IMPLEMENTATION GUIDE

ENHANCED ACCESS

Providing the Care Patients Need, When They Need It

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TABLE OF CONTENTS

Introduction 1
- The Change Concepts for Practice Transformation: A Framework for PCMH 2

Why Focus on Access? 4
Provide 24/7 Access 6
- On-Call Systems 6
- Health IT Systems 7
- After-Hours and Urgent Care Clinics 7
- Access via Secure Email 7
- Access via Telephone 8

Reduce Other Barriers to Care 9
- Health Insurance 9
- Transportation Remedies 11

Balance Supply and Demand 11
Increase Capacity 14
- Reduce No-Shows 14

Case Study: Significantly Reducing No-Shows 17
- Add Same-Day Access 18
- Simplify Appointment Types 19
- Work More Efficiently 19

Case Study: Redesigning Front Desk Workflow 21
Adopt Innovative Forms of Access 22
- Offer Group Visits 22

Case Study: The Benefits of Group Visits 23
- Shift Supply to Cover Gaps 24
- Recurring Imbalances 24

Decrease Unnecessary Demand 26
- Foster Continuity 26
- Max Pack Visits 27
- Extend Revisit Intervals 27

Provide Alternatives to Traditional Face-to-Face Provider Visits 28
Clear the Backlog 29
- Work Smart 29
- Work Hard 30

Conclusion 30
Additional Resources 31
Appendix A: Health Information Technology 32

Introduction

Enhanced access is a fundamental concept of the Patient-Centered Medical Home (PCMH) Model of Care because it is an essential key for improving patient outcomes, improving patient experience, and reducing healthcare costs.

The goal is an accessible practice with no barriers. Patients get the care they need and want, when and how they need and want it.

Improving access requires practices to think differently about practice design, provider and staff organization, and their daily work. Enhancing patient access begins with a commitment to eliminating barriers to care including those related to a patient's ability to pay. Eliminating barriers to care means providing patients with 24/7 access to their care team during office hours; and, when the practice is closed, providing access to advice through a live coverage system. PCMH practices provide patients with a variety of patient- and family-centered options (same-day appointments, telephone, email, and group visits) that increase the practice's efficiency and capacity to care for all patients who need care in real-time. To ensure access over the long-term, a practice must also be able to balance supply and demand on a daily basis. This requires clear access goals and tactics to deal with the variations that occur on a day-to-day basis. The best systems are designed to anticipate and respond to these variations in real-time.

Message to Readers

Practices beginning the PCMH transformation journey often have questions about where and how to begin. We recommend that practices start with a self-assessment to understand their current level of "medical homeness" and identify opportunities for improvement. The SNMHI's self-assessment, the Patient-Centered Medical Home Assessment (PCMH-A), is an interactive, self-scoring instrument that can be downloaded, completed, saved, and shared.

Readers are also encouraged to download additional Safety Net Medical Home Initiative Enhanced Access materials:

- Enhanced Access Executive Summary provides a concise description of the Change Concept, its role in PCMH transformation, and key implementation activities and actions.
- Sample On-Call Guidelines.
- Guide to Appointment Confirmation Calls .
- Secret Shopper Exercise.
- Time to Third Next Available Appointment.
- No-Show Management Guide.
- Standardized Switchboard Process Map.
- Recommended materials from other sources are provided under Additional Resources.

A PCMH practice meets patient needs in as close to real-time as possible—and care teams are able to leave at the end of the day, having finished today's work today.

While the changes required to enhance patient access can be challenging to implement, the potential payoff is substantial. Barriers to care negatively affect clinical outcomes, patient experience, staff satisfaction, and healthcare costs. Further, changes that improve access by removing barriers to care are a multiplier for many of the other changes practices make on the PCMH journey. Lastly, if patients can't get access to care when and how they need it, the benefits of all of the other improvements the practice has made (e.g., self-management support) will remain out of reach.

The Change Concepts for Practice Transformation: A Framework for PCMH

"Change concepts" are general ideas used to stimulate specific, actionable steps that lead to improvement. The Safety Net Medical Home Initiative (SNMHI) established a framework for PCMH transformation to help guide practices through the transformation process. The framework includes eight change concepts in four stages:

- Laying the Foundation: Engaged Leadership and Quality Improvement Strategy.
- Building Relationships: Empanelment and Continuous and Team-Based Healing Relationships.
- Changing Care Delivery: Organized, Evidence-Based Care and Patient-Centered Interactions.
- Reducing Barriers to Care: Enhanced Access and Care Coordination.

The Change Concepts for Practice Transformation have been most extensively tested by the 65 safety net practices that participated in the SNMHI, but they are applicable to a wide range of primary care practice types. The Change Concepts have been adopted by a number of other improvement initiatives, reflecting their generalizability in primary care regardless of patient population or practice structure. The Change Concepts were derived from reviews of the literature and also from discussions with leaders in primary care and quality improvement. They are supported by a comprehensive library of resources and tools that provide detailed descriptions and real examples of transformation strategies. These resources are free and publicly available.

