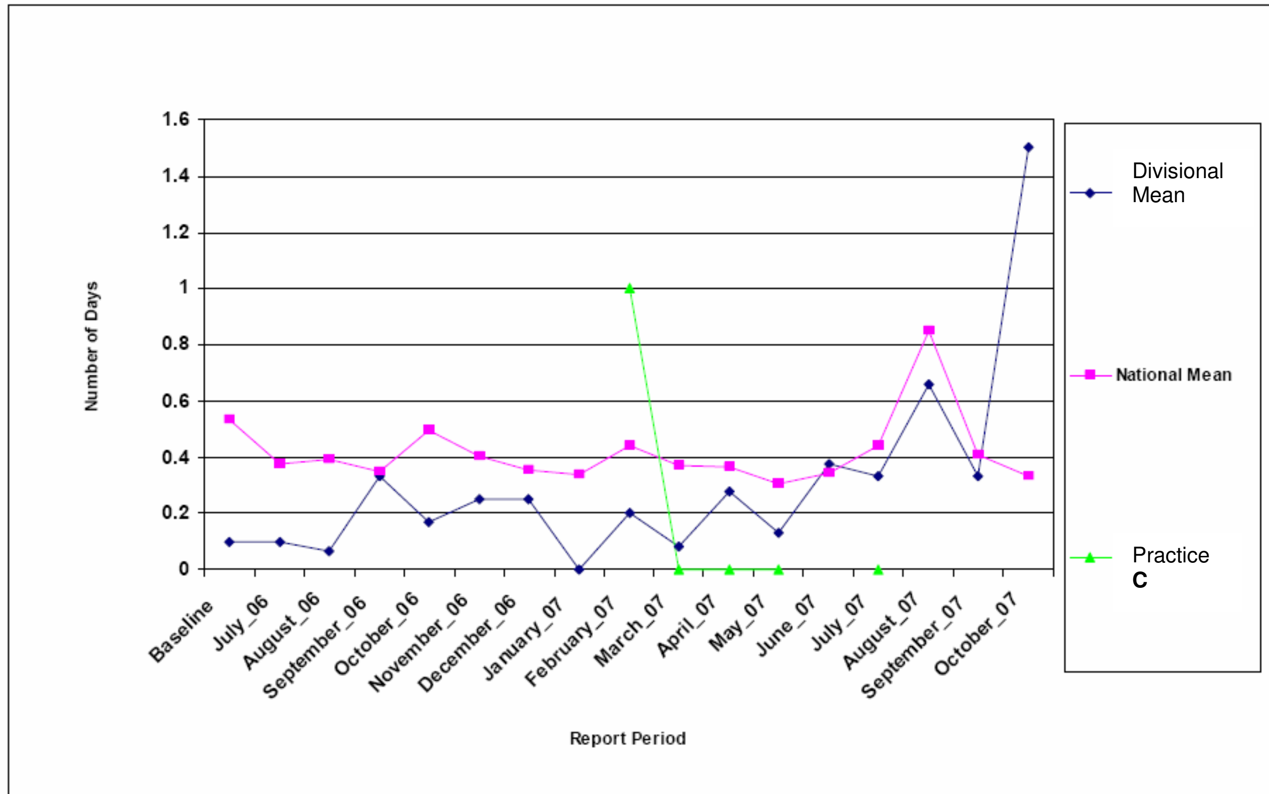
The GP third available appointment may not be a useful measure for improvement in Practice C. As they initially ran an open access model for GP, the calculation for 3AA would not have included GP. However, this measure would have included GP after January 2007, when an appointment based system was implemented. Therefore, this measure may not be valid for a pre and post implementation comparison.

Practice C – Access Measures





No. of days until the GP 3rd available appointment.
Practice vs. Divisional and National Mean Trends - Wave 3
Number of Days
3
2.5
2
1.5
1
0.5
0
Baseline
July_06
August_06
September_06
October_06
November_06
December_06
January_07
February_07
March_07
April_07
May_07
June_07
July_07
August_07
September_07
October_07
Report Period
Divisional Mean
National Mean
Practice C


No. of days until the Nurse 3rd available appointment.
Practice vs. Divisional and National Mean Trends - Wave 3
Number of Days
1.6
1.4
1.2
1
0.8
0.6
0.4
0.2
0
Baseline
July_06
August_06
September_06
October_06
November_06
December_06
January_07
February_07
March_07
April_07
May_07
June_07
July_07
August_07
September_07
October_07
Report Period
Divisional Mean
National Mean
Practice C

Attachment 13 – Case Study, Practice D

Practice D Profile

Practice D is located in the rural district of Young, which is in the South West region of NSW. Practice D is a busy practice with 7 GPs, who all work a full time case load. The practice is governed by an associateship arrangement; there are 4 associates and 2 contractors. In 2005, one of the associates joined the National Primary Care Collaborative Program and has been a driver of change within the practice since commencing the program.

