

1. Work down the backlog (for example, by adding extra overbook slots to schedules, extending clinic hours, adding clinic sessions, reviewing wait list to see if medical needs could be met by phone call or other means)
2. Reduce demand (for example, by extending reappointment intervals, creating alternatives to face-to-face visits, and using referral guidelines)
3. Understand supply and demand (for example, by knowing how many appointment slots a clinic has, knowing what the provider panel size cap is, knowing how many patients come in, call in, or are scheduled each day for the clinic)
4. Reduce appointment types (for example, by reducing the number of separate clinic profiles, standardizing the length of appointments)
5. Plan for contingencies (for example, by anticipating and planning for situations like provider leaves and the annual flu vaccination season)
6. Manage the constraint (for example, by figuring out where the “logjams” occur in the patient care process and figuring out actions to deal with them)
7. Optimize the care team (for example, by using standard protocols, matching patient needs to skills of appropriate team members, not necessarily always a physician)
8. Synchronize patient, provider and information (for example, by starting clinic on time, checking charts for completeness, accuracy and presence at appointment)
9. Predict and anticipate patient needs at the time of the appointment (for example, by using regular clinic team “huddles” to communicate and deal with possible situations that may arise, using clinical reminders to get as much done in each visit as possible)
10. Optimize rooms and equipment (for example, by having the same supplies available in each exam room, making sure supplies are continuously stocked, using “open” rooming).

**Advanced Access: 10 Points**

## Advanced Access FAQs

Medical office practices struggling with access delays and the attendant phone problems and dissatisfaction continue to be drawn to Advanced Access (aka Open Access, AA, OA) scheduling. In our experience as faculty with the Institute for Healthcare Improvement we have worked with teams from across the US, Canada, and Europe as they have tested and then adopted this approach to reducing waits and delays. In that work we hear a continuing stream of questions and thought it might be helpful to explore those frequently asked questions.

What follows in no order of importance are questions frequently asked by clinicians and office practice teams and our answers culled from years of helping teams work through these issues.

A detailed exploration of the core concepts of Advanced Access can be found on the IHI web site at: <http://www.ihi.org/IHI/Topics/OfficePractices/Access/>

**With advanced access do I ask people to only call on the day they want to be seen or can I book patients into the future (chronic conditions follow up, well child check, prenatal, etc)?**

AA does not mean “no schedule/walk in clinic.” It means we have an accurate estimate of demand and can flex our supply to meet variation in demand.

Any day’s schedule is going to be made up of patients who called that day, called the day before, the week prior, the month prior, just like your schedule looks today. The point is that the sum total of the work is within our capacity and we’re able to flex to meet the variation in demand and have contingency plans in place for when the demand/supply gap grows.

Regarding how far out to book patients in follow up: book them out as far as makes sense. This means that you don’t confuse the schedule with a reminder system. If an appointment on the books is an illusion (i.e. we have you on the schedule, you are almost certain to no-show or re-schedule, but at least we won’t lose track of you) then we are confounding two functions – reminder system and office visit schedule. If the appointment in the future is an illusion, it blocks the use of the schedule for its primary purpose – to give an individual a real time at which they will meet with a clinician.

Assess your patient population. Which sub-group(s) of patients are highly likely to no-show? How far out is the ‘break point?’ After the break point, consider using a reminder system rather than the schedule. See “what to do about chronic no-shows” below.

**Is advanced access the same as a walk-in clinic / does it mean we just give up the schedule?**

No. We maintain schedules (see “scheduling chronic condition follow up” above as well as “schedule shaping” below).

It is also not the same thing as holding/freezing parts of the schedule for “urgent” or “routine” appointments. We put schedulers back into the business of scheduling and let nurses do nursing. There is no reason to have a provider or nurse weigh in on scheduling when an appointment is being offered “today.”

There is one important caveat: if the scheduler perceives that the patient wants an inappropriate delay “I want an appointment next week for my son with asthma and shortness of breath.” Or if the locus of care might be inappropriate “I’d like to bring my husband right over with his crushing sub-sternal chest pain, shortness of breath...” In these cases, nurses weigh in to make a clinical assessment and triage accordingly.

