Toolkit for Time to Third Next Available Appointment (TNA) Indicator

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Contents

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Overview

Objectives of the Primary Health Care Indicator Set

Alberta's Primary Health Care Strategy (the Strategy) sets out the desired outcomes for the Primary Health Care system. AH is working with key stakeholders and subject matter experts to develop and implement a meaningful Primary Health Care Indicator Set that will measure progress towards the Strategy's outcomes, including better access, and will lead to improvements in evaluation, accountability, quality improvement and standardization of best practice.

Objective of the toolkit

Primary Care Networks (PCNs) have a tactical and strategic role in supporting measurement. In addition to providing ongoing support to individual providers and clinics, PCNs are an integral part of provincial monitoring and accountability processes.

This summary toolkit provides the guidance necessary to report on the indicator described as the 'Time to Third Next Available Appointment' System Level Performance Indicator in Schedule B of the PCN Funding Agreement.

It is written for PCN evaluators or comparable staff members who will be leading the initiative on measuring time to third next available appointment (TNA) and reporting annually on the progress within the PCN and its member clinics.

The PCN leadership team may use the toolkit for reference when making key decisions on indicator reporting options and implementation timing. It will help them determine what skills and resources are needed to implement measurement activities, build systems for data collection, transmission, aggregation and reporting.

The toolkit provides necessary information to report on the first stage of the TNA indicator. Alberta Health is working toward a final goal of measuring Median Time to Third Next Available. It is recognized that developmental work is required to achieve this final goal, and this developmental indicator is an important step toward the full goal.

Contractual requirement (adjusted)

- The PCN Funding Agreement requires PCNs to report on a set of indicators in their Annual Report to AH. The initial set of indicators was listed in Schedule B of the PCN Funding Agreements. PCNs were instructed to report on these indicators as informed by definitions to be provided in a "Guideline" prepared by the Minister. This toolkit is the "Guideline".
- The indicator, "Median Time to Third Next Available Appointment with a primary care provider for the Fiscal Year" as listed in Schedule B, has subsequently been adjusted/defined to be a measure of progress towards measuring TNA.

- The specifications and instructions in this toolkit make up the complete reporting requirements and definitions for this adjusted indicator and release PCNs from the obligation of reporting the "Median Time to Third Next Available Appointment with a primary care provider for the Fiscal Year" to AH.

Summary specifications

Indicator results for each fiscal year will be reported to AH in the PCN Annual Report that is due on June 29th of each year beginning with the 2016-2017 fiscal year. Results will include the numerator, denominator and the percentage.

Summary definition of indicator

The percentage of physicians[1] in the PCN that are measuring TNA consistent with Appendix 1.

Numerator

The number of physicians in the PCN providing TNA measurement results to the PCN during the year consistent with the guidance provided in Appendix 1.

Denominator

The number of physicians in the PCN that offer scheduled services to patients.

Supporting definitions

Physicians included in the numerator are:

- working in clinics where appointment times are available to be booked in advance by patients (aka offering scheduled services), and are
- submitting results to the PCN.

Note: Physicians who work in clinics that operate only a walk-in service, or that do not allow patients to schedule appointments well in advance of the appointment date/time will not be included in the numerator or the denominator.

Rationale for the indicator

Rationale for measuring access

Many Albertans continue to lack access to a primary care physician and for those who have a physician; many are challenged with being able to receive services when they require it. As PCNs, member physicians and other health providers work to clearly identify patient panels, the next step is to assess the current state of access for an appointment. This will help organizations and providers identify opportunities where delays in access to services may be addressed.

[1] The requirement is to report only on physicians and exclude other health providers in this first stage. The inclusion of other health providers is expected in future stages. PCNs and clinics will benefit from ongoing measurement of all health providers with scheduled patient visits.

Rationale for measuring TNA

TNA is a gold standard measure, evidenced in international literature as a gauge to help measure access to services from a patient perspective. It is broadly used as the foremost measure of patient access by healthcare organizations internationally, and is supported by the Institute of Healthcare Improvement (IHI) for access improvement work[2]. Additionally TNA is supported and used by AIM Alberta program[3], which has a primary mandate to improve access to, and efficiency of, appointments in primary care clinics in this province.

Rationale for measuring and reporting on progress

This is a stepping stone to obtaining the outcome indicator of TNA and metrics to drive access improvement.