A few years ago the practice become involved in the training program and now has access to registrars. They currently have one registrar at the practice, however, find that the changing number of registrars has an impact on their access picture. The General Practitioners are supported by a nursing team consisting of 3 Practice Nurses (2 FTE), one of whom is an EPC nurse. The nursing team also consists of 2 Enrolled Nurses (1 FTE). The clinical staff are supported by a large reception and administrative team. Most days of the week, there are a minimum of three front desk staff supported by one telephonist. There are 10FTE administrative staff, who are under the direction of 1 Practice Manager (0.8FTE) and an Office Manager (0.8FTE).

The practice has visiting allied health providers including a foot care nurse and general counsellor, who both work once a fortnight. Furthermore, they have several visiting specialists: gastroenterologist, endocrinologist, two general surgeons, paediatrician, dermatologist and respirologist.

The practice is located 1 km from a hospital and the practice’s doctors service the local hospital as well as the retirement village and 26 bed rehabilitation & palliative care facility.

The practice sees a patient base of roughly 16000-17000 patients. Due to shortages of medical services in the area, this practice services patients from surrounding shires, resulting in a high patient population. With regards to chronic disease profiles, the patient sees a significant portion of patients with diabetes and CHD, with registers indicating that they currently have 274 CHD patients and 441 diabetic patients. They also see a significant number of asthmatic patients. In addition, the practice anecdotally reports an increasing number of clients with psychological conditions, in particular depression.

The practice is currently using MD3 as their clinical software program and Mediflex as their billing package.

Participation in the Access Study

The practice recognised that access had always been an issue and felt that it needed to be addressed. Although they had tried a few different strategies throughout the years, they continue to have problems with balancing the needs of their acute and chronic disease patients. The lead staff participating in the NPCC, thought that partaking in the Access Study would provide a vehicle to systematically analyse their access problem.

Practice D's Access Journey

Practice D started their work in access initially by looking at their Did Not Attend (DNA) appointments. They measured the number of DNAs at the practice for one week. The practice found that their DNAs were not particularly high even though they had an access problem. This led the practice to start looking more systematically at their access situation.

The practice started measuring their demand, initially for a two week period. Although this showed a trend, it soon became apparent that the practice needed a greater measurement range in order to get a more robust and reliable data set. Further examination revealed that "on day" demand was heaviest for Monday, which is consistent with national findings. When this was matched with capacity, however, it was determined that requests for on day appointments did not outweigh capacity. Further research was then done to determine whether this demand may have been due to doctor's requests for patients to rebook or whether it was due to patient requests for rebooking. The practice found that rebooks were not as high as initially anticipated, with only 33% of patients being booked in the future.

The practice also looked at appointment times and delays that patients often experienced when the doctor was running late. This led the practice to do a patient education campaign around the significance of the standard consult time of 12-15 minutes. On the back of 10,000 encounter sheets, the practice printed information on the meaning and significance of the standard consult time. Interestingly, the practice followed this up with a staff questionnaire to ascertain the impact of the campaign and whether staff felt it was a worthwhile thing to do. Overall, doctors felt that it was positive, however, reception staff did not have much feedback as they infrequently received any comments from patients. Due to the doctors' positive responses to this campaign, it was planned on being done again in 6 months time.

Another significant change made by the practice was their use of follow-up appointments. The practice was finding that follow-up appointments were representing a significant challenge on high demand days. Consequently, the practice made a deliberate effort of ensuring that follow-ups were done on the less popular days. Furthermore, they also instigated a strategy whereby only the GPs were allowed to book follow-up appointments. GPs were advised to write a follow-up request on a sheet that was handed to the patient when they were returning to the front desk. Although this strategy did produce some success, the practice found that on-day appointments were increasingly being used in place of follow-up appointments.

During all of these changes, practice D had been collecting information on the Access measures. The focus of their work on Access turned to the GP third available appointment measure, with the aim of reducing this measure, which was 10.49 days at baseline. This practice also collects Practice Nurse third available appointment, which was 2.6 days at baseline. The PN third available appointment reached 2.75 days at its peak, however, on the whole has remained under 2 days.

Armed with the goal of reducing the GP 3AA and with the knowledge that demand does not outweigh capacity, they instigated a trial. Two doctors were chosen for this trial, which involved transforming the appointment system for these two doctors. The

main change involved reducing appointment variability for these doctors. Appointment booking types were reduced down to three types- standard consult, OD (on day) appointment and follow- up appointment. This new system was piloted for one month. Prior to the introduction of the one month trial, education sessions were held during staff meetings for both doctors and reception staff.

