

Quality improvement in action

Learning from four years of collaborative access work in Australia

Andrew W Knight MBBS MMedSci (clinepid) FRACGP

General Practitioner, The Upper Mountains Medical Centre, Clinical Senior Lecturer in General Practice, Western Clinical School, The University of Sydney and Chair, The Expert Reference Panel on Access, The Australian Primary Care Collaborative

ABSTRACT

Background Through the three years of the first phase of the Australian Primary Care Collaborative there was considerable adaptation of the work to improve access translated from the UK to the Australian environment. Changes in four areas are described.

Methods and results *Measures:* ‘third available appointment’ was retained as a measure of delay. A patient satisfaction survey was revised and a new measure added looking at unmet demand. *Team:* requests from practices resulted in the production of a set of ‘team principles’ designed to help practices build capacity for improvement in their teams. *Name:* the name of the topic seemed to be a barrier for some practices. After much thought, the name of

the improvement topic was changed from ‘Better Access’ to ‘Access and Care Redesign’. *The product:* the content of the access topic was revised. Change ideas were divided into ‘foundation work’, which all practices were expected to do to improve access to care for patients. Once this was completed, practices were encouraged to select a ‘pathway’ which best suited their situation.

Conclusion Four possible changes are offered for consideration to those planning to do access work with general practices based on the learning from the Australian Primary Care Collaborative.

Keywords: family practice, health care quality, access and evaluation, primary health care

How this fits in with quality in primary care

What do we know?

Improving timely access to primary care is an important area for quality improvement internationally.

What does this paper add?

The paper presents changes in thinking about implementing access improvement growing out of the first phase of the Australian Primary Care Collaborative (APCC). These included development of the measures, the practice team, the name of the improvement topic and the change ideas being promoted.

Background

Australia has embarked on a second four-year phase of a national primary care collaborative addressing diabetes, coronary heart disease and access. The programme has evolved from the National Primary Care Collaborative implemented in England,¹ which in turn was based on the breakthrough collaboratives associated with the Institute for Health Care Improvement in the United States.²

The first phase of the Australian Primary Care Collaborative (APCC) involved more than 600 practices from across Australia. Overall there were improvements in the measures relating to the clinical topics but little movement in access measures.³

Access remains one of the three topics in the second phase. There is a perception that the skills, concepts and shift in mental models driven by work to improve

access underpin organisational changes necessary for significant improvement in the clinical topics. The challenges of achieving measured improvements in access have been the subject of much thought and discussion within the organisation. Why did we see little change in the access measures? Were the measures unable to indicate the improvements that seemed to be being made? Were there practice factors that prevented improvement? Was there something wrong with the messages being taught at the learning workshops?

The measures

About 30% of recorded plan/do/study/act (PDSA) cycles were on principles of improving access. Practices measured time to the ‘third available appointment’ throughout the life of the collaborative, and also asked patients about their satisfaction with access to clinicians. ‘Third available appointment’ is the length of time in days between the day a patient makes a request for an appointment with a physician and the third available routine appointment. Were these measures too insensitive to pick up changes?

The expert reference panel for access met to consider the measures and possible improvements. The panel concluded that the internationally used ‘third available appointment’ remained the best measure of delay in providing appointments. While not easy to understand initially, it is easy to collect and gives direct information about how an appointment system is performing. The panel designed a new question for measuring patient satisfaction with access. It decided to collect a measure of unmet demand. For this measure, practices collected data on the number of patients who could not be given an appointment over a week. Piloting of this measure and early reports from practices in the second phase of the programme suggested that this might be a useful indicator of access improvement (see Box 1).

Box 1 Access and care redesign measures for phase 2 of the Australian Primary Care Collaborative

- *Third available appointment*: calculated once a month
- *Patient survey*: patient agreement with the statement ‘I was able to get an appointment with the person I wanted on the day I wanted’ on a scale of one to ten; measured over one week once monthly
- *Unmet demand*: the number of patients turned away measured over one week per month

The practice team

Early in the first wave, practices began asking for advice on how to engage the other members of their practice teams in improvement. Participants returning to their practices identified lack of skills and organisational structures for implementing change. Colleagues were sometimes slow to catch the vision for improvement in any area, and particularly in access. We decided to give practices guidance on how to build their teams.

Our impression is that teamwork is a particular weakness in Australian general practice. The Australian funding model is mainly fee for service. This means that the financial drive is for practices to maximise their clinician–patient contact time and minimise their administration time. Our observation was that this can result in under-investment in building the practice team. We came across practices that had no meetings at all. Reports were that some clinicians perceived any time spent communicating with each other was wasted time away from patient care.

We reconvened the expert reference panel and hired a consultant on high-performance teams. We wrote a ‘team’ change principle and added it to our manual. The principles are summarised in Box 2. This resource has been well received by practices and widely used. Our impression is that the first thing most practices do after the first learning workshop is hold a team meeting (sometimes their first ever). The ‘team principle’ is now the first principle of all three topic areas in the APCC.