### **Does open access work because we give up continuity?**

No. Practices that do this well improve the rate of continuity as this leads to a reduction in demand. When patients see their own provider consistently they tend to receive a higher rate of preventive care, reducing the likelihood of “please schedule a follow-up with your primary to address that non urgent issue.”

Continuity becomes one of the main drivers of appointing in an advanced access system. The first question a telephone agent asks is “who is your provider (or team)?”

### **Do I ever limit the number of new patients I accept?**

Yes. To maintain control over supply and demand, this is an absolutely critical variable to manage. If you cannot control the flow of new patients, it may not be possible to maintain advanced access unless the natural influx of new patients somehow magically equals the rate of patients leaving your practice or you are able to grow the practice continually to meet the demand.

### **But what about all those needy people out there who want to be served by me?**

You have to make a choice: continue to book out far into the future and manage the influx of new patients through waits and delays and the attrition from the line, or actively manage the new patient volume by being up front and saying “We’re full.”

The reason I feel the second is the honorable path is that advanced access leads to a net reduction in work load around scheduling and therefore the opportunity to offer care to more people. The workload reduction comes in the nursing time no longer spent on the phone playing “mother-may-I” as well as the diminished phone time for patients and schedulers (one large organization measured found a reduction in telephone appointing time from nine minutes before implementation to one minute post implementation). This workload reduction translates to increased team capacity and the ability to offer more satisfactory services to more people.

### **What can I do if the community demand for care exceeds my capacity?**

First: become very very efficient. Create a highly functional team approach to care and reduce your work burden through implementation of EMR, advanced access. Reduce demand by improving continuity of care, supporting patients in self-management, group visits.

If you've done all that and still cannot meet the demand, hire new providers. If you are unable to hire any more providers and still have not met the demand, your community needs to work with you to attract new providers.

The option that is no longer on the table is to allow practices to restrict access through delays: "Our next available new patient non urgent appointment is three months from now."

**Does AA work in Pediatrics/Family Medicine/Internal Medicine/OB GYN/etc?**

Yes. The principle of managing supply and demand works in all settings. Each specialty and setting has unique features that might require some extra work to manage well. OB GYN is a good example.

An OB GYN MD splits time between the OR, the labor deck, and the office practice. In the office, the OB GYN MD provides primary and specialty care mixed with procedures. Each of these separate threads of work have their unique demand and must be met with equal supply. Each demand stream experiences variation. To provide advanced access in all aspects of care, an OB GYN practice will typically build a complex team of individuals working with a complex set of interlocking schedules. In addition to the OB GYN MD, these individuals may include nurse midwives, NPs, PAs, physicians dedicated to GYN care only or some other narrower scope of practice (e.g. high risk OB, perinatology, etc).

Advanced access in an OB GYN practice requires simultaneously managing the supply and demand of each thread, creating enough flexibility to meet the variation in demand. An OB GYN practice achieving advanced access takes their current skills in managing these multiple schedules and figures out how to manage and shape the demand and supply while eliminating backlog.

These techniques are the same in every practice, so, with modification to the issues of the specialty and setting, advanced access works in all settings.

**Does AA work if I round in the hospital/round in a nursing home/teach part time in a local medical school/moonlight in an ED/etc?**

This is the same issue as part time. Advanced access works when the supply equals demand, with the caveat that the supply must be able to flex enough to meet demand variation. If a clinician has 20 hours to dedicate to office practice per week, everything will work out if the demand for that clinician is 20 hours per week and the variation in demand is within the scope of flexibility of that clinician and/or team.

**Does "flex my supply to meet demand" mean I just gave up all control over my life?**

No. If you keep your total panel size in synch with your supply, you live with the typical daily and seasonal variation. This variation tends to be less than that seen in systems with delays that then exacerbate variation by adding double and triple bookings to meet

demand. The predictability of a system without delays is better, so variation is diminished.

On any given day a clinician and/or team may be constrained by a time limit and unable to meet the full day's demand (mandatory inservice, grand rounds, violin lesson). Some of the excess demand can be pushed forward to tomorrow or pushed to another team. Neither is great, but these are two of the contingency plans some teams adopt to manage unusual variation in supply and demand. You will come up with those contingency plans that are palatable and effective for your team.