Key Changes for Enhanced Access

The eight Change Concepts provide a framework for PCMH transformation. Each change concept includes multiple "key changes." These provide a practice undertaking PCMH transformation with more specific ideas for improvement. Each practice must decide how to implement these key changes in light of its organizational structure and context. The key changes for Enhanced Access are:

- Promote and expand access by ensuring that established patients have 24/7 continuous access to their care teams via phone, email, or in-person visits.
- Provide scheduling options that are patient- and family-centered and accessible to all patients.
- Help patients attain and understand health insurance coverage.

Key Terms for Enhanced Access

AVPY
Average Visits per Patient per Year.

Continuity of care
The frequency with which patients are seen by their assigned provider/care team versus other providers in the practice.

Demand
Known and anticipated needs of patients for care. Demand is a reflection of patients' need for care or service and is measured by a visit, a phone call, an email, a message through a portal, or other means by which a patient says: "I need something from you."

Demand can be for a visit or medication, for clinical advice, self-management, care management, financial eligibility, or other support; or for information for forms or other paperwork, typically for jobs, school, or camp.

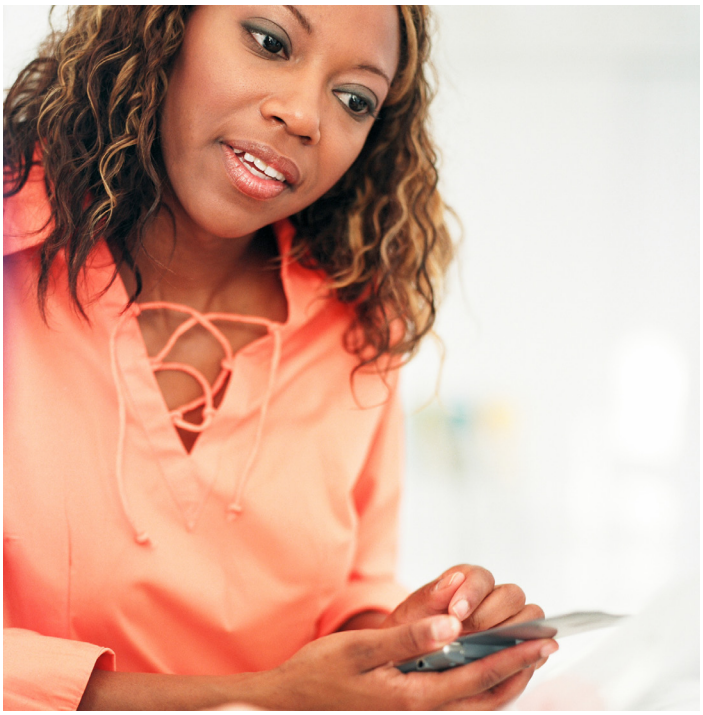
Panel size
The number of individual patients assigned to the care of a specific provider/care team.

Right panel size
Number of individual patients a provider can support based on provider's appointment availability.

Supply
Supply is used to denote the amount of something, typically the number of staff that are available, the number of providers, the number of appointment slots, or the number of hours of service.

Capacity
The term "capacity" reflects the maximum or optimum amount that can be produced with a certain set of resources (e.g., the supply). Capacity is the ability of a practice to meet patient demand for care. Variables include staff resources, team effectiveness, availability of appointments and other avenues for care, physical space, and tolerance (the ability of a care team to manage a specific workload).

Supply and Capacity: The Multiplier Effect
The difference between supply and capacity is a multiplier effect that takes the supply and makes it greater than its parts. An example is that a certain number of staff have the capacity to produce a specific amount of work to meet patients' needs. However, when we organize the same number of staff into care teams with specific roles and responsibilities, the capacity to meet patient demand increases. Teams are a **multiplier** for the supply. If we add better designed workflows for the teams to use, the capacity increases even further.



Why Focus on Access?

Access to primary care is a defining characteristic of high-performing health systems and thus a fundamental concept of the PCMH Model of Care. Studies show that enhancing patient access, particularly providing access to 24-hour advice and to the patient's provider of choice, improves outcomes, patient experience, and reduces the cost of care.[1] Table 1: Benefits and Outcomes Associated with Enhanced Access, provides examples of how enhanced access benefits patients and families, providers and care teams, and practices and communities.

Enhancing patient access is an essential key for improving patient outcomes, improving patient experience, and reducing healthcare costs.

When patients face waits or delays in receiving care they are more likely to skip appointments, forego care, or go to another practice or facility for care. Missed appointments lead to missed opportunities for early diagnosis and treatment, and missed opportunities for preventive care. A no-show appointment blocks another patient from receiving care and wastes a valuable resource. Patient no-shows also disrupt workflows. If patients defer to another source of care, because they cannot get timely care from their primary source of care, continuity is compromised. The practice may also lose an opportunity for revenue.

The goal of enhanced access in the context of a PCMH is to improve the probability that patients get the care they need, when and how they need it, from their personal primary care provider and care team.