The practice also returned to their review of demand for each given day versus capacity. It was found that Mondays were the busiest days with Tuesdays and Thursdays coming in next. However, it was found that the most frequent day requested for bookings was Thursday. With this knowledge, the practice made important changes to their appointment system. They made available more OD and vacant appointments on the Mondays and Thursday. Furthermore, they shifted the follow-up appointments and procedures to the less busy days.

The Current Appointment System

One main feature differentiates the look of the appointment system before and after the practice undertook work on the Access topic; the extent of appointment type variability. Prior to the Access topic, the practice's appointment system had a number of different appointment types. Currently, they have four different appointment types: standard appointment, on day appointment (OD), follow-up appointment and antenatal appointment. Recently, the clinic has also started offering "Quick Clinics" to accommodate patients who require a very short appointment. These "Quick Clinic" appointments are for 1-1.5 hours per day and GPs work these clinics on a rotating roster. The appointments are designed to meet specific needs, including scripts, simple minor ailments and medical certificates. These appointments are for one problem only and this is monitored by having each patient write their most important concern on a slip of paper that is handed to the doctor. The doctor only addresses this concern and advises the patient to book another appointment if they have multiple needs.

Access Study Data

Access Measures

See attached.

Staff Survey

Two responses were received for the staff survey, both from management staff at the practice. Interestingly, these surveys clearly identified the role of GP members in driving change at the practice with regards to Access. The respondents did not feel that the topic had empowered them to make changes at the practice as the improvements were still dependant on doctor numbers and requirements. Respondents also did not feel that the Access topic had improved business efficiency or that the practice runs more smoothly. A specific mention was made of the instance in which demand exceeds supply and the difficulty of this situation. Furthermore, both respondents did not feel that work conducted on the Access decreased the amount of stress they felt when dealing with patients. They cited that stressed still occurred when patient requests could not be accommodated, however, the beneficial aspect of the work on Access was that it provided the practice with protocols for dealing with these situations. Although respondents did not feel that the changes have resulted in them

being happier at work, they did enjoy the challenge and the ability to source new ideas from other practices to solve a common problem.

Overall, the greatest benefit of the work undertaken on Access is that staff have been motivated to try to overcome their access problems. In particular, it has assisted with getting GPs on side to implement change and utilise data to direct the changes being made. The greatest challenge has been the effort required to obtain the data. In addition, the process of gaining agreement from the practice team to make a change can be challenging. However, everyone is willing to cooperate to achieve an outcome.

Patient Survey

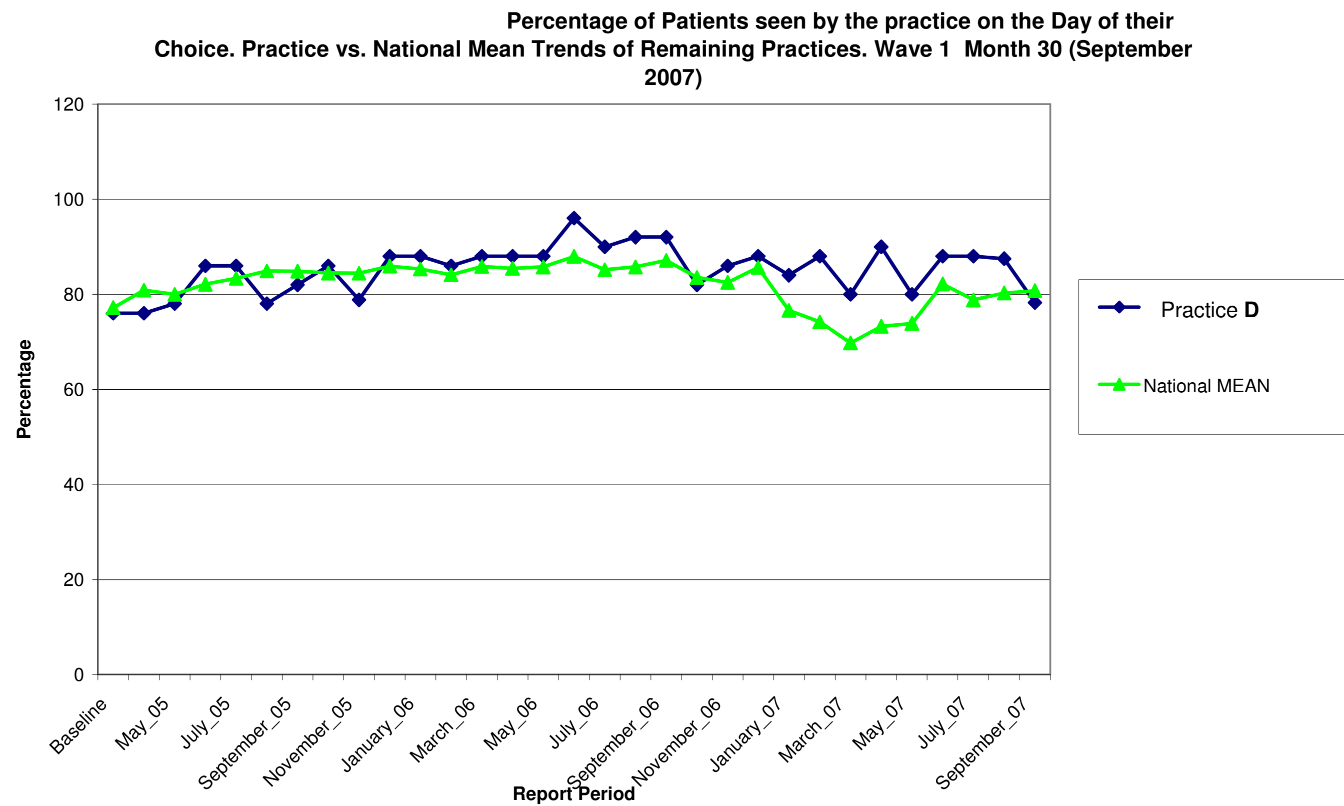
Collated results are shown in Attachment 9 of the report.