More below in the discussion of part time docs.

### **Does this work for part time docs?**

Part time makes it more difficult but not impossible. The goal is to match supply and demand. The easiest part time scenario is to offer some appointment access at least 4-5 days per week, even if it is very limited on any given day.

Part time providers need back up when they are not available. Offering patients the back up provider takes more time and decreases patient satisfaction, so part-time raises the cost and reduces satisfaction, but must be balanced against our ability to create work environments that are attractive. I am part time (about 30%) in practice in a solo office with backup from another solo office. I'm willing to take the satisfaction hit so that I can have a life, and am willing to bear the associated expense.

Larger offices with many part time providers have the burden of work to piece together teams that have horizontal presence over the week, as well as the work of negotiating cross-coverage arrangements: "Each must agree to see two patients per day for the absent provider." This is extra uncompensated work and another reason that larger offices are less efficient and have a larger percent of revenue going to pay for overhead.

### **What is the correct panel size?**

The perfect panel size is that which drives demand equal to your supply. You have to arrive at that number over time. It is not a target. Don't fall for any of the so called benchmarks. You want a balance between supply and demand.

Supply is made up of the care team's numbers and capability and work hours. Demand is made up by the scope of practice, the number of patients, their age/sex/illness burden and their historic rate of seeing care. These variables are too huge for the average practice to nail down, and when you put them all together, the product of the error factor exceeds credulity.

So how many patients should a provider have? Start with how many you have now. If you are able to keep up with all the work and offer advanced access scheduling, you are fine. If not, you must reduce demand and increase supply.

### **What do you do about patients who chronically no-show?**

Nothing reduces no-show rates like offering an appointment today. We'll get very cranky with patients who no-show on the same day they called for an appointment, and you then have to come up with an honorable policy you all can live with to answer the question: "When if ever do we discharge patients from the practice?"

For those you keep and who continue to no-show, or those for whom you know are highly likely to skip the follow up they need in 1 week/month/year, you can put them into a reminder system. Use a 3x5 file (or better, an electronic reminder system) and start chasing those patients who failed to follow through on the intended care. Many practices find that they don't have to chase 100% of those in the reminder system, a large proportion of those patients actually did come in some time close to the right window.

What to do for the patient who repeatedly calls and fails to show up same day, but our practice is not willing/able to discharge: treat them like a walk-in. When they call, you can offer them an appointment, but with a 90% chance of no-show, go ahead and book another person at the same time. If this 90% no-show person really does come, work them right into the schedule and thank them for coming (i.e. don't punish them the one time they do follow through).

**Does advanced access mean seeing every patient when the patient wants to be seen (i.e. am I going to have to work all nights and weekends for the rest of my life)?**

No. We work to achieve balance between work and life so that we can enjoy what we do and help those who come to us for care. Part of the balance is going home. You determine your best hours of operation. This defines your supply. Try to spread it out over the week as much as possible (as the incidence of demand is not restricted to particular days of the week).

At some time in the day a patient calling and wanting a visit will be unable to make it in to the office before you close. You have the choice of staying late or offering that person an appointment the next morning.

**Everybody wants to come between 3-5 PM. How can we manage that?**

We shape demand. When offering an appointment, we offer those that are typically in a low demand time of day. "Dr. Jones can see you today at 10:30A." The patient might not really like that time, and you could negotiate another time. Enough patients tend to accept the offer, so that you are able to smooth the demand a bit, creating better flow.

Schedule shaping takes work. The scheduler must have a crystal clear understanding of high and low demand times. Schedule shaping sometimes takes scripting. In a larger practice, variation in the way schedulers talk to patients can create problems. "But yesterday Steve let me choose the time I wanted to come..." Larger more complex practices sometimes have to have meetings to develop scripts for schedulers so that each say the same things to avoid the appearance of preference.