Reporting on progress will encourage PCNs and clinics to begin or expand their measurement of patient access, from the patient's perspective, while minimizing the reporting burden and allowing for a culture of measurement for improvement to evolve over time

Information provided by this indicator can be used to inform implementation strategies and plans for improving access.

Principles for Reporting

- PCNs are reporting to AH on behalf of clinics.
- Identifying data at the physician or clinic level will not be submitted to AH.
- At this time aggregated TNA (time (number of days) to third next available appointment) results will not be reported to AH.
- The PCN will determine its own approach to communicating TNA results back to physicians and clinics to promote improvement. Factors to consider include:
    - Desire for anonymity and PCN relationship agreements with physicians,
    - Comparison to peers within or between clinics,
    - Trends and impact of improvement initiatives.
- The PCN may rely on its member clinics to make the determination of whether or not the measurement is in compliance with the Appendix recognizing that consistent and ongoing measurement is an important element of improving access.

[2] http://www.ihi.org/resources/Pages/Measures/ThirdNextAvailableAppointment.aspx
[3] http://www.albertaaim.ca/index.php/measurement/what-to-measure

Compilation instructions and templates (for PCNs)

Template for reporting from the clinic to the PCN

Clinic Name							
	Count of days to 3rd next						
	Physician identifier						
	A	B	C	D	E	F	....
Reporting date							
5-Apr-16							
12-Apr-16							
19-Apr-16							
26-Apr-16							
3-May-16							
10-May-16							
17-May-16							
24-May-16							
31-May-16							
7-Jun-16							
14-Jun-16							
21-Jun-16							
28-Jun-16							
Number of weeks where a measurement was taken							

Figure 1

Draft template for reporting in the PCN Annual Report

(subject to revision in the annual updates to the PCN Annual Report template)

The number of physicians in the PCN providing scheduled services that are measuring time to third next available appointment.	xxx
The number of physicians in the PCN that are providing scheduled services.	xxx
The percentage of physicians in the PCN that are measuring time to third next available appointment.	xx%

Figure 2

Indicator Reporting Limitations

Many PCNs and clinics do not have experience in measuring TNA. Therefore the initial data reported may be subject to measurement error.

PCNs currently have resource pressures and may not have resources available for closely monitoring all measurement activities. The assumption is that the PCN will rely on clinics' representations that they are following the guidelines. PCNs can encourage compliant measurement and accurate reporting of the indicator by:

- Providing support (tools, templates, and links to external organizations) for implementation.
- Communicating the non-judgmental aspect of measuring for improvement and the need to report accurately the progress being made.
- Reporting results back to physicians and clinic managers.

Contact Information

TNA Indicator Reporting Questions

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Online Tracking Tools and Other Measurement Support

Access Improvement Measurement (AIM)
Measurement Support Team - measurement@AlbertaAIM.ca
David Letourneau, AIM Measurement Advisor – 780-342-8132
AIM Online Measurement Tool Instructions - http://www.albertaaim.ca/index.php/measurement/tools

Appendix 1: How to Measure Third Next Available Appointments in Alberta

Introduction: Why is timely access to appointments important?

Delay of care is an undesirable feature of healthcare provision. When care is delayed there are negative impacts to clinical care and outcomes. Delay for appointments has been traditionally accepted as inevitable. Despite the best efforts of physicians and other health providers[4] (guided by current understanding) to work harder and longer it has been seen at best to be challenging and at worst to be impossible to reduce delays.

Delay for appointments has a negative impact on continuity of care between physician and patient. When a patient cannot receive timely access to care from his/her own physician and is forced to seek care elsewhere, continuity is diluted. If they choose to wait for care their clinical status could deteriorate.

Evidence shows that patients who consistently see the same physician use significantly fewer health care services[i], have better outcomes and lower costs[5]. When patients can consistently see their own physician without delay, care improves via the already established relationship and understanding of relevant history. In this way both patient and physician satisfaction also rises.[ii]

Knowing the delay for your patients to get in to see you is the critical first step to improving access. By understanding your current state of delay, in conjunction with panel size, you will now have a firm foundation on which to build improvements and to measure progress while leveraging the assistance of groups such as Alberta AIM and supports provided by your own PCN.

What is TNA?

