HEALTHCARE ADMINISTRATION DESIGN ESTABLISHED ON A TOTAL-ACCESS BASIS

MODELO DE GESTIÓN ASISTENCIAL BASADO EN EL PRINCIPIO DE ACCESIBILIDAD TOTAL

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At present, the assessment of patient satisfaction is the most important parameter in health care quality. This modifies the vision of health care maintained to date. For this reason, health services must focus on citizens because they are the true evaluators of health care quality.

The ophthalmology service health care management model of the Moraleja hospital of Sanitas (1) is primarily based on the principle of total accessibility. Our objective is to offer the patient new alternatives to traditional healthcare services (appointments, emergencies) adapted to the particular needs of each and every one within the current healthcare framework of growing demand for services and improvement of perceived quality and global satisfaction indicators. In short, the principal aims at organizing available resources in order to facilitate immediate access to consulting practices with exact and specific assistance, providing a «product» in agreement with the needs and expectations of patients.

DESCRIPTION OF THE TOTAL ACCESSIBILITY MANAGEMENT MODEL

The model described below is operational since April 2007. The ophthalmology practice has its first focus on patients with appointments at 15 minute intervals for 12 hours a day from Monday to Friday. The mean of simultaneous agendas per day is of three in the morning timetable and four in the evening, to which we must add a programmed agenda on Saturday mornings entrusted to the ophthalmologist on duty.

During the practice hours the diagnostic or therapeutic supplementary explorations are made, with the exception of campimetries and fluorescein angiography (FA) which, due to their duration, are programmed in different agendas. The remaining ophthalmological tests are carried out within the practice, which allows us to coin the term «high resolution consultations». On the other hand, the practices also attend the emergency cases referred by the hospital reception, consultations for inpatients referred by other specialists and finally the health check ups (7-8 per day).

The internal organization of the practice is divided in sections corresponding to different specialties (anterior Paul, retina, glaucoma, pediatric ophthalmology and strabismus, etc). This was seen as necessary and was facilitated by the progressive development in knowledge and technologies for all medical specialties, and constitutes the best way of providing highly specialized assistance in what concerns scientific, technical expertise and competitiveness. However and in order to avoid the generation of isolated compartments, this organization is not distributed in differentiated agendas. Instead, it is merely functional but not organic in order to avoid the well-known consequences of organization and models built in isolated departments which entail delays in provision of services and waiting lists.

The difference lies in that all patients can be included in the agenda of any ophthalmologist with the only flexible exception of pediatric or adult ophthalmology. Subsequently, for successive visits the ophthalmologists will refer the patient to the specialization appropriate to the pathology. In this regard, clinical practice justifies a more functional

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and effective organization than the sub-specialties agendas from the viewpoint of avoiding waiting lists. A mean interval of appointments set at 15 minutes, together with the constant presence of three or four ophthalmologists, allows us on most occasions to absorb the demand as well as affording the possibility of giving up qualitative jump by providing immediate coverage without prior appointment to all patients were request it, either by inclusion in the appointment agenda or externally through the «Call-Center». The key element is the mean interval time and the number of concurrent ophthalmologists, which facilitate the right conditions and environment for them to carry out their work in a stress free and satisfactory manner under the best conditions which exclude any perception of anxiety or distress.

In this scenario, it is easier to reach the second objective mentioned above, that is punctuality (for patients with appointment) as well as immediate assistance (for patients without appointment). In addition to this, there is a third objective which is more important from the viewpoint of perceived quality and has no organizational precedent, which is anticipated assistance for the majority of patients who arrive early for their appointments.

By way of conclusion, the total accessibility management model involves a rigorous and strict organization which delivers a supply which always exceeds the amends, a high level of training and preparation as well as knowledge and expertise of ophthalmologists and staff. It also includes a number of rules which must be adhered to by all members of the organization, most importantly, generosity and confidence in order to obtain long-term benefits. Under this approach, some authorized opinions may argue that this model sacrifices quantitative productivity in order to give priority to working conditions highly favorable for the health professionals. However, in what concerns healthcare (where the products to be delivered is health), the organizations which enhance production and short-term profitability, in addition to becoming inflexible with time, will probably give rise to stress among professionals with ensuing reductions in quality of service and competency in the long term.

One of the quantifiable effects of this management model is related to the occupation rate of waiting rooms and it comparison with other adjacent services. The ophthalmology practice, which in 2006-2007 was among the first four hospital services in volume of consultations together with Obstetrics-Gynecology, Traumatology and Ear-Nose-Throat, has a waiting room which usually has mid-to low occupancy rates. This could be interpreted as a flow of patients entering and leaving the room in accordance with the demand and as punctuality in the fulfillment of appointment times. It could be stated that the occupation rate of a waiting room is inversely proportional to the capacity of the service to see patients. It would be more difficult to assess the benefits of this, but it would appear to be advantageous in what concerns occupation of space, reducing waiting room murmur and providing greater comfort. On the contrary, it would be negative if it gave the patient the perception of poor quality when, upon entering the room, it was filled over half or two-thirds of its capacity. Probably, a balance between both extremes would be most efficient.

The total accessibility healthcare model is supplemented by the Saturday agenda, which operate just like the prior appointment agendas. The design and execution of the Saturday agenda arises from two conditions: first, a considerable proportion of patients find it difficult to visit the doctor during their working hours, which leaves Saturday as the best time to do so. The same can be said of children and students. Secondly, the presence of the ophthalmologist in the hospital on Saturday mornings ensures coverage of emergencies because this specialist is not “on call” (as is the case on Sundays and holidays), but physically present. In addition, it facilitates scheduling other health-related activities such as medical checkups utilizing the same resources.

**PILLARS OF THE TOTAL ACCESSIBILITY HEALTHCARE MANAGEMENT MODEL**

1. Management of scheduled visits with prior appointment
   a) Immediate access – absence of waiting lists
   b) Immediate attention – punctuality or anticipation
   c) High resolution consultations
   d) Simultaneous consultations – «teamwork»
   e) 15-minute appointment intervals
   f) Training, experience and sub-specialization
   g) Provision of emerging technologies
   h) Function-based organization
2. Management of visits without prior appointment
   a) Immediate access and attention
   b) Integration in regular agendas
   c) Supply exceeding known demand
3. Supplementary assistance
   a) Urgent consultations during regular timetables
   b) Inter-specialty consultations of inpatients
4. Management of Saturday visits
   a) Offers an alternative for patient
   b) Specialized coverage or urgent cases

TEN POINTS FOR THE IMPLEMENTATION OF THE TOTAL ACCESSIBILITY MODEL

1. A high degree of commitment of the organization members with the principles of healthcare provision of the service.
2. A high level of training, qualification and professional experience. Development of sub-specializations.
3. Appointment intervals (15 min) adapted to optimized, relaxed and constant healthcare delivery. Optimum working conditions.
4. Programming at least three simultaneous consulting rooms.
5. The supply should exceed the known healthcare service demand.
6. Provision of the technical means required for performing ophthalmological tests.
7. Incentivation and motivation of professionals: payment based on medical actions, productivity, availability of emerging technologies, ongoing medical training, teaching and research.
8. Involvement of the professionals in the service management: Objective-based Participational Management (OPM). Transparency in management.
10. Close cooperation with the administration bodies and general objectives of the hospital. Strategic plans for the hospital and the Service.

REFERENCES