**Can this work in a solo practice/large group practice?**

Yes/yes. Advance access is based on matching supply and demand. Solo practices have to look to other practices for back up, but remember that you must have some mechanism in place now for when the solo provider takes vacation (if the individual never takes vacation, they are in burnout mode and won't be practicing that long).

Larger practice have the benefit of built-in back up, which is a nice benefit to very slightly offset the greater complexity and expense of group practice.

### **How long until the backlog is gone?**

One method to calculate the length of backlog reduction:

1: Print out your schedule from today through the day of your third next available long appointment.

2: Count the number of future appointments that are taken up with bad backlog.

The difficulty with this step resides in the assumptions we make about the meaning of bad backlog. The intent is to count those appointments that have been deflected to the future due to inability to see that person "today." Challenge your assumptions by saying "If I had a wide open schedule and was hungry for patients, would I offer to see this person today?"

3: Choose your preferred backlog reduction strategies.

Strategies differ in the rate at which they reduce backlog. Most obvious: adding one extra patient slot per day. Some strategies have immediate payoff (adding a slot), some later (four month follow-up rather than three month).

4: Compare the backlog reduction strategy to your backlog.

If you have 100 appointments of bad backlog and add one extra patient slot per day, working four days per week, it will take 25 weeks to eliminate backlog if all else is held constant.

Remember: backlog reduction is painful but is usually shorter than expected. This is due to the more-than-additive effects of multiple strategies: improving continuity, extending re-visit intervals, max-packing visits, adding slots, etc.

### **Where do you start?**

1. Measure supply and demand enough to understand day-of-the-week variation as well as likely seasonal variation.
2. Link every patient to a PCP.
3. Create care teams.
4. Set dates for starting backlog reduction and for achieving advanced access
5. Start reducing backlog.

### **Where can I learn more about advanced access?**

Go to:

<http://www.ihl.org/IHL/Topics/OfficePractices/Access/>

## Advanced Access References

(From Mark Murray MD)

Belfiglio, Genevieve. You mean I can see my Doctor Today? *The American Journal of Managed Care*. 8(8): 701-705

Berry, L.L., Seiders, K., & Wilder, S.S. (2003). "Innovations in access to care: A patient-centered approach." *Annals of Internal Medicine*, 139(7): 568-574.

Bodenheimer, T. Innovations in primary care in the United States. *British Medical Journal*. 2003; 326: 796-798

Bodenheimer, Thomas, MD, Bernard Lo, MD and Lawrence Casalino, MD, PhD. Primary Care Physicians Should Be Coordinators, Not Gatekeepers. *JAMA*. June 2, 1999-Vol 281, No. 21.

Boelke, Catherine, MBA, CMPE, Barbara Boushon, BSN and Susan Isensee, MD. Achieving open access: The road to improved service and satisfaction. *MGM Journal*, September-October 2000: 58-68

Carlson, B. Same-day appointments promise increased productivity. *Managed Care*. 2002: 11(12): 43-44

Carlson, Bob. Working Too Hard, Doctor? Poor Work Flow Could Be to Blame. *Managed Care*. July 2002: 48

Chesanow, N. Pick the team, and write the game plan. *Medical Economics*, February 21, 2000 pp.75-84.

Chien, C, DM Steinwachs, AF Lehman, et al. Provider continuity and outcomes of care for persons with schizophrenia. *Mental Health Services Research*. 2000; 2:201-211

Dewitt, Paula. Finding the Time: Clinics pursue new strategies to reduce wait time for appointments. *HealthLeaders*. September 2004, 11(9): 72-73

Duffy TE. Urology advanced clinic access concepts. Presented at the 4<sup>th</sup> Annual International Summit on Redesigning the Clinical Office Practice, St. Louis MO, April 14 2003

Gordon, A.B. Oct 2002. Success story: Building healthy relationships at Alaska Native Medical Center. *Continuous Improvement*. Issue 19, IHI Newsletter. Retrieved January 15, 2004:  
<http://www.ihl.org/resources/successstories/ci1002alaska.asp>

Gordon, Ann. Success Story: Open Access at Primary Care Partners. *Idealized Design of Clinical Office Practices*. Issue 8, October 2001. Available at: [www.ihl.org/IHI/Topics/OfficePractices/Access/ImprovementStories/Open+Access+at+Practice+Care+Partners.htm](http://www.ihl.org/IHI/Topics/OfficePractices/Access/ImprovementStories/Open+Access+at+Practice+Care+Partners.htm).