TNA is the accepted measure of delay for an appointment. It is defined as:

"The number of calendar days between the day a patient makes a request for an appointment with a physician and the third open appointment in the schedule for a physical, routine or return visit exam"

The third next available appointment is used, rather than the first or second, because it is a more reliable reflection of system availability; the first or second next available appointment may be available due to a cancellation or some other unpredictable event. [iii]

Patient perspective is critical, as we must see the delay as it is experienced from the patient point of view. Therefore when counting TNA we count all calendar days including those that the clinic is closed due to weekends or holidays.

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[4] This appendix references measurement of physicians' TNA to be consistent with current reporting requirements as set out in the 2016 toolkit. Measurement of other health providers TNA is encouraged as a positive step towards improved access to primary health care services.

[5] See References on page 10 (#6 to #11) of the Guide to Panel Identification for Alberta Primary Care (2014) http://www.topalbertadoctors.org/file/guide-to-panel-identification.pdf

How to Measure TNA

The following guidelines for measuring and collecting TNA data are provided as a standardized methodology for obtaining best data. No matter where you are in process as an individual physician, clinic or PCN it is strongly advised that these standard steps and principles be adopted. For some this will mean beginning to collect TNA for the first time and for others this may mean re-examining your processes and adding in steps to ensure standard collection.

Who?

TNA should be collected for all physicians who see patients via scheduling and should be collected by a team member who has access to all schedules. This is typically a front of office scheduler such as the receptionist.

Where?

While many EMRs allow for the automated production of delay data and in some case may generate graphs of this data, recent feedback indicates that this data is frequently inaccurate due to system calculations which do not correctly capture delay. Therefore it is strongly recommended that TNA is manually counted by viewing the schedule for each physician unless the clinic has verified that its EMR data are accurate.

When?

TNA should be collected for all physician in the same clinic on the same day of the week (month) and at approximately the same time.

E.g. – prior to noon on Wednesday

Doing so allows for stable alignment of the data and better analysis. It is further suggested that each PCN adopt a standardized timeframe for all physicians within their group to collect TNA thus allowing again for alignment leading to more comparable analysis.

Carve Outs Must be Excluded

Carve outs are appointments held for specific kinds of patients or clinical needs. These time slots should not be included when counting TNA as they are in essence being held for special circumstances and can only be filled for and by the identified specific need. The definition of TNA precludes counting these appointment types.

Examples of carve outs are time slots:

- Held only for procedures
- Held only for physicals
- Held only for pediatric patients
- Held only for “urgent” concerns or for walk in patients

Carve outs can be identified in a schedule even before the appointments are booked as per the example below. We see appointments that are being held for pediatric patients, urgent concerns and physicals. The yellow fields are open appointments for any indication and the blue fields are booked appointments.

Time of day	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Mon
9:00 – 9:10			Urgent	Urgent	Urgent			
9:10 – 9:20								
9:20 – 9:30		Physical only						
9:30 – 9:40								
9:40 – 9:50								
9:50 – 10:00	Ped only							Ped only

Determining Appointment Lengths using Building Blocks of Time

Determine the length of your shortest appointment slot offered (E.g. 10 minutes). Longer appointments are comprised of multiples of these building blocks. For example an annual physical examination may be booked for 30 minutes which would be 3 – 10 minute blocks equaling a total of 30 minutes or a minor procedure might only be 2 – 10 minute slots equaling a total of 20 minutes.

When counting the TNA weekly simply look to see when the third next available empty building block is.

You need not be concerned about how many empty building blocks are adjacent following the third next available appointment in the schedule. Natural variation in the schedule will mean that this will vary from week to week similarly to how requests for appointments come in.

In the example below, the blue fields indicate booked appointments, while the yellow fields are available time slots. The orange fields indicate the clinic is closed.

If the count is done on Monday at 9:00 AM the Third Next Available appointment appears on Thursday at 9:10 AM and the delay is 3 days. If the count is done on Thursday at 9:00 AM the Third Next Available appointment appears on Monday at 9:20 AM and the delay is 4 days. Remember patient perspective of the wait is critical and so we must count the weekend. It does not matter the day of the week the count is done on as long as it is done on the same consistent day across the clinic and preferably across the PCN.