Table 1: Benefits and Outcomes Associated with Enhanced Access

Stakeholder	Benefits / Outcomes
Patients and families	• Access to care when needed (24/7). • Continuity with care team and provider; improved care outcomes, reduced unnecessary demand. • Multiple ways to obtain care: group visits, telephone follow-up, e-visits, scheduled visits with provider or care team. • Clinical needs met in a timely manner. • Avoided/reduced unnecessary use of emergency department (ED). • Improved satisfaction and experience with care.
Providers and care teams	• Improved continuity promotes knowledge of patients and ability to provide care more effectively. • Fewer gaps in care. • Ability to predict and respond to patient needs more rapidly. • Less chaos and more control. • Improved satisfaction.
Practice	• Potential increased RVU billing. • Reduced no-show rates reduce guess-work and promote more effective use of daily appointment supply. • Improved staff satisfaction and potentially reduced turnover. • Fewer patient complaints.
Community	• Improved outcomes promote health of the community. • Reduced ED use. • Reduced hospitalization rates, particularly re-admission rates.

Implementation Overview: Design Changes

Changes in the overall design of the practice—including provider and staff organization, as well as how providers and staff think about and carry out their work—are required to enhance patient access.

The following sections in this Guide provide specific strategies and present tools that practices can use to enhance access by:

- Providing 24/7 access and accessible, patient- and family-centered scheduling options.
- Reducing other barriers to care.
- Increasing capacity.
- Reducing unnecessary demand.

Provide 24/7 Access and Accessible, Patient- and Family-Centered Scheduling Options

The PCMH standard of care sets a high bar: Promote and expand access by ensuring that established patients have 24/7 continuous access to their care teams via patient-centered options such as phone, email, or in-person visits.

Although the journey to achieving this goal may be long, we believe it is the right standard. Patients' needs don't always follow office schedules. People get sick at odd times; even well-organized people can discover that they have run out of a prescription medication on a weekend; ear infections don't just happen on weekdays. It is sometimes truly too difficult for a parent or patient to make an appointment during regular business hours.

Enhanced access helps patients get timely clinical advice so they can make better-informed decisions about self care and prevents them from making unnecessary emergency department visits.

In an ideal system of care, patients would have 24/7 access to **their** provider and care team, and providers and care teams would have 24/7 access to **their** patients' information.

Movement toward 24/7 care can be difficult, as it may put new requirements upon providers to supply overnight, weekend, and holiday coverage. Once the practice makes the commitment to 24/7 access, the practice will need to implement an on-call system for coverage at a minimum. In the section that follows, we describe steps a practice can take to implement an on-call system as well as several other tactics and technologies that can be used in addition to an on-call system to provide patients with care when they need it.

Tactics and technologies that practices can use to help achieve 24/7 care include:

- On-call systems.
- Health IT systems.
- After-hours and urgent care clinics.
- Email access and patient portals.
- Telephone access.

See the Additional Resources section for more information on 24/7 tactics.

On-Call Systems

An on-call system that can connect a patient to a provider at any time the practice is not open is the minimally acceptable standard of care in today's connected world. This system might route calls through an answering service that connects to the practice's providers, or to clinical staff in a local hospital system, a nurse advice line, or urgent care clinic.

Staffing the system with the practice's providers is best because it increases the chance that the patient will interact with someone they know, increases access to information, and enables more effective follow-up.

- Large practices may have a sufficiently large provider base to share in a call-rotation system and avoid burnout.
- Several smaller practices might work together to create a coverage network. Be sure to consider how the covering provider will access patient information.
- If neither of these approaches is feasible, look for a group that provides coverage. Ensure that it will give you and your patients what you need for continuity.

Any approach that provides 24/7 access to a live person is a step ahead and a baseline requirement. See the corresponding tool from Harbor Health Services, On-Call Guidelines for examples.

Health Information Technology Systems

Critical to the implementation of 24/7 access is a health information technology (HIT) system that:

- Makes patient information securely available to the on-call provider.
- Enables real-time documentation.
- Ensures that after-hours care recommendations get back to the primary team immediately. A mandatory response to this notification, which signals that the primary team is accepting responsibility for the ongoing care, is also recommended.

To learn more about HIT, see Appendix A: Enhanced Access and Health Information Technology.

After-Hours and Urgent Care Clinics

A practice can expand office hours by using staggered shifts or moving some weekday availability to the weekend. Some practices may find individuals who prefer alternative schedules; others ask new hires to work more evenings and weekends; and others might rotate the evening and weekend shifts.

Most of the time these off-hour patient sessions are run with a smaller staff and use only part of the facility. Staff who work these alternative times often report that they like the simplicity and focus of the sessions over the more hectic pace of the typical clinic workday.

While after-hours and urgent care services are an important tactic for enhancing patient access, they are not a substitute for same-day appointment availability for every provider.

Potential Drawbacks

- Less continuity. Off-hour sessions are usually designed to meet off-hour needs of the entire practice and thus will have some negative impact on provider-patient continuity. Continuity of care improves clinical outcomes, increases patient and provider satisfaction, and can reduce unnecessary follow-up visits.
- No improvement in overall access. If patients' needs are not fully met by expanded-hours sessions, additional visits may occur—causing an increase in demand and partially negating the after-hours clinic's impact on access. Monitor the rate at which patients seen in expanded-hours sessions are referred back to their primary care provider. If this is happening often, determine how to better meet patient needs in the expanded-hours sessions.
- Patient preference for after-hours care. Some patients have a stronger preference for after-hours care than for continuity with a single provider.
  - Monitor trends and continue to encourage continuity.
  - As needed, make adjustments in provider's schedules to add more after-hours availability to meet patient preference and also provide increased opportunities for continuity with patients.
- Lack of follow-up with assigned primary care provider. If providers are assigned regularly to after-hours sessions, there may be a tendency to "keep" patients rather than to refer them back to their assigned PCP for follow-up and ongoing care.