Graber, M.L. Improving access in VA clinics. *Veterans Health System Journal*. 1999; 4:13-17

Grandinetti, D.A. Make the most of your staff. *Medical Economics*, Apr 24, 2000: 56-66

Grandinetti, D.A. You mean I can see my doctor today? *Medical Economics*. March 20, 2000, pp. 102-114

Grumbach, K., Bodenheimer, T., (2004, Mar 10). "Can health care teams improve primary care practice?" *JAMA*, 291(10): 1246-51.

Kilo, C. and S. Endsley. May 2000 As good as it could get: Remaking the medical practice. *Family Practice Management*. 7(5): 48. Retrieved January 15, 2004: <http://www.aafp.org/fpm/20000500/48asgo.html#14>.

Kilo, C.M., Triffletti, P., Tantau, C., & Murray, M. (2000). "Improving access to clinical offices." *The Journal of Medical Practice Management*, 16(3):126:132.

Kofoed L, Ramirez ME. Achieving same day access in a Veterans Health Administration mental health clinic. In press, *Federal Practitioner*. 2004

Lee, Thomas. Editorial: Ecology in Evolution. *New England Journal of Medicine*, June 28, 2001. Vol. 344: 2014-2020. Number 26

Lippman, H. Practice in the twenty-first century. *Hippocrates*. January 2000: 38-43

Lippman, H. Same-day scheduling. *Hippocrates*. February 2000: 49-53.

McDonald J, Brown N, Ellis P. Using telephone prompts to improve initial attendance at a community mental health center. *Psychiatric Services*. 2000; 51:812-814

Moore LG. "Strong" evidence for improved access. Available at : [www.ihl.org/resources/successstories/ci0401success.asp](http://www.ihl.org/resources/successstories/ci0401success.asp). Accessed September 10, 2004

Murray, Mark and Donald Berwick. Advanced Access: Reducing Waits and Delays in Primary Care. *JAMA*, February 26, 2003, Vol. 289, No. 8

Murray, Mark, Thomas Bodenheimer, Diane Rittenhouse, and Kevin Grumbach. Improving Timely Access to Primary Care: Case Studies in the Advanced Access Model. *JAMA*. February 26, 2003, Vol. 289, No. 8

Murray, Mark. Modernizing the NHS. Patient Care: Access. *British Medical Journal*. June 10, 2000, Vol. 320, 1594-6.

Murray, Mark, MD, MPA and Catherine Tantau, BSN, MPA. Must Patients Wait? *Journal on Quality Improvement*, August 1998, Vol. 24, No. 8

Murray, Mark, MD, MPA and Catherine Tantau, BSN, MPA. Redefining Open Access to Primary Care. *Managed Care Quarterly*, August 1999

Murray, Mark, MD, MPA. Reducing Waits and Delays in the Referral Process. *Family Practice Management*, March 2002

Murray, Mark, MD, MPA and Catherine Tantau, BSN, MPA. Same-Day Appointments Create Capacity, Increase Access. *Executive Solutions for Healthcare Management*, February 1999.

Murray, Mark and Catherine Tantau. Sept 2000. Same-day appointments: Exploding the access paradigm. *Family Practice Management*, 7(8):45-50. Retrieved January 15, 2004: <http://www.aafp.org/fpm/20000900/45same.html>.

Murray, Mark, MD, MPA. Waiting for Healthcare: Physician offices can dramatically reduce how long patients wait for appointments: Editorial Postgraduate Medicine, February 2003, Vol 113, No. 2. [http://www.postgradmed.com/issues/2003/02\\_03/editorial\\_feb.ht](http://www.postgradmed.com/issues/2003/02_03/editorial_feb.ht)

Nicholson, I.R. Factors involved in failure to keep initial appointments with mental health professionals. *Hospital and Community Psychiatry*. 1994; 45:276-278

O'Hare, D., and J. Corlett. (2004, February). "The outcomes of open access scheduling." *Family Practice Management*. February 2004: 35-38.