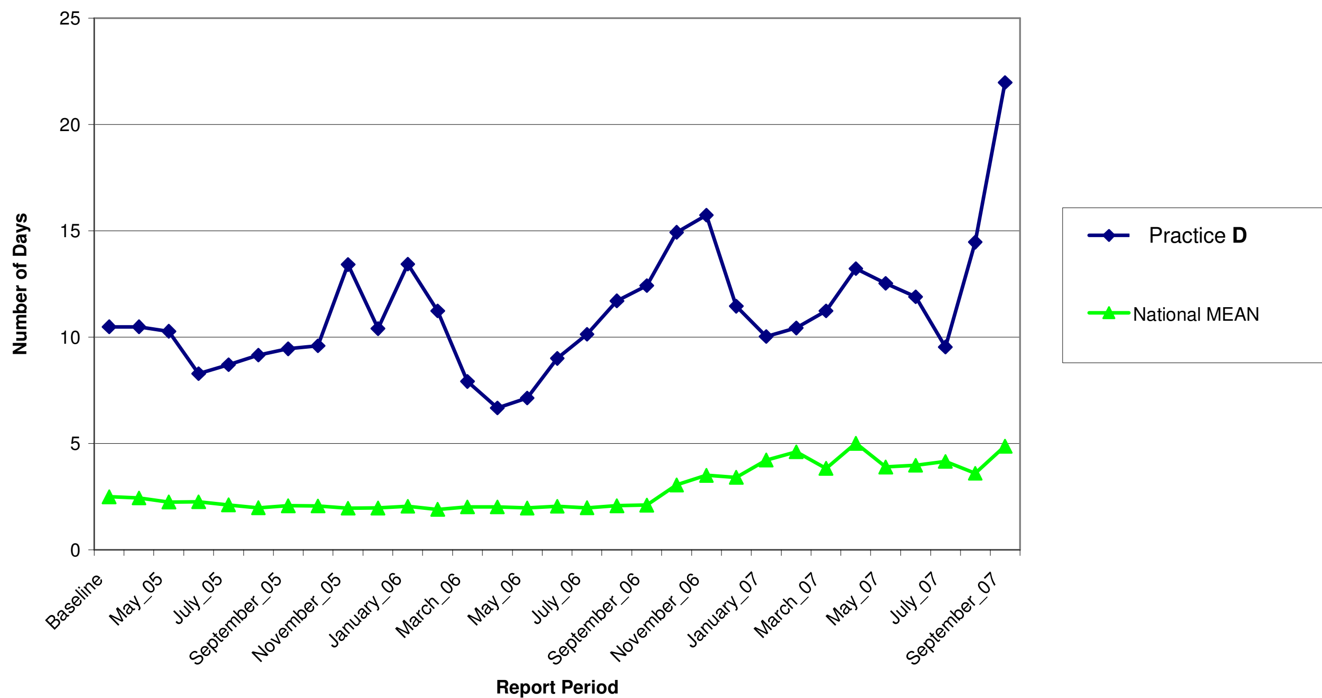
Lessons Learnt

Since undertaking work on the Access topic, this practice has had a number of insights the work that they have done on Access:

- The work undertaken on the Access topic has been important, however, the most effective method of dealing with patient demand has been to have enough General Practitioners consulting at the practice.
- However, there is scope to streamline the appointment system if General Practitioners are prepared to change the way that they practice medicine.
- The ageing of the population has impacted on the practice’s Access picture. An ageing population is related to a higher incidence of chronic disease that takes more GP time to deal with. Although Practice Nurses do assist with this work, ultimately it means that the GP sees a fewer number of patients.
- PDSAs are a valuable tool to involve staff in achieving a goal and measuring progress against this goal.
- Ultimately, the work involves never giving up- one must keep plugging away to get the desired results.