Access via Secure Email and Patient Portals

Secure email and patient portals offer patients the opportunity to contact their care team when it is convenient for them, free up office visits for patients with more complex problems, and make it possible for staff to send information to patients without tying up the phones.

While "e-visits" are not currently reimbursed by most payers, they may be financially beneficial when a low RVU visit is completed quickly via email and a high RVU patient is seen in the clinic. Additionally, many providers and nurses report (anecdotally) that they are able to move through a list of patient notifications much more quickly when done via email than by telephone.

Steps to Take

- Check with your EHR vendor for a secure messaging module or try a stand-alone secure messaging system.
- Draft an email agreement and start asking patients for their email addresses.
- Find a care team willing to test email use with selected willing patients to reduce follow-up phone calls.
- If the burden is not great, track call volumes, email volume, and staff and patient satisfaction.

Access via Telephone

In a PCMH, the goal is to provide timely access to patients in a way that best meets their needs whether by phone or visit. Being able to see the phone system as a means of providing access is a great help to patients and staff alike.

Patients who call the practice need to have the issue they call about resolved. Developing a process to allow patients to have access to clinical advice by telephone and resolving the issue on the first call are ambitious and worthy aims. Achieving this will greatly increase patient experience and substantially reduce call volume and re-work.

The Power of Direct Connection

Group Health Cooperative, based in Seattle, Washington, has been a leader in PCMH transformation. An important part of Group Health Cooperative's transformation was finding ways to build relationships between patients and their care teams. This included indentifying ways to help patients connect **directly** with their care teams whenever they had a question or need. Group Health Cooperative redesigned the process for responding to patient-initiated phone calls so patients could reach their provider and care team directly and on the first call. Key lessons from this work include:

- **Think about the phone system as a point of access for patients and not just a generator of work.** If patient needs are resolved on a call, they may not need to come in for a visit. You are setting up the phone system to facilitate patients' access to their care team so they can take accountability for the care of their panel of patients.
- **The goal is to meet the patient's need on the first call.** Whether it is for an appointment, or to get clinical advice about symptoms or a new prescription, if the patient can be matched with the member of the staff most able to resolve the problem, that demand is met and the issue resolved. The best match might be the provider, a nurse, or a medical assistant. At Group Health, staff realized, "If I actually resolve this call, I won't get three other calls, two text messages, and a patient who shows up in urgent care."
- **Minimize hand-offs and messages.** These drive re-work, cause delays for patients, and drive staff dissatisfaction. (Helping patients get answers or arrange the services they need is what creates the most satisfaction for primary care staff.)
- **Exploit the technology available in modern phone systems**. Set up routing hierarchies to match a) the patient's reason for call with b) the person most likely to be able to provide the answer or the service. Plan to use the system's data capacity to collect data on demand and performance in meeting the demand. Group Health measures first-call resolution, percentage of calls that are answered, and the percentage of calls answered in 30 seconds to determine periods of high demand so staff can be deployed in the right numbers to the phones at peak call periods (i.e., matching supply with demand).

Reduce Other Barriers to Care: Financial and Transportation

Cost is a major obstacle to healthcare in the United States and transportation can be a barrier for many patient populations. All the effort to improve access will be of little use if patients can not afford care or reach the practice. PCMH practices proactively address barriers that may limit patient access.

Health Insurance Eligibility Screening and Enrollment Assistance

State policies regarding eligibility for financial assistance vary significantly. Problems arising from eligibility criteria can add significant expense to the practice and barriers for patients. Below is a sampling of techniques used by practices to streamline this work.

- **Use dedicated and trained staff.** This is specialized work that shifts with evolving legislation as well as payer-determined criteria. Many FQHCs have enrollment specialists who help patients learn about payment options and insurance programs.
  - To be most effective, trained staff dedicated to this work are located in or very near to the clinics where patients receive care.
  - The registration specialist has a separate phone line and keeps an appointment calendar.
- **Separate registration work from the first office visit.** Practices use at least three methods to minimize the impact of registration details on the clinical workflow:
  - Mini-registration by telephone. A phone call is scheduled in advance of the office visit. During this call, demographic details can be verified; insurance eligibility, sliding fee scale, or patient payment responsibility can be reviewed; and patients can be advised of the documents they need to bring to complete the full registration process.
  - New patient orientation. These sessions can be done on an individual basis or in a group setting. Benefits include a higher degree of patient engagement and responsibility in self-care. (See case study.)
  - Separate "registration visit." While two separate visits (one for registration and one for care needs) may initially seem inconvenient, patients and staff quickly realize the benefit of enhanced patient engagement and downstream time savings. Registration visits are set up in one-hour blocks, during which time the specialist can help a patient or an entire family review required paperwork, introduce the sliding fee scale, and assist the patient/family with insurance enrollment when eligible. In addition, medical record numbers can be assigned, demographic information can be entered into the practice management system, and the patient/family can be educated on patient rights and responsibilities—including selection of a primary care provider, the importance of keeping appointments, and payment responsibilities.

