



## **Third Next Available Appointment (TNA) – Q and A**

### **Question:**

Can you tell me how you calculate TNA? Do providers who only work 3-4 days a week get punished because of extra days in between the days they work?

On the first Monday of the month I search within our scheduling system for the TNA for the particular appointment type, provider, and location. Then I count the number of calendar days to the third next available appointment of that type for that provider to get the TNA number. There is no further calculation that goes into it.

The effect of a part-time schedule would depend on what days were not worked, for example if a provider only worked Wednesday through Friday the best that could be expected for their TNA would be 2. They would never be at 0 because they are never going to have a same day appointment on a Monday.

Should we measure TNA consistently for all providers and just adjust the goal for the part time providers?

### **Mark Murray Response:**

These questions point out the challenges we have with measures. There is a judgment involved.

At this juncture what I commonly see is an "accommodation strategy"- that is, if we feel we cannot achieve the goal, we change the goal or change the measures and "lighten up." Big problem.

We have to deal with this situation honestly and with transparency. The goal is to match our capacity to patient demand. We do this by minimizing the delays. If we choose supply variation that is, time out of the office, then we simply cannot match demand that day to the supply. This is a choice. But we can "recover." With the right panel size and planning we can reduce the delay to that provider such that on the day he/she returns, he/she returns with open capacity and can catch up and the measure of TNA will be that day. We can do this without carving out and holding/freezing appointment slots.

So if the TNA is measured on a day when the provider is absent (similarly to how it would be measured if the provider were on vacation), that measure will honestly reflect the absence of that provider. I don't think we should change the measure or the aim. At the same time, we recognize that we don't expect the absent provider to reach a goal of 0 for TNA but we expect the provider will recover and have no wait for the days he/she is present, and achieve this without having to hold or carve out appointment slots.

The "punish" word is interesting. It implies a strong judgment. We just have to avoid changing the goals or the measures for each individual situation. Providers who work part time must understand that their TNA will never (or rarely) be 0, except on the days they are in the clinic.

It seems there are two issues here. The first is that it appears the TNA count is done once every month (first Monday). I think we ought to measure TNA weekly. TNA is a critical measure for how the system performs and we have to track it diligently. However, once TNA stabilizes at zero or minimum, then I would track future open capacity, which is a better measure for stable systems.

### **Question:**

That hurts providers who do not see patients on Mondays since they'll never get to a "same day appointment" state unless they start working on Mondays (and work towards that same day availability goal) or the day of the calculation changes to a day they actually work (and again have worked towards that goal). A provider working Monday-Thursday will always measure better using "data" than the provider working Thursday-Sunday, all other things being equal in the practice. If I got this right I have to agree with Dr. XXX...this is not fair.

### **Mark Murray Response:**

This is not about "fair" this is about how well the system performs. Do we successfully use our capacity to meet demand or not? Let's look at fairness through the customer's eyes as well.

I will repeat what I said: there is a huge problem here with how we view measures. The term "fair" and Dr. XXX's comments all imply judgment – doctors' perceptions that they are "good" if they have a short wait and "bad" with a long wait. There are really a few issues here:

- a) If the organization chooses to "allow" supply to be absent, then since demand continues unabated whether providers are present or not, there will be a delay. That delay does not change if we change the day we measure. Somehow I get the impression that we think if we just create intentional blindness and measure when we can look good, the delay just magically disappears. It doesn't. So what are we measuring for - to make providers look good or to see how well the system performs??

There are ALWAYS delays. Even a full-time clinician will have some (intentional) delays due to vacations and other issues. We don't change the measure for her because she went to Florida for a week.

- b) The goal here - and I repeat - is to minimize delays. We would like that minimization to be as short as possible. If a provider is gone and we choose to "allow" him/her to be gone, it is not possible to avoid that day's delay. On the other hand, we CAN eliminate the delays on the days when those providers are present: I repeat:
  - Get the right panel size
  - Commit to seeing your own patients and don't make them wait
  - Read the paper on "Appointing into the Future"
  - PLAN
  - Don't use a carve out model except post-vacation

## **Question:**

So the question here is why do we limit the count to that one day? Why not do it a couple different days of the week separated by a couple days, for instance. Also, consider an exception to only count on a day a provider actually sees patients. This would entail a shift in data collection, but if it better captures a provider's practice it may be better to change now than continue collecting less-than-ideal data the same way just because it was done that way in the past. Some change is good.

## **Mark Murray Response:**

If it makes you feel better to measure on different days so that all the providers have a chance to achieve the goal then go ahead. But changing the day does not change what the customer experiences.