Practice D – Access Measures




Number of Days until the GP 3rd available appointment. Practice vs. National Mean Trends of Remaining Practices. Wave 1 Month 30 (September 2007)
25
20
15
10
5
0
Number of Days
Baseline
May_05
July_05
September_05
November_05
January_06
March_06
May_06
July_06
September_06
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March_07
May_07
July_07
September_07
Report Period
Practice D
National MEAN

Attachment 14 – Financial Consultant's Report

A Business Case for 'Better Access'

The objective of 'Better Access' is to ensure that:

The patient receives their appointment on the same day with their preferred provider.

A broad interpretation of the primary care team has been taken, which includes the ability for patients to select a Practice Nurse as their preferred provider. Ultimately the emphasis is on a multi-disciplinary primary care team model for general practice.

Are your appointments meeting patient demand?

Better access is all about getting supply and demand in equilibrium. A common myth is that demand is infinite. In fact, demand is not insatiable, but actually finite and predictable. 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.

Periods of high or low demand can be anticipated, based on an analysis of demand data collected on all requests coming into the system. A system based on Better Access uses these predictions as the framework to match its supply to the needs of a population of patients for any specific service. Therefore, measure supply, measure demand, and then compare the two.

Understanding the patterns of both demand and supply on a weekly, monthly, or seasonal basis is a fundamental prerequisite to instigating focused efforts aimed establishing a balance between these two variables. This may include shaping demand to match supply, and/or increasing (or decreasing) supply during periods of high (or low) demand.

Demand and supply can be said to be in equilibrium when there is no backlog of appointments and no delay between when the demand is initiated and when the service is delivered. A gap between supply and demand not only contributes to a delay in meeting patients' needs, but it can also be expensive and generate waste in the system.

Factors that affect Demand and Supply

The key determinants for demand are:

Practice population, type of services and provider specialty interests.

They key determinants for supply are:

1. Infrastructure

The nature and size of the practice, the number and type of consulting rooms available, location, easy access to public transport, IT services (e.g. computerised appointments, medical records and billing).

2. People

Understanding the vision and goals of the practice owners is paramount. Owners provide leadership that is fundamental for any change in organisational culture. Furthermore, patients' needs should be accurately assessed and matched with the appropriate staff skills and experience. A multi-disciplinary environment, encouraging the role of allied health professionals as part of the care team significantly increases capacity.

3. Systems & Processes

This involves the establishment of strong systems and procedures to manage work flows and measure patient satisfaction on a timely basis. Development of protocols that deal with clinic structure, staffing, appointments, patient education and how to use resources are critical.

What is the business case for 'Better Access'?

The business of medicine is an oxymoron; however they are not mutually exclusive concepts. Improved access to high quality care is dependent on the financial sustainability of a practice. Consequently, any change aimed at improving access to care needs to have the support of the key players in the practice. Practice owners are the most critical players and their leadership and ownership of the issue is fundamental to the success of any change effort aimed at improving access. We note all of the NPCC case study participants are practice principals.

Owners ultimately decide whether to support change within a practice. Understanding their role and some key factors that influence their decision making will assist in determining the best GP Access solution for a practice.

What is the Business Model of a General Practice?

The majority of practices generate their income by charging a fee or a percentage on the doctor's gross turnover or from income generated by employee doctors. A common rate is 40% of practice receipts. This fee or income is then used to meet practice overheads such as wages, plant and equipment, facilities and practice systems. The left over income is called profit. Profit is used to reward the owners of the practice for the risks they have undertaken in owning and operating practice infrastructure on behalf of their doctors.

Clearly, maximising the efficiency of appointment times and making the best use of practice infrastructure will maximise the profitability and sustainability of the practice. The main reason for this is because up to 85% of a practice's costs are fixed. Any incremental changes will have little or no impact on the cost of running a practice but can have a significant increase on practice profits. We shall explore examples of this later.

Does 'Better Access' increase an investment return?

The ability to increase patient appointment availability clearly increases the revenue opportunity available to the practice, which translates into increased profitability.

We recommend an "eat well, sleep well" approach. Eat well focuses on meeting the financial objectives of the practice. Sleep well refers to providing greater access and higher quality care within the financial parameters of the practice.