Accessibility is a primary concern for low-income patients. Safety net practices, which provide care regardless of a patient's ability to pay, provide a range of services to help improve vulnerable patient's access to healthcare. These include enabling services such as interpreters, community outreach, Medicaid eligibility planning, case management for supportive services to address nonmedical needs, transportation, and childcare.[2]

- **Track eligibility renewal/expiration dates.** Many practices experience a high degree of "churn" associated with the patients' inability to proactively renew their eligibility with specific health insurance coverage programs.
  - Establishing a registration process that tracks enrollment dates and renewal/expiration dates can prevent churn and ensure that patients stay enrolled, thereby maintaining a seamless revenue stream for the practice and uninterrupted access for the patient.
  - The registration specialist can be responsible for tracking renewal dates and conducting outreach to patients/families to ensure that re-enrollment is completed prior to expiration dates.
- **Other approaches** with proven success include:
  - An on-site financial screener who helps clients apply for Medicaid, CHIP/CHP+, etc.
  - An out-stationed Medicaid enrollment specialist available in the practice on a regular basis. This specialist can provide links to community resources as an adjunct to practice resources.
  - A community health worker/promotora who attends health fairs and other community gatherings to provide outreach about Medicaid enrollment to potentially eligible attendees.

Shepherding the enrollment process should lead to reduced burden on front desk staff, increased reimbursement for the clinic, reduced churn, and—most importantly—an increased ability for patients to afford care.

Price Transparency

The prices of healthcare services vary, yet most healthcare organizations do not make their fees transparent to patients. Not knowing the cost of care can be a barrier for patients who do not have insurance, who are unsure what exactly their insurance covers, or who have limited insurance (e.g., high-deductible plan). Patients can delay or forgo care if they are concerned about the cost, or if they cannot afford the cost of care recommended to them. Knowing the cost of care is an important piece of information for patients in shared decision-making and should be part of these discussions.

Consider ways to address patients' concerns by helping them understand the cost of care prior to an office visit, treatment, test, or prescription. Also consider ways to help patients find affordable care and services in their community. Ideas to consider:

- Post a list of your most commonly billed CPT codes with patient-friendly descriptions along with charges; some practices post these in waiting rooms or online.
- Make sure clinicians know the most common charges for the services they provide. Give providers a "cheat-sheet" to help patients make informed decisions about their care.
- Put together cost packages for comparison. For example, controlling lower extremity edema (Unna boot including office visits every two weeks; 3M™ Coban wraps; or a compression hose). Include options of where to purchase and average cost.
- Know where the best "deal" is for common tests (e.g., perhaps the imaging facility 30 minutes away charges less than the one down the street and offers a timely payment or cash discount).
- Get average costs and upfront costs from referral sources (e.g., initial visit charge, upfront, required payment to the gastroenterology office performing a colonoscopy).
- Designate a patient-friendly biller who can explain charges to patients on an as-needed basis (i.e., no appointment needed).



Transportation Remedies

For many patients, transportation to the practice can be a barrier. These barriers can exist for elderly and/or low-income patients without access to a car or a reliable public transportation system. For patients who live in a rural area, getting to the primary care practice can require hours of travel each way.

In a PCMH, these transportation barriers are not just the patients' problem; they are a shared concern with the practice. So how can a practice help to reduce transportation barriers for their patients? The first step is to know your patients, identify which ones may have a barrier, and pinpoint what that barrier is.

Ask patients what barriers impact their ability to get to the practice or arrive on-time. For example, some safety net practices have reported that bus delays are a major reason for patient lateness.

Once you have this information, you are in a place where you can begin to work with patients and community-based organizations—and on your own system design—to reduce the barriers that would otherwise prevent a patient from getting timely access to the care and services that they need.

Specific ideas to test in your practice:

- Use secure email and patient portals to avoid unnecessary journeys to the practice.
- Use telehealth technology to connect patients (especially in rural areas) with specialists, social services, or other care providers.
- Identify community partners that could provide transportation services for patients. Options vary by community, but could include non-profit, civic/community, or faith-based organizations that operate van services (e.g., Rotary, YMCA), or local or state government agencies that provide transportation for elderly or disabled persons (e.g., Area Agencies for Aging and Disabled).

Finding ways to reduce or eliminate barriers due to transportation may be challenging, but the solutions will significantly improve some patients' access to care and enrich their experience of their medical home.

Balance Supply and Demand

To create sustained and reliable access, a practice must start with a commitment and infrastructure to provide 24/7 access. To ensure access over the long-term, a practice must also be able to balance supply and demand on a daily basis. This requires clear access goals and tactics to deal with the variations that occur on a day-to-day basis. The best systems are designed to anticipate and respond to these variations in real-time. They are also supported by processes that allow for communication among staff members and rapid response to daily conditions.

