SHARE & LEARN: HELPING PATIENTS TO ACCESS CARE

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OVERVIEW

Timeliness is a cornerstone of good primary care. Yet too many patients in Canada have difficulty getting a timely primary care appointment. According to the 2019 Canadian Community Health Survey, among Canadians with a regular health care provider, only 38.7% reported that they could receive a same day or next day appointment with someone from their regular healthcare provider's office[1]. Thirty-four percent of Canadians reported that it was very or somewhat easy to get medical care in the evenings, weekends or holidays without going to the hospital emergency department; and only 22% of Canadian primary care physicians offered patients the option to request appointments online in 2019[2]. Additionally, fewer Canadian primary care physicians (23%) offer patients the option to ask medical questions via email or a secure website compared with the Commonwealth Fund average (65%)[2].

Our department has striven to understand and improve access for years. Specifically, wait times on the phone have been a longstanding and seemingly intractable problem. In 2022, we launched a series of virtual sessions where our 14 teaching sites could share how they have tried to improve wait times on the phone, identify common challenges and solutions, and learn from each other.

BACKGROUND

To better understand patient experience during the COVID pandemic, the University of Toronto's Department of Family and Community Medicine's (DFCM) teaching sites collaborated to launch a joint patient experience survey in June 2020. To date, six waves of the survey have been sent out to thousands of registered patients at each teaching site. The results of these surveys helped us understand both areas of strength and opportunities for improvement. One common area of improvement that arose related to booking appointments and, more specifically, phone wait times.

According to the results of the survey:

- The majority of patients (>70%) are booking their appointment by phone; only 10% used online booking for their most recent appointment.
- In those who called to book their appointment by phone, close to 20% had to wait more than 10 minutes before being able to speak to someone who could book their appointment; about 10% of patients had to leave a message and get a call back.
- Even though most patients are still rating their overall experience with booking appointments over the phone as excellent or very good, there's a substantial number who are rating it as fair or poor.
- In those who rated as fair or poor, 60% waited too long on the phone and more than 40% had to call multiple times. About 10% of patients were unable to leave a message.
- 35% of patients felt they had an urgent need for an appointment, but they were not able to reach the clinic. This percentage varied considerably across DFCM sites.

Share & Learn sessions were then created as an opportunity for teams to share how they have tackled these challenges at their own sites using a QI approach.

ABOUT THE SHARE & LEARN SESSIONS

Since teams are unique in context/culture, behaviours, and resources, and therefore may follow different pathways to achieving this common goal, three virtual Share & Learn sessions were developed as a shared initiative for teams to explore what approaches other teams have taken, what outcomes they attained, and what they learned throughout the process. The Share & Learns were well-attended with between 30-40 attendees at each session, representing all 14 of the DFCM teaching sites. Attendees included family physicians, nurses, administrators, and patient partners amongst others. At the end of each session feedback was collected though a live online survey platform, as well as through a post-session evaluation that was emailed to all attendees. All of the respondents said they felt sessions were relevant and applicable, and felt motivated to take action. Ideas that attendees felt they could implement in their own practice included online booking systems, adding website forms, having pod-based phone systems, switching to a centralized pool for phone calls, using secret callers to monitor phone wait times, tracking and recording phone data (content, volume), optimizing the administrator to call ratio, assigning specific tasks to administrators, and self-check-in.

The following report summarizes key learnings from the share and learn sessions.

UNDERSTANDING THE PROBLEM & INSIGHTS GAINED

THE PROBLEM

Chronic negative feedback from frustrated patients regarding phone access and overwhelmed staff, receptionists, and clinicians prompted teams to seek out new ways to improve wait times on the phone.

The most common complaints heard from both patients and staff were:

- Poor phone access due to long wait times on the phone and having to call multiple times to get through
- Issues with having a hospital-based phone system:
    o Many dropped calls and long wait times from hospital to the clinic
    o Not providing "call forwarding" feature to remote workers during COVID-19 pandemic
- Patients, staff, and clinicians generally feeling frustrated & overwhelmed

This data came from several different sources in addition to the Patient Experience Survey such as informal feedback from patients at check-in and during their clinical encounter; consultations with administrative staff, providers, and Patient Advisory Committees; and analysis of phone system data and Google review data.

APPROACHES TAKEN TO UNDERSTAND THE PROBLEM

The teams took a variety of different approaches to better understand the problem from all sides, including both human and system factors that might be contributing to the issue. Steps taken by the teams include:

- Process mapping
- Surveying patients to better understand the top reasons why they call the clinic
- Tracking call traffic, call volumes, number of calls answered and voice mails returned, wait times, and length of calls
- Mystery Shopping (members of the Family Health Team called the clinic systematically and recorded their experiences)
- Identifying call volume trends, bottle necks, and high demand times to resource accordingly
- Conducting site visits by the executive director and manager to observe various teams functioning and the distributed workload
- Calculating the right ratio of staff to phone calls
- Weekly tracking and continuous data feedback to the phone staff, clerical coordinators, and leadership
- Consulting stakeholders including Patient Advisory Committees, administrative staff, and physicians and involving them in all steps of the process including the development of change ideas and decision making

INSIGHTS GAINED:

- Electronic processes can have both positive and negative impacts. For example, an e-prescribe tool embedded in the EMR was not functioning as intended and the administrative and nursing staff spent an inordinate amount of time on the phone discussing prescription renewals.