What changes can be made to improve the quality of patient access to general practice that will also yield a return on investment?

The principle of investing is simple. For any given level of activity this investment carries both an inherent risk and an implied return. The return is expressed in both financial and non financial terms. As a rule of thumb, an investment (spend) in practice operations should yield a 30% operating profit margin (also known as the "hurdle rate") on any additional revenue generated. So, for example, if you spend $7.00 then revenue should increase by $10. Therefore, an investment should generate a $3 profit to the owners.

To justify a change in activity, owners of a practice should either:

- satisfy the hurdle rate; or
- the activity should remain cost neutral where it can be demonstrated that the activity will result in a significant reduction in risk (and or improvement in quality).

Marginal loss activities must be avoided as they are not sustainable in the long term

Generally, the greater the perceived benefit the more likely there will be significant uptake of a change. When a change is not support, barriers frequently include the presence of significant financial and time obligations and/or the complexity of the proposed change. The requirement for a doctor to implement change should be kept to a bare minimum and where possible eliminated.

Improving quality in practice and investment returns can be assessed by reviewing two key areas:

1. **Assessing Risk**

   A key objective is reducing medico-legal and commercial risk. Examples include improving GP access, reducing misdiagnosis, improving patient compliance and reducing doctor burn out or stress.

2. **Financial Sustainability**

   A key objective is to ensure any changes do not adversely impact on the practice's finances. Patient loyalty and satisfaction is a good example. Increased patient dissatisfaction and/or no shows are key indicators of declining patient loyalty and increased medico-legal and commercial risk. Such trends demonstrate a practice's indifference to patients. More importantly, this trend results in a "multiplier effect". For every one negative patient experience, another 8 patients may not attend the practice due to 'word of mouth'. Practices also lose the opportunity to increase fees or may experience higher fee disputes due to a perception of lack of service or care. Patients tend to be more to critical and open to litigation, which increases the stress level sof doctors and practice staff.

Example 1 - *Counting the cost of the multiplier effect*

Assume the average consult is $40 and every Australian visits a practice 5 times a year. One patient represents $200 of practice income per annum. They usually introduce family members, perhaps 4 persons per annum on average. As a minimum, one patient generates just under $1000 per annum.. Due to 'word of mouth', a negative patient experience can result in a loss of 8 patient visits to a practice. Overall, the practice loses a minimum of $8000 per annum.

Example 2 - *A business case for investing in a computer system to reduce no shows*

As an example, a new computerised appointment system costs $5,000 per full time equivalent doctor. However, this system is able to reduce the no-show rate by 20%. Based on 7,000 services (which is the average patient number per full time equivalent GP) a year, this equates to 1,400 patients or $56,000 ($40 per average patient fee x 1,400 p.a.).

Clearly, this demonstrates that implementing a change can be financially feasible if the impact of a problem is correctly measured and the right solution is implemented.

Example 3 - *Improved Access to Care using Care Teams to meet clinical targets*

A recent research paper from the Australian Parliamentary Library argues that Practice Nurses working in GP clinics could take more responsibility to improve the healthcare system. Practice nurses can help with wound care, immunisation, pathology collection and coordinating the care of patients with chronic diseases. Author Rhonda Jolly, said research into the "substitutability" of nurses for doctors shows *"nurses could assume up to 70 per cent of the work currently undertaken by doctors and that this could enhance the quality of primary care services*".

Childhood Immunisation Program

Medicare's Childhood Immunisation program allows Practice Nurses to see patients with no General Practitioner attendance. Depending on the practice size, immunisation clinics can see up to 2000 patients per annum. Dedicated speciality clinics can be run by a Practice Nurse using an appointment based system. This is not only efficient but also viable. Currently Medicare pays the practice $40.40 per patient. Practices with a spare consulting room are missing out on $202 per hour (assuming 5 patients per hour) by not implementing a dedicated immunisation program. Importantly, implementing this clinic will not increase the doctor's workload.

The bottom line is that lack of timely and continued access to care is not only a financial risk but also a medico-legal risk and quality issue.

Case Studies

Is there any anecdotal evidence to show that practices will be better off and/or not worse off, by moving to ‘Better Access’?

Five case studies were submitted for analysis. Each made changes during different periods in a 12 month cycle. Not all data was complete and not all changes were the same, other than a change improvement was made in each practice. The following summarises notable trends:

1. All practices reported a significant improvement in patient satisfaction and appointment waiting times. One practice operated under an open access system and there was a slight decline in access noted by changing their appointment system.

2. All practices reported a consistent 15% increase in practice overheads over their 12 month period. This was regardless of the level of income or patient activity. It is not clear whether this increase was due to the impact of the study or other external cost pressures.