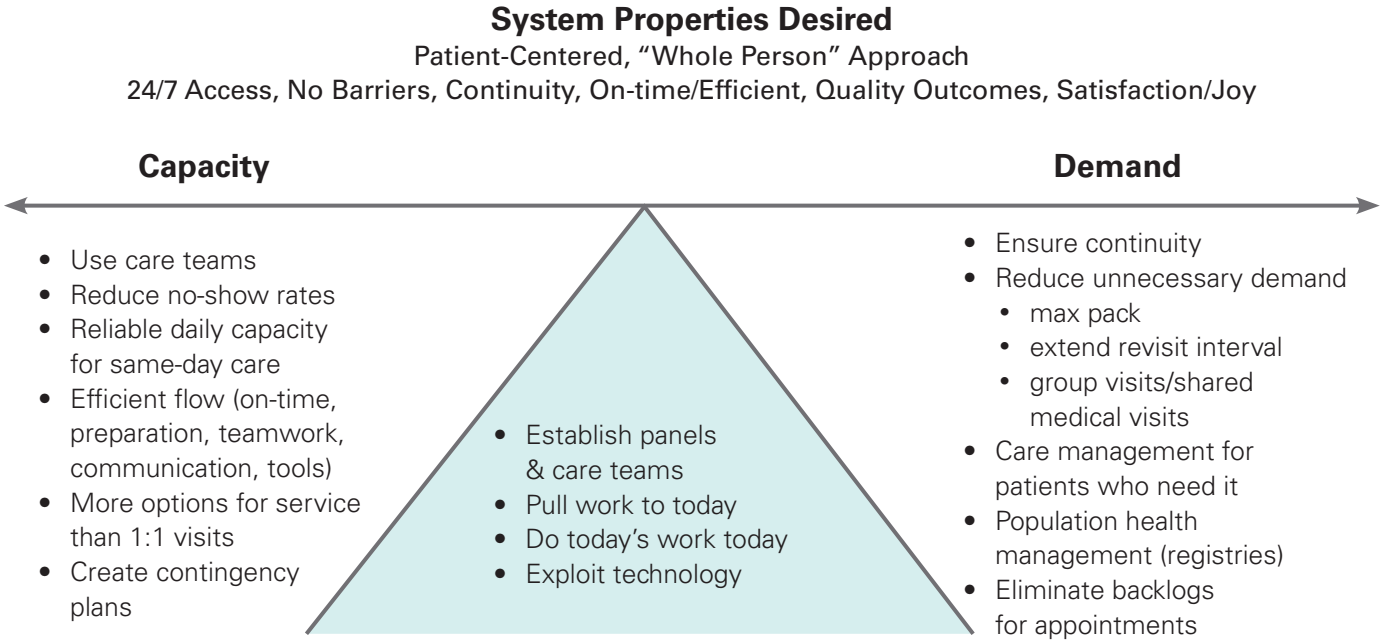
Figure 2 shows some of the high-leverage changes that practices can make to enhance access. These include:

- Assigning patient panels to specific care teams.
- Clearly defining and delegating roles and responsibilities of the care team, making the most effective use of each team member and the team as a whole.

Throughout this Guide the assumption is that practices beginning to tackle access will have already created patient panels and built well-organized care teams. These are essential prerequisites for the creation of a high-performing system designed for patient access.

- To learn more about patient panels, see the Empanelment Implementation Guide.
- To learn more about care teams, see the Continuous and Team-Based Healing Relationships Implementation Guide.

Figure 2: High-Leverage Changes to Balance Supply and Demand



Source: Adapted from work completed by the Primary Care Development Corporation for the San Francisco DPH "Changing the Way We Care" Collaborative.

The first step to balancing supply and demand is to measure it. The goal is to learn what specifically drives supply and demand gaps in the practice. See the Primary Care Practice Telephone Tracking Log on page 21 of the Outpatient Primary Care Dartmouth Clinical Microsystems Greenbook for more information.

Another early step is to ensure leadership and organizational support for the changes required to balance supply and demand. Practice leadership—medical and administrative—can support reliable access by establishing operating procedures and organizational goals designed to achieve each of the following:

- Increase supply. (There are problems with relying too heavily on this approach, which are described later in this section.)
- Increase capacity.
- Decrease unnecessary demand.

At the start of an enhanced access initiative, most practices find that there are long delays for patients to obtain an appointment for a routine visit. Short-term pushes to clear backlogs may be needed in conjunction with the longer-term process changes.

Making changes to improve access can be difficult. Sharing data with staff that demonstrate the impacts of supply/demand gaps on patients and staff can help begin the conversation and engage everyone in suggesting ideas to move the process along. It is also important to test new processes designed to improve access and to share the results. (For information on how to conduct successful rapid-cycle testing of changes for improvement, see the Quality Improvement Strategy Part 1 Implementation Guide, *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance*,[3] and the Institute for Healthcare Improvement (IHI) website.)