Open Access Scheduling boosts patient satisfaction. *Consumer Driven Healthcare*. Vol. 1 No. 1, September 2002, page 13-16

Parchman, Michael and Sandra Burge. Continuity and quality of care in type 2 diabetes. *The Journal of Family Practice*, July 2002, Vol 51, No. 7: 619-624

Petitti DB, Grumbach K. Variation in physicians: recommendations about revisit interval for three common conditions. *Journal of Family Practice*. 1993; 37:235-40

Plauth, Anna E., MD, MPH, and Steven D. Pearson, MD, MSc. Discontinuity of Care: Urgent Care Utilization Within A Health Maintenance Organization. *The American Journal of Managed Care*. November 1998, Vol. 4, No. 11.

Raddish, Michele, MD, MPH, Susan D. Horn, PhD, and Phoebe D. Sharkey, PhD. Continuity of Care: Is it Cost Effective? *The American Journal of Managed Care*, June 1999, Vol. 5, No. 6.

Randolph, Greg, Murray, Mark, Swanson, Jill and Margolis, Peter. Behind Schedule: Improving Access to Care for Children One Practice at a Time. *Pediatrics*, March 2004, 2004; 113:e230-e237, Vol 113 No.3

Schall, Marie, Terry Duffy, Anil Krishnamurthy, Odette Levesque, Prashant Mehta, Mark Murray, Renee Parlier, Robert Petzel and John Sanderson. Improving Patient Access to the Veterans Health Administration's Primary Care and Specialty Clinics. *Joint Commission Journal on Quality and Safety*, August 2004, Vol. 30, No. 8

Schwartz LM, Woloshim S, Wasson JH, Renfrew RA, Welch HG. Setting the revisit interval in primary care. *Journal of General Internal Medicine*. 1999; 14:230-5

Smith, Jane. Redesigning Health Care: Radical Redesign is a way to Radically Improve. *British Medical Journal*, May 26, 2001, Vol 322, 1257-1258

Solberg, Leif, I.M.D. The KISS Principle in Family Practice: Keep it Simple and Systematic. *Family Practice Management*, July–August 2003. 10(7): 63-67

Sparr LT, Moffitt MC, Ward MF. Missed psychiatric appointments: who returns and who stays away. *American Journal of Psychiatry*. 1993;150:801-805

Terry, Ken. Don't Be Afraid of Same-Day Scheduling. *Medical Economics*. November 5, 2004, Vol 81, No. 21, page 64.

Terry, K. Re-engineer your practice – starting today. *Medical Economics*, January 24, 2000 pp. 175-188

Valenti WM and Bookhardt-Murray J. Advanced- Access Scheduling Boosts Quality, Productivity and Revenue. *Drug Benefit Trends* 16 ( 10): 510,513-514, 2004 Cliggot Publishing, Division of CMP Healthcare Media. Available at : [http://www.medscape.com/viewarticle/492839\\_1](http://www.medscape.com/viewarticle/492839_1)

White, B. (2001, October). "Starting a revolution in office-based care." *Family Practice Management*, 8(9): 29. Retrieved January 15, 2004: <http://www.aafp.org/fpm/20011000/29star.html>

White, Susan. Brief Report: 13<sup>th</sup> Annual National Forum on Quality Improvement in Healthcare. *Journal for Healthcare Quality*, Vol. 24, No.4, July-August 2002: 39-42

Williams, M.E. Help me now: improving access to mental health services. *California Coalition of Community Mental Health Agencies Newsletter*. 2001, 10:23-24

Witt, Mary and Suzanne Tinder. Advanced Access: Healthcare partners Sees Patients the Same Day. *Group Practice Journal*. Vol. 51, No. 2, February 2002, page 36-40

Zampello F. Focus on: clinical practice redesign. VISTAS Newsletter. June 2002. Available at: <http://wphca.org/vistas%2006-02.html>. Accessed September 10, 2004

You can see the doctor now: *Buffalo News Editorial*, April 4, 2000, Section B-2