- Institutions should explore all stakeholder perspectives on workflow processes to ensure optimal usability and accessibility. For example, a new phone system that was implemented by one institution, with no consultation or input from the team, resulted in a change in the process of how patients were queued. This was identified as a potential cause for suboptimal patient satisfaction.

- There are many factors influencing phone traffic (beside agents such as the volume of the calls, staff available to answer the calls, etc.) that we may not even think of, and this makes it very complex. For example, a complicated phone tree itself may cause patients to get lost and remain for long times on the line which can make the traffic even higher.

COMMON CHANGE IDEAS & THEIR IMPACT

There were four common change ideas that teams tested in response to the problem of long wait times on the phone:

TELEPHONE SYSTEM CHANGE

Impact:

I. Division of the call centre into multiple pods/hubs (e.g., North and South pods) to divert calls to the appropriate site with dedicated phone staff member for that

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- This change improved team communication, patient access and experience
- Having dedicated phone staff for each site helped relational continuity as staff built rapport with patient and increased staff satisfaction as there were fewer booking processes to remember per call
- There was no clear impact on wait times

II. Keeping the call centre model but adding the option for automatic redial, queuing system, and voicemail for unanswered calls
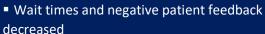
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- This change improved same day/next day access
- Received positive Patient Advisory Committee feedback
- No more patient complaints regarding the telephone system

III. Updated phone tree to include more dial options for frequent inquiries (call options) which directly forwarded patients to the appropriate staff or information being requested

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- This change reduced time spent with patients on the phone, and reduced time patients spent on hold in a call queue

IV. New phone systems – Voice over Internet Protocol system (VoIP) that allows you to make and receive phone calls over the internet instead of landlines

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- This change improved call quality and functionality
- Wait times and negative patient feedback decreased
- Administrative staff described fewer dropped calls
- Providers in clinic or working remotely appreciated the call forwarding functionality

ONLINE BOOKING AND E-COMMUNICATIONS

I. Implementation of an online booking system or enabling patients to book through email

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Impact:

▪ This change increased patient access and staff satisfaction; however, it did require some staff and patient training to tailor to patients' needs (different ag groups, language levels, etc.)

II. Launch of an online system/patient portal, for example: Health Myself/Pomelo, as an alternate mode of non-urgent patient communication

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▪ This change increased patient access to the clinic, although the impact on phone access is unclear
▪ Patients appreciated the convenience and rapid response of the online communication system
▪ Presented a great relief for phone lines
▪ Saved time for staff as messages provided clear communication of the reason of contact compared to phone calls
▪ Made the screening easier

CALL VOLUME MANAGEMENT

II. Registration staff supporting phone staff when volumes are high

III. Modifying work hours to high volume call periods e.g., staggered lunch times

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Impact:

▪ These changes resulted in positive feedback from staff including having greater job satisfaction, finding it easier to complete tasks, and feeling that they were better able to deal with patients

IV. Re-distributing tasks: staff assigned to tasks rather than to clinicians/residents

WAITING ROOM REDESIGN

I. Implementation of check in kiosks with clear instructions on how to do self-check in

II. Providing information about staff and what their role is that day (e.g., a poster with the staff member's name and photo with a brief note that they are answering phone calls today to ensure rapid responsiveness)

Impact:

▪ These changes increased satisfaction in both staff and patients

KEY LESSONS LEARNED

As with any quality improvement project, the data does not tell the whole story and understanding context is key. Through this process, teams learned just how complex the issue of phone access is - there are a multitude of factors influencing the ease with which patients can access their care team, and approaches that work at one site may not work at another.

Team members need to balance the introduction of new changes with the readiness of their staff/organization to embrace these changes. One idea is to have all key stakeholders involved from the early stages of the process to ensure buy-in. For example, at one site, involving their Patient Advisory Committee was essential in moving both physicians and staff who were opposed to change to a place of acceptance as well as in securing funding for these changes and getting Senior Management support.

Both telephone wait times and staffing shortages can be mitigated with electronic solutions, such as a patient portal or online booking system. Teams found that these electronic systems can enhance the provision of both virtual and in-person care; however, it is important to understand that this alone will not result in a decreased workload. For example, while implementing an online booking system at one site did increase administrative staff satisfaction, it simultaneously increased physician workload, specifically regarding answering booking. It is important to take care around implementation; continuous feedback and data monitoring is crucial to help assess the changes made and to generate PDSAs.

CONCLUSION

Timely access is a critical element of high-quality care. Long wait times on the phone was a common are for improvement among our 14 academic practices in Toronto and known to be an issue affecting timely, high-quality primary care internationally. Through three Share & Learn sessions, our practices identified four areas of change: telephone system change, online booking and e-communications, call volume management, and waiting room redesign. However, how successful these change ideas were in shortening wait times often depended on context of the specific clinics and details related to implementation. Sharing and learning from practice experiences can support practice improvement efforts.

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