Unintended Consequences of Traditional Responses to Patient Demand

When practices experience a higher demand for services than staff can realistically provide, they typically employ "solutions," such as double- or triple-booking patients. However, these solutions are often unsuccessful because they require more work and/or complex processes that are unsustainable. They may also have unintended consequences that bog down the practice or deny patient-centered care.

Understanding supply, capacity, and demand—and designing a system to balance them—is a much more successful approach for any practice. Table 3: Comparative Responses to Patient Demand compares traditional solutions to accommodate patient demand alongside the PCMH solutions covered in this Guide.

Table 3: Comparative Responses to Patient Demand

Traditional Response	PCMH Response
Double- or triple-booking urgent-need appointments with those scheduled weeks before. Push the demand to "tomorrow" to protect today's capacity.	• Use open access scheduling so that patients with immediate needs can be seen the same day. • Reduce the no-show rate to open up more capacity. • Use alternate methods to provide service; this can help to open more appointments for same-day demand.
Develop complex appointment scheduling patterns to accommodate providers' preferences.	• Use one appointment type that meets the needs of patients and providers.
Offer patients the first available appointment with any available provider.	• Ensure continuity of care with PCP and care team so that acute needs and ongoing care are addressed by the same team.
Nurses triage all calls and requests to manage demand.	• Match patient need to the most appropriate team or staff member most likely to be able to help the patient get what they need in real time. • Use care teams to provide care to patients on their panel. • Train nurses and medical assistants to provide self-management education to patients. • Develop methods for providing clinical advice and follow-up support to patients by phone. • Develop efficient methods to process Rx refills and other paperwork that patents need.

Increase Capacity

Practices often think that to increase capacity, more staff need to be hired and/or providers must see more patients per hour. However, we know from the work of hundreds of primary care practices that these changes, without other system adjustments, lead to higher costs and are unlikely to produce a sustainable increase in the practice's ability to offer meaningful access to patients.

While hiring increases or changes in daily patient volume may be necessary to increase capacity, first consider these options (described in more detail in the following pages):

- Decrease the no-show rate.
- Provide same-day appointments on a daily basis.
- Simplify appointment types.
- Increase workflow efficiency to allow:
  - Effective use of all daily capacity.
  - Staff to complete today's work today and finish their work each day on time.
- Develop and implement more options for patients to access care than one-to-one, face-to-face visits with providers.
- Create contingency plans for likely events that create gaps in supply.

In traditional practices it is a daily struggle to provide access, perform today's work today, and finish with a sense of accomplishment.

Reduce No-Shows

Missed appointments lead to missed opportunities for preventive care and early diagnosis and treatment. A no-show appointment prevents another patient from receiving care and wastes a valuable and limited commodity: provider and staff time. On a daily basis, no-shows hobble a practice's ability to effectively use capacity and create chaos as care teams try to anticipate how many same-day requests for service can fit into a fully booked or overbooked schedule. Traditional solutions compound the no-show problem:

- Double-, triple-, and quadruple-booking patient appointments in an attempt to ensure that the daily supply of visits is used. (Determining where to overbook appointments relies on guessing which patients will keep their appointments and which will not.)
- Establishing rules and consequences for patients who frequently no-show in an attempt to change patient behavior. (This tactic is usually ineffective and is not a patient-centered approach.)
- Using RNs to triage same-day demand in an attempt to manage who gets in today and who waits until later for care. (This tactic diverts a critical clinical resource from the stream of care and creates a barrier to access for patients.)

Why Do Patients Fail to Keep Their Appointments?

Ask staff at any primary care practice and there will be several closely held beliefs about why patients no-show for appointments. There is a better way to find out: Ask the patient.

There are many common reasons patients "no-show" for an appointment, these include:

- When patients face waits or delays in receiving care:
  - They are more likely to forget about the appointment and/or the urgency for the visit will have passed by the time the appointment arrives.
  - They are more likely to experience scheduling conflicts as other obligations arise.
  - When patients do not feel able to ask for a convenient time or date, or are told that there are no other options, they may accept an inconvenient appointment that they are later unable to keep.
- When the care team has not spent enough time discussing the importance of follow-ups, patients do not understand why keeping the appointment matters.
- When patients do not understand the importance of rescheduling an appointment, they are unlikely to contact the practice when a conflict prevents them from keeping the original one.
- When patients do not know how to alert the practice of a conflict, they cannot make a timely request to reschedule.

  When patients are disrespected, they may intentionally miss their appointments:
  - In one study, patients defined disrespect as "you waste my time in the office and you don't listen to me."[4]
  - After staff at a large urban safety net practice implemented a new workflow that substantially reduced cycle time, they asked a patient about his visit that day. The patient remarked: "Why I loved it. It was fast and I got time to talk to the doctor. If all of my visits could be like this one, I'd keep more of them."
  - Patients also feel disrespected when bumped from a scheduled appointment due to a late change in a provider's schedule (whether due to sickness, a sudden meeting or conference, or a late plan for vacation or a day off).
  - Bumping patients sends the message that patient time is not valuable and that keeping appointments is not important. For example, patients at Revere Family Health Center reported that they knew how busy providers were, assumed their no-show would not matter, and that staff would appreciate having the extra time to get work done. Providers at Revere learned from their patients how to tailor systems to meet patient needs. To learn more, see the Revere Family Health Center case study.