3. The majority of practices reported an increase in practice fees as a result of improving their appointment system. Some increases were marginal whereas others were significant. Generally, GP contact hours also increased.

4. All practices reported a reduction in the number of items billed, however there was an increase in hourly rates.

5. Practices on higher hourly rates experienced a fall in their rates. Consequently, their overheads increased higher than those with a lower hourly rate. The contrary occurred for those practices with a lower hourly rate, which may suggest the existence of an optimal hourly rate.

6. For the majority of practices the billing rate per item appears to have slightly decreased even though the billing rate per contact has slightly increased. This suggests more patients are being seen with fewer items claimed.

All practices noted that moving to ‘Better Access’ requires clear communication, a commitment by the practice and strong leadership by the principals. It is difficult to make a conclusive statement as to the effect of moving towards ‘Better Access’. The 12 month study needs to continue for a further 12 months to make meaningful comparisons which measure practice specific improvements. The inter-practice conclusions also are limited. Different practices implemented different changes at different times of the year, which made this analysis difficult. Accordingly the comments in this report are general in nature.

There is no clear evidence to show practices are worse off with any change aimed at moving towards ‘Better Access’. Income and patient satisfaction is likely to improve overall.

Patient Demand and Supply Indicators

Setting practice measures that are easy and meaningful for practices to collect and analyse is critical to monitoring performance. The following structure should be used by practices. Measures should be carried out quarterly as a minimum, although monthly is preferred in order to track meaningful trends, especially seasonal or unusual highs and lows. This improves the practice’s ability to predict demand. No single ratio or measure can definitively determine whether the ’Better Access’ objective has been met. As a number of factors are interdependent on this outcome, it is important to evaluate a number of suggested ratios

before reaching an overall conclusion. This will better highlight any significant factors contributing to the health outcome.

Outcome Measures
Outcome measures tell a team whether the changes it is making are actually leading to an improvement — that is, helping to achieve the stated aim. For example, 50 percent reduction in delays in diabetic appointments, or 30 percent reduction waiting time in the doctor's practice.

Process Measures
Process measures tell a team whether a specific process change has been accomplished and whether it is having the intended effect. A team often establishes several process measures in the course of its work. The assumption is that improvement in a process measure will have an eventual impact on the outcome measure. For example, process measures might be the accuracy of registration information or the availability of x-rays at the time of the doctor's exam or sufficient doctor appointments per day.

Balanced Measures
This measure is used to make sure that changes to improve one part of the system are not causing new problems in other parts of the system.

Financial Measures
Use these measures to provide a broad guide as to whether any change being implemented has a financial impact on the practice's financial sustainability. These should be measured quarterly. A more accurate measure is achieved by comparing results on an annual basis. If external benchmark measures are available this would be a useful exercise. The key is to measure the financial impact before the change and then after the change.

Patient Demand and Supply Indicators

Patient Demand

1. Patient satisfaction

Percentage of patients seen on the day of their choice with their preferred provider

Formula: Number of patients rating their satisfaction with their choice of provider on the same day as "Excellent", divided by the total number of patients surveyed. Multiply the result by 100.

Goal: Greater than 80 percent of patients rating their needs were met as "Excellent".

2. Clinical Need Indicator

Formula: Number of doctors and practice staff rating their satisfaction that the practice has met their patient's need of their choice of provider on the same day as "Excellent", divided by the total number of doctors and practice staff surveyed. Multiply the result by 100.

Goal: Greater than 80 percent of doctors and practice staff rating their patients' needs have been met as "Excellent".

Measures 1 & 2 are quality outcome measures.

3. Practice population per Full Time Equivalent GP/Provider (based on 38 hours per week)

Formula: The number of regular patients, divided by the number of fulltime equivalent doctors and practice staff (based on a 38 hour work week).

Goal: No greater than 1000 patients per FTE GP/provider.

This ratio is a demand measure. It measures the number of regular patients that visit the practice divided by the full time equivalent GPs or providers. This gives an indication of the capacity that will be required to meet patient demand.

500 patients per FTE would indicate a lower patient demand requirement versus 1500 patients per FTE. This later figure may indicate a high patient demand and therefore lower patient satisfaction. Should a local practice close down this indicator will be sensitive to local conditions.

This indicator could clearly show where there is excess demand especially when it is compared to national averages.

The author has contacted Medicare Australia to determine whether the practice population per FTE provider can be released. They have confirmed that this information can be provided for a provider and a practice. The current childhood immunisation program uses a similar measure. A regular patient under this program is a patient who visits the practice more than twice in a given financial year. It is recommended that the NPPC program requests that this data is released annually or quarterly through PIP payment advice reports to all practices.

4. Daily Demand

Daily number of patient requests for appointments.

