



## Optimizing Primary Care Delivery

A gap exists between current healthcare performance and possibility. This gap exists not only in the delivery of effective and evidence-based clinical care, but also in the operational delivery of care itself - how the care is delivered - and in the delivery of satisfying care. This gap exists not only between systems and possibility, but also within systems between sites, and within sites between individuals.

Paraphrasing the Institute of Medicine report, the goal for optimized primary care practice delivery is to deliver the best care, in the best way, on time, every time. Achieving the ultimate goal, then, involves a complex choreography and requires the successful connection of a number of critical components. Previous attempts to narrow the gap between current performance and possibility in all of these dimensions have failed, primarily due to the fact that these efforts have been attempted in isolation, or the failures are due to a lack of understanding or a misunderstanding of the basic overall dynamics of flow.

Healthcare systems - both operational and clinical care - are flow systems. In flow systems, we match the demand for service with the supply of service (resource). The most effective, the most efficient and the most satisfying flow systems (demand-supply matching systems), work without a wait. The complex choreography of connected supply components can only go as fast as the slowest step or component. At the heart of clinical and operational improvement is the need for reduction of delay.

Our healthcare systems lack relationship and purpose, seem disconnected from the patients that the system intends to serve, and are characterized primarily by a system or internal focus rather than directed by "patient-centeredness." The delivery of clinical care is fragmented, isolated, non-systematic, and from the patient's perspective is often delivered by luck rather than by intention. The relationship patients desire, the trust they want to have, and the comprehensive care they deserve, is far too often non-existent.

Our healthcare systems are plagued by waits and delays that lead to patient, provider and staff dissatisfaction, increase the cost of care, sub-optimize the revenue, and adversely affect clinical care. When we focus on the reduction of delays, we are able to simultaneously improve on all these parameters.

### Customers and Value

Despite efforts to develop patient-centered care, there is often a failure to operationalize this. Investigations and evidence show that patients desire:

- The opportunity to choose a primary care provider
- Access to that provider when they choose
- A quality healthcare experience, which means "respect my time" and "don't make me wait"
- Up-to-date, evidence-based and quality clinical care

Cost is a strong consideration, but cost most commonly in this country, it is borne not by the individual patient but by intermediaries (government funding, insurance companies, etc.).

## **Delivery of Value**

In healthcare, every day, all day long, one patient at a time, one service at a time, we match the demand for service with our supply of that service. We live in a flow system. The most successful systems will match supply to demand without a waiting time. The most effective (clinical outcome), the most efficient (the cost/revenue ratio) and the most satisfying systems match supply to demand without a wait. At each step in a flow system there is a demand, there is a supply, and there is a waiting time. The work flows. Our goal as stated above can only be achieved if the work flows smoothly, if there's perfect balance all of the time so that value is delivered perfectly on time, every time. Whether we acknowledge this or understand this, this is the basic and fundamental dynamic that exists in flow systems. Matching the demand to the supply is really not a choice. We either match the demand to the supply poorly, or we match it well - it's not a choice.

## **Balance**

In flow systems, the balance between the demand and the supply is critical. There has to be a balance between the demand for service and the delivery or supply of service, at the organizational level, the site level, the department level and the individual level. The balance at the individual level is driven by customer desire. Patients want the opportunity to choose a primary care provider, and they want access to him/her when they choose. For that clinician to be successful, he/she has to have a balance between the workload demand and his/her workload ability. This workload balance is measured by the determination of the **panel size**, which is the macro level from which demand for service arises. The panel size or the number of customers within the organization, at the site, at the department and at the individual clinician level has to be balanced against opportunity and ability for service delivery. Identification, determination and measurement of panel size at all of these levels are critical for success. In addition, evidence and studies demonstrate that continuity of care - seeing the same identified and linked provider - results in better clinical care. There is no data or evidence or study that has demonstrated that random service delivery (discontinuity) results in improved or even the same level of clinical care. Thus, the two critical system design elements for success in healthcare delivery are continuity and the reduction of waiting time. Designing systems with these elements as system property will result in improved patient, clinician and staff satisfaction, as well as less cost, higher potential revenues, and improved clinical care and outcomes.

## **Delivery of Care**

Healthcare is a team sport. Evidence, investigation and study have shown that clinicians cannot provide optimal care working in isolation, and particularly working with visit-by-visit approaches. There is far too much knowledge and far too much information. For successful, optimized clinical care, clinicians need others (team members) to share in the care delivery, information systems to monitor, track and measure care delivery, and systematic approaches for optimized care delivery. The planned or chronic care model

provides us with a systematic approach for clinical care delivery. The original model de-emphasized the critical importance of the care delivery features. We have modified the basic planned care model to explicitly address leadership, care delivery systems, and community outreach as system design elements, and reinforced the value of self-care/self-management, decision support, and information technology features as practice elements. This modified planned care model incorporates explicitly the value of continuity and a no-wait culture.

## **Clinical Care**

We can never optimize clinical care - measured by compliance with preventive service guidelines, the management of patients with chronic illness or by measurement of early detection of serious illness - unless we can get patients to their own provider without waiting. At that point we are in a position to optimize clinical care. Just as it takes a "system" to optimize flow for the appointment or other service and at that service, it takes a "system" to optimize clinical care.

## **Process for Improvement**

There are four (4) components within the process for improvement:

- **Team.** The people that do the work need to transform the work. The likelihood of successful change occurring from outside announcements or implementation is small compared to the likelihood of successful change occurring when this is accomplished by the people who actually do the work
- **Aim.** The team needs a focus or an aim, or goal. In supply/demand flow systems, the aim or focus is always on reducing the waiting time, because the most effective, efficient and satisfying systems in flow work without a wait.
- **Change.** If we keep doing what we're doing, we're going to keep getting what we've got, so in order to make improvements, we have to change our actions and behaviors.
- **Measure.** How do we know that the changes we've made have actually resulted in improvement? We need to measure. The focus on measurement is initially on reduction of waiting time both for and at the service. We need measurements of demand, which include measurements of macro demand at the practice panel and individual panel levels, and then the demand that arises from that panel, as well as measurements of supply. In addition, we would measure no-show (defect) rates and continuity (success) rates, as well as clinical care and clinical outcomes.

We would use the same process for both operational and clinical improvement. The change strategies are different but the process is the same.

## **Summary**

In order to build the most successful systems for clinical care outcomes, we need to build a system that can get patients to their identified clinician without waiting. In order to work without a wait, we need to have a balance between the workload and the worker. The first step in optimization of a primary care practice, then, is to build the operational foundation that can ensure that patients can see their own doctor without waiting. The second step is

to identify and clarify the operational team whose role is to put the clinician in a position to be successful. Next, a practice develops a clinical profile to determine the needs of its patients, and then develops a clinical care team that responds to those specific care needs. Development of a system that works without waits requires the use of a set of principles to eliminate the waiting times for and at the service. The development of teams also includes a set of principles, and the delivery of clinical care is driven by a set of systematic principles. Putting this all together requires forming a team, setting an aim, making the systematic changes necessary, and measuring the results of the changes.