Box 2 Team principle change ideas

- 1 Set realistic goals
- 2 Communicate with other team members
- 3 Engage the practice team
- 4 Assign roles and responsibilities
- 5 Reflect on and review what you are doing

The name

There was concern that the name ‘Advanced Access’, as popularised in the descriptions of the work of Murray and Tantau,⁴ was not intuitively understood by practices. We attempted to convey a clearer idea of what we were getting at by using ‘Better Access’, but still found we had to do a lot of explaining before participants could start to apply the underlying concepts to their own context. At times it seemed that clinicians felt criticised or threatened by the name. Feeling besieged and overwhelmed by demand, the last thing they wanted was to be told they had to provide ‘better access’.

After much consideration and revisiting, we came up with name ‘Access and Care Redesign’ for this topic in the second phase of the collaborative. Having the word ‘access’ in the name retained a connection with the international access literature. The ‘Advanced Access’ concepts for change, when properly understood, provided practices with useful tools for understanding and changing their businesses. ‘Access’ resonated with the overall aim of the topic where a standard set was that 90% of patients should be able to access their health-care professional of choice on the day of their choice.

‘Care Redesign’ was a term that clinicians found relatively easy to understand. The term has emerged as one of the six pillars of the chronic care model,⁵ and is used in other contexts also.

It was hoped that by combining the two terms into ‘Access and Care Redesign’, we could construct a topic title that was more transparently relevant. Even practices that were able to get their patients in to see the clinician could understand that they might improve their effectiveness through ‘care redesign’.

The product

During the first three years the product we offered was ‘Advanced Access’ as pioneered by Murray and Tantau,⁴ and disseminated by Oldham.⁶ As the programme progressed, it became clear there were a number of barriers to acceptance of this topic.

Problems with the product

Unlike the principles of diabetes and heart disease care, the principles of access were novel for the general practitioners and practice staff we were in contact with. We observed that the practices required considerable time to become familiar with these ideas.

Furthermore, it became clear that ‘Advanced Access’ required major behavioural change on the part of patients and practice staff. We identified a number of critical success factors that affected the ability of practices to implement such large changes.

Advanced Access as we taught it was a binary concept. Practices either achieved ‘Better Access’ or they did not. We had little to say to practices that were overwhelmed with demand and were looking for relative improvement and incremental change.

Response to the product

The success in teaching Better Access, the extent of actual implementation of changes, and the impact on access in those practices have not been formally measured in Australia. Many practices have made

changes in the way they organise access, as evidenced by the PDSA cycles recorded as successive waves of the collaborative have progressed.

It is likely that the response has been similar to that demonstrated in UK evaluations, which have found that many practices have made changes but with considerable variation in the extent to which they have done so.⁷ There has been some dilution of the concepts as they have diffused into the wider general practice community.

Very few practices in Australia were willing to try to implement all of the changes of Better Access as it was taught. Even fewer truly understood them. Our observation is that most practices used some of the ideas and made useful change.

Changes to the product

The original Advanced Access ideas for change fall into two broad categories. Some can be undertaken incrementally, behind the scenes, with reduced risk of engendering overt resistance through challenging patient and staff behaviours that have been established over many years. These principles include measuring demand and capacity, shaping the handling of demand, matching the team to the reshaped demand, and making contingency plans. These changes are good business practice. We believe they are the essential building blocks that must be in place and familiar before practices can progress in access and care redesign. We now call these changes ‘foundation work’ and believe all practices can and should implement them (see Box 3).

Box 3 Access and care redesign change principles for the second phase of the Australian Primary Care Collaborative

Foundation work

Know your business:

- understand the current capacity of the practice
- understand the profile of demand

Change your business:

- communicate with staff and patients
- shape the handling of demand
- shape patient behaviour
- match the capacity of the team to the reshaped demand
- embed and monitor the system
- contingency planning

Pathways

advanced access
managing demand
increasing capacity
increasing quality

While this foundation work is probably never complete, practices may reach the point of wanting to embark on more radical changes to achieve improvement. We have called these next steps beyond the foundation work 'pathways', and to date have identified four.

In the next four years we will trial the 'Pathways'. Practices that achieve a measured balance between demand and capacity may elect to do the work of removing backlog and running an Advanced Access system. Others may find that despite their best efforts at shaping demand and matching their team internally, they continue to work with unacceptable delays. They may elect to adopt more radical steps to shape demand or to increase capacity. Those practices that have excess capacity may choose to take a radical approach to seeking new patients, reaching out to underserved populations, or increasing the quality of care provided to their existing panel.

Conclusion

The years of collaborative work carried out in Australia have helped drive many changes in general practice and demonstrated the capacity and enthusiasm of general practices to improve what they do. There has been a lot of learning along the way. These changes to four areas in access were chosen from among many as high-value ideas that could help those contemplating undertaking similar work with general practices to improve access.

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ADDRESS FOR CORRESPONDENCE

Dr Andrew W Knight, 98–108 Bathurst Road, Katoomba NSW 2780 Australia. Email: aknight@pnc.com.au

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