The measurement is nowhere near as important as how well we work. I would be completely satisfied if all providers saw all their work on the day they worked and as a consequence planned with their team so that they could accomplish that. No work (demand) would be pushed to the future. The system performs as well as it can, given the choices we make.

The tension here is between system performance and measurement. Sometimes these don't seem to reconcile. For example, "I see all my work when I am there. I never push work to the future but the measure makes me look bad because the measure occurs when I am not there." The measure shows the performance of the system through the customer's eyes and despite the fact that I am performing optimally given my choices, I look "bad." Frankly I am not worried about that. What I worry about is when the TNA is past zero on days when I am present. Then I am not performing optimally. That's a problem.

I would not change the goal to give providers an excuse, simply because then the excuse is built in and it is easy to miss poor performance by hiding behind the excuse.

I would not change the measure. This is the right measure. The measure is really a patient measure and a system performance measure and it is the right one.

On the other hand, I would interpret my measures differently. A provider who is gone on Monday (and that may be a problem of another kind) and we measure on Monday will always have a delay of at least one day. This is our choice. At the same time, if she is here on Tuesday and her delay is 2 days or more, we have a problem.

## **Question:**

Second (addressed more thoroughly by Dr. Murray), as the interest of the Joint Commission is to improve patient safety, the interest of OC3 (and the Medical Home model) is to improve patient access to his/her primary care provider. Anything less than "24-7" availability starts chipping away at immediate access, so in a "single-PCP-to-patient" environment, the less you are not at work, the less is your patient access to the PCP...you just can't get around that.

## **Mark Murray Response:**

Continuity is king. All the data and evidence shows the same thing - See your own patients and you will provide better care. No excuses.

## **Question:**

I agree with Dr. Murray, the aim and measures should not change (e.g., some change is not good). It is easy to see why this is more stress provoking to part time providers and those working 4-day weeks with 3-day off intervals (longer waits are likely routine if taking 3 consecutive days off per week than alternating days off and at work), but it's really just a matter of degrees difference from anyone else. Patients may have longer waits for seeing their provider in these part time provider practices, but again, it's only a matter of degree. This is one of the many places where we have to accept that the "single-PCP-to-patient" model and stress on continuity needs to be balanced with convenience of access to care via another provider "close to the medical home."

## **Mark Murray Response:**

I digress - patients should see their own provider for all provider visits. Sometimes they need to see someone else - a different type - that's okay.

## **Question:**

For part time providers, measuring future open capacity may be a way to avoid some of the pitfalls you mention with TNA and part time providers. Remember, future open capacity is measured by picking a timeframe - say 1 month – then looking at the open spots in the numerator and all the spots in the denominator. Move the timeframe ahead one week every week you measure it. This method is a capacity measure, like TNA, but it considers all of the appointments, not just the third open. Have you considered trying that?

## **Mark Murray Response:**

Future open capacity is a good measure for systems - both practices and individuals within practices - that have reached/achieved their goal of no unnecessary delays and are committed to maintaining that goal. Future open capacity is not a good measure when the goal has not been achieved or where the providers are looking for excuses and a place to hide when they don't finish all the work each day. Since future open capacity is measured into a future of a month (sometimes a week) there is a great deal of flexibility. Hence, a practice or individual could be sub-optimally performing (pushing work from one day to the next or even across weekends or to UC) and these behaviors (and the viewpoint of the customer) can get lost within future open capacity.

My final comment:

There are a number of issues here:

1. What are the measures for? To grade or assess providers' behavior and/or to see how the system functions for our patients?
2. All measures can be manipulated by those measured to make them look "good."
3. "When we measure" changes the results or outcome of that measure. Should we change the "when we measure" to change the outcome? Why do we do that? As an excuse?
4. When measures change from "I am changing to get better and measuring to show that I am getting better" to "I am measuring to sustain my achievements," there is a subtle shift toward wanting to look good.

How can we reconcile most of these issues?

1. Make "see your own patients; don't make them wait" a system goal. No excuses.
2. Require providers to see all their own patients and not have any delays. This means the leaders have to monitor panel size and help and this means that the providers have to plan for contingencies and expect some variation in activity.
3. Since the providers will finish the work each day (the expectation, the system property, the culture) we can measure TNA on any day and "understand" why our supply choice may affect any individual outcome and we can use future open capacity successfully.

I think we spend too much time trying to make sure that providers "comply." I think we just make the system work. We build the culture for no delays then the measures should measure the patient's experience, not provider behavior.