Time of day	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Mon
9:00 – 9:10								
9:10 – 9:20								
9:20 – 9:30								
9:30 – 9:40								
9:40 – 9:50								
9:50 – 10:00								

Figure 1

Standardized Steps to Measuring TNA

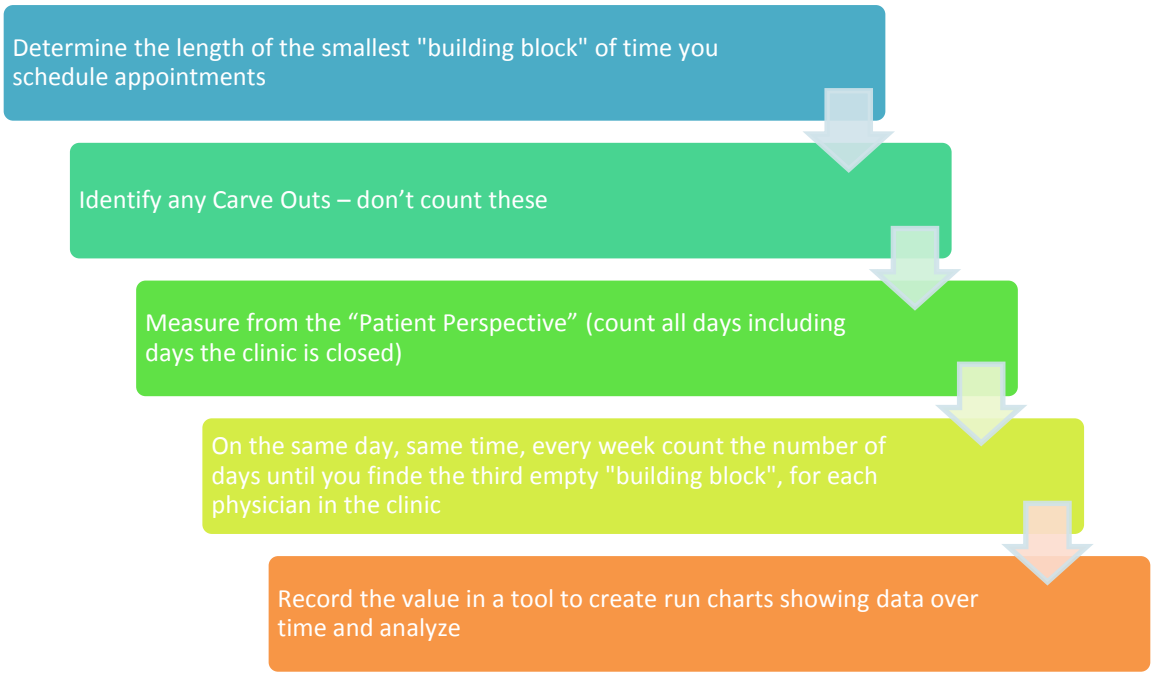

Figure 2

Part Time Physicians

TNA can be collected for part time physicians with the understanding that values will typically be larger (longer delay) due to the very nature of them only being present in the clinic on predesignated days. However improvements to access can be made no matter what the physician full time equivalent may be based on appropriate panel size and other principles of access improvement. If two or more part-time physicians share a calendar for a common panel of patients the measurement reported should be of that shared calendar.

Walk-in clinics

Unfortunately for those physicians and clinics who do not pre-schedule any appointments and who only open up schedules on a daily basis TNA cannot be measured. By the very nature of this type of system it is impossible to measure delay. This is not to say that delay does not exist, it is simply not visible. The delay for appointments exists outside of the visibility of the clinic. Patients queue up each day to get one of the appointments made available daily and if they are not lucky enough to obtain one of the openings, they must again join the virtual queue in hopes of getting an appointment the next day and so on.

Some clinics may have a combination of scheduled and unscheduled appointments. In this environment it is possible to measure TNA for the scheduled appointments using the steps noted above.[6]

[i] Cook, T. System Level Opportunities for Panel Management in Alberta Symposium: Using Panel Management to Improve Primary Healthcare Practice and Patient Outcomes Wednesday, December 4, 2013; https://d10k7k7mywg42z.cloudfront.net/assets/53274e584f720a06b300066a/Panel_Management_Symposium_Presentation_Summaries.pdf

[ii] AdlerR, Vasiliadis A, Vikell N. The relationship between continuity and patient satisfaction: a systematic review. Fam Pract. 2010 Apr;27(2):171-8

[iii] http://www.albertaaim.ca/index.php/measurement/what-to-measure

[6] Any time in the calendar scheduled for walk-in appointments would be considered a carve out.