ACCESS TO CONTINUITY

Purpose: To assist primary care clinics in optimizing processes for patient access to care so that their patients can receive care when they want or need it.
Aim Statement: By x date, patient continuity to the family physician (and team) is greater than 80% and patients can be offered a same/next day appointment for any primary care related need as measured by TNA (TNA ≤1).
Outcome Measure: Each provider has high relational continuity (≥80%) & low TNA (≤1 day)
Balancing Measure: Physician and patient satisfaction (goal: maintained or improved)

Key documents: Access to Continuity Trail Map, ***Full Change Package, Evidence for PBPs***

High Impact Changes	Potentially Better Practices (PBPs)	Process Measures	Tools
1. Build your team capacity for improvement to advance as a patient's medical home	1.1 Establish an inter-professional improvement team and consider including a patient with lived experience to build quality improvement skills	Regularly scheduled team meetings	• Sequence to Achieve Change Workbook: template & sample • IHI Open School • Patient Partner Guide
2. Know your paneled patients	2.1 Review how your patients access care in the practice and the health neighbourhood	Reviewed HQCA report: • average annual visits for panel • panel continuity rate Reviewed CII/CPAR report: • % of patients in panel conflict	• HQCA Primary Healthcare Panel Report Online Request Form • Understanding HQCA Continuity Data Online Module
	2.2 Assess the balance of supply and demand for appointments by provider to identify key improvement strategies	• Panel Size • TNA • Supply • Demand	• Ideal Panel Size Worksheet • A2C EMR Guides (future) • DSA Data Tracker
3. Provide access to your paneled patients by managing demand and variation *(continued next page)*	3.1 Commit to access to continuity as a team		• Coordinated Approach to Continuity and Attachment in Primary Care • Access to Continuity Infographic

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ACCESS TO CONTINUITY CHANGE PACKAGE

High Impact Changes	Potentially Better Practices (PBPs)	Process Measures	Tools
3. Provide access to your paneled patients by managing demand and variation *(continued from previous page)*	3.2 Select the optimal care delivery method for patient needs	# of non-face-to-face appointments	• Patient Scheduling Tool • ACTT Virtual Appointment Guide • Virtual care toolkit (future) • Prenatal Care Case study
	3.3 Identify strategies to reduce demand	Return visit rate	• Team Based Care Case study • Group Medical Visits Guide • Max Packing
	3.4 Plan for appointments that predictably take longer and for unexpected occurrences	Cycle time	• Cycle Time Tracker
	3.5 Establish clear roles and responsibilities for clinic processes & enable all team members to work to full scope	Completed: yes/no roles & responsibilities guide	• Roles and Responsibilities Guide • Introductions with Intention • Huddles • Clinical Microsystems Greenbook
	3.6 Assess backlog and develop a plan to address unplanned backlog	# of backlogged appointments	• Backlog Calculation Tool

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ACCESS TO CONTINUITY CHANGE PACKAGE

High Impact Changes	Potentially Better Practices (PBPs)	Process Measures	Tools
4. Provide access to your paneled patients by optimizing supply & reducing variation	4.1 Simplify appointment types and times and eliminate carve-outs and other scheduling restrictions	# of appointment types	• A2C EMR Guides (future) • Avoiding "Carve-Outs"
	4.2 Synchronize elements of the appointment & improve clinic flow	Cycle time	• Cycle Time Tracker • Synchronization Tool
	4.3 Optimize the clinic environment to free up team member time & minimize interruptions	# of interruptions	• Clinic Walk Through Tool
	4.4 Develop procedures to minimize the impact of supply loss	TNA	• Post Vacation Scheduling
	4.5 Address factors contributing to no-show rate	% no-shows	• Improving No-Shows
	4.6 Shape supply & demand to match daily, weekly and seasonal patterns	Demand Supply	• Shaping Supply & Demand Case Study
	4.7 Schedule patients to maximize continuity	Internal panel continuity	• The Hierarchy of Booking
5. Coordinate care in the health neighbourhood	5.1 Establish processes that facilitate effective transitions of care	# patients with visit within 7 days post hospital discharge	• Home to Hospital to Home Change Package • Collaborative Care Agreements