The wait time for an appointment is the difference between when the demand for that appointment is declared and when the supply is applied.

Demand is defined as the daily number of patient requests for appointments, no matter when the appointment is actually scheduled. It can be measured by the individual provider and even aggregated at the practice level. It can also be measured by the day and by the week. Demand data is most useful when compared with supply data (number of available appointments).

Demand for appointments comes from two sources: internal and external. External demand is generated when patients request an appointment, or are referred for an appointment. External sources are phone calls, walk-ins, faxes, emails, and 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

Goal: Less than Daily Capacity

Data Collection Plan:

On at least the same week each month, for each provider, collect data on the daily demand for appointments and tally results.

Supply Indicators

5. Daily Capacity

Daily number of clinic appointments (filled and unfilled).

The wait time for an appointment is the difference between when the demand for that appointment is declared and when the supply is applied. Therefore, it is important to understand supply and demand for appointments when trying to improve delays for appointments.

Supply refers to the total resources (people, equipment, offices and exam rooms) available to a clinic. When the total resources are managed well, a clinic creates openness in its schedule or space to care for patients.

Patients experience this openness primarily as the availability of clinic appointments. In most

systems, the amount of clinician time available for appointments is the bottleneck. Hence, capacity is the total hours of clinician time devoted to appointments.

Goal: Greater than Daily Demand

Data Collection Plan:

Determine the number of FTE providers available in a given period. Then measure the number of patient visits (per specific period) each provider is capable of seeing in the present system. Do this by multiplying the number of appointment slots per hour, then by hours per day. Multiply appointments per day by number of days per week (excluding time away from the practice) to obtain appointments per week. Multiply appointments per week by number of weeks per month (excluding time away from the clinic) to obtain appointments per month. This calculation shows approximately how many appointment slots (or hours of availability) each provider, or a system of providers, has available.

6. Doctor - Patient Turnover

Formula: The number of patient contacts divided by doctors' available time per hour.

7. Support Staff - Patient Turnover

Formula: The number of patient contacts divided by practice staff time available per hour.

Goal: No greater than 4 patients per GP/provider per hour.

These are efficiency and process measures that indicate whether sufficient time is spent with patients. If consults are more than 6 per hour, this would suggest insufficient time is being spent with patients and patients are being turned away. If consults are less than 3 per hour, this may suggest that better appointment management to increase access is achievable. This would also show whether there may be excess capacity with doctors and support staff that could be better utilised.

Note: 3rd Available Appointment – although this is an accurate measure, it not easy for participants to understand so it is not recommended.

Balancing Measures

8. Percentage of Patients Satisfied with Phone Access

Patient satisfaction with getting through to the practice office by telephone.

Formula: Number of patients rating their satisfaction with phone access as "Excellent", divided by the total number of patients surveyed. Multiply the result by 100.

Goal: Greater than 80 percent of patients rating their recent attempt to get through to office by telephone as "Excellent".

Data Collection Plan:

Create a simple survey to ask patients the following question (or something similar): "How would you rate a recent experience getting through to this office by telephone?"

Choose one week each month to randomly ask 50 patients (e.g. flag every other appointment, or the first 50 appointments) to complete the survey at reception and drop it in a box. Tally the results.

Source: http://www.ihi.org./IHI/Topics/OfficePractices/Access/Measures

Financial Measures

9. *Revenue per patient per hour:*

Formula: Fee for Service Income plus Practice Incentive Payments per patient, multiplied by patients seen per hour.

Goal: A minimum of $170 to $200 per hour must be generated.

Data Collection Plan:

Collect fee information from the practice's billing system. Aggregate the total hours the practice is open for actual face to face consulting and divide by total patients seen in a 38 hour work week.

Assess on a quarterly and annual basis and clearly identify the time period before and after any access changes are made.

10. *Overheads per Patient per hour*

Formula: Total overheads per patient multiplied by patients seen per hour.

Goal: Between $64 to $104 per hour must be expensed. Any less is favourable but may affect quality of care.

Data Collection Plan:

Collect fee information from the practice's general ledger (for example, practice total costs in profit and loss statement). Deduct overheads such as any payments to doctors and related on-costs including super, professional indemnity, motor vehicles.

Aggregate the total hours the practice is open for actual face to face consulting and divide by the total patients seen per in a 38 hour work week.

Assess on a quarterly and annual basis and clearly identify the time period before and after any access changes are made.

When comparing the two ratios above, the 'Overheads per Patient per hour' must not be greater than 40% of the 'Revenue per Patient per hour'.

If this is the case, carefully assess if there are any unusual factors such as once off costs or revenue items that may have affected the overall result.

Attachment 15 – Rewritten Access Section of the Program Handbook