Root of the Problem

The traditional solutions described in Table 3: Comparative Responses to Patient Demand do not work because they do not target the root cause of no-shows: a system designed to control demand and patient behavior rather than one designed to allow practices to meet patients' needs for care by balancing supply and demand and matching capacity and demand on a daily basis.

Steps to Take

To address the wide variety of causes for no-shows, a wide variety of changes are needed:

- Provide greater **same-day or next-day capacity** as well as opportunities to have patients' needs addressed in ways **other than a visit**.
- Focus on improving **efficiency** of the patient visit.
- Increase scheduling efficiency by reducing the number of **appointment types** and times.
- Train all staff in effective communication methods for engaging patients as partners in their own care. (See the Patient-Centered Interactions Implementation Guide for a variety of ways to engage more effectively with patients.)
- Support "continuity care." Use systems and strategies to help each patient develop a continuous relationship with his/her provider and care team. For examples of communication strategies, see the Scripting for Appointment Scheduling tool.
- Use confirmation calls for prescheduled patients.
  - Confirmation calls will provide the practice with information about which patients are likely to show up for the visit.
  - If calling all patients is not possible, call those in slots with the highest likelihood of disrupting daily flow, (e.g., first and last patients scheduled in each daily session; patients with a history of frequent no-shows; patients with physical exams or planned care visits which take more time and may involve scheduled time with other staff in the practice; new patients because they have not established a relationship with the practice yet and have a tendency to high no-shows as a group).
  - See the corresponding tool, Guide to Appointment Confirmation Calls for detailed steps on using these tactics.
  - Also consider other ways to remind patients of their appointments including text messaging, emails, or even mail. Assess the needs and preferences of your patients.
- Contact patients who were no-shows and ask what kept them from the appointment. Ask how you can help them to keep future appointments.
- Conduct "secret shopper" calls to understand patient experience when trying to get an appointment. See the Secret Shopper Exercise.
  - Practices often assume they know how easy or hard it is for a patient to get a timely appointment or to get connected to the care team. Using the secret shopper approach can really help a practice identify what is working and what needs improvement in that regard.
- Make sure patients know how to contact the practice to cancel or reschedule an appointment.
  - Consider a voice mailbox where patients can leave messages. Task a staff member with monitoring and responding to voicemail in a timely manner throughout the day and develop a process for acting on the messages (canceling the appointment, rescheduling with the patient, etc.).
  - Discuss why rescheduling is important and how no-shows negatively affect the practice.
  - Publicize the phone number for canceling or rescheduling by printing it on a business card or the care team card, publishing it on the practice's website, and posting it in the waiting area and exam rooms.
  - Tell patients about the voicemail box at every visit and let them know it is okay to change or cancel, and why they need to alert the practice in advance. Open communication can help empower patients who may be uneasy about "cancelling on their doctor."

Consider implementing a new patient orientation process (either through a registration appointment or group orientation visit). This allows the practice to rapidly introduce and orient new patients to the practice and to their providers and care teams. It is an opportunity to establish mutual expectations for the care team and patients regarding a variety of topics, including the importance of keeping appointments.

Case Study: Significantly Reducing No-Shows by Enhancing Access

Revere Family Health Center, Cambridge Health Alliance, Revere, Massachusetts (2010)

In 2004, Cambridge Health Alliance (CHA) opened the Revere Family Health Center in Revere, Massachusetts to address healthcare needs in a severely underserved community. Annual visits at the clinic grew from 1,800 in 2004 to 26,000 in 2009, demonstrating the immense need for service.

The clinic developed strong referral networks early on with local emergency rooms and primary care providers who were closed to new patients. Yet they found that no-show rates for new patients remained very high at 50% and 25% for returning patients.

"We were getting lots of referrals, but 50% of those patients did not come. We had so many new patient slots and they didn't show—it was an access and also a flow problem," says Soma Stout, MD, Co-Medical Director. "We felt a deep need in the community for access to care, and if we had an appointment slot, we wanted to make sure patients were using it."

Initially, CHA Revere did a lot of proactive work with phone calls and letters to remind patients about appointments, with little result: a 1% reduction in no-show rate. So, Stout says they did the only thing they could do: they asked patients what was going on. "We learned a lot. Our reminder letters were going out in English and Spanish, but we needed Portuguese for the large Brazilian population," says Stout. "But on a bigger picture, the way we were scheduling and the way our patients' lives worked wasn't coinciding. So we adapted our scheduling system to meet the lifestyles of our patients, rather than trying to get the patients to meet our scheduling system."

CHA Revere adopted three new initiatives to enhance access:

- **New patient orientation.** These thrice-weekly group visits are run by a local high school graduate from the community who speaks three languages. The clinic provides new patients with questions & answers developed by its patient advisory board, and also solves issues like problems with insurance and setting up charts for new patients ahead of time. Then patients are scheduled for an appointment with a provider a few weeks later. "New patient appointments scheduled within one to two weeks showed a 14% no-show rate; when appointments stretch out to 28 days, no-shows jumped to 40%," says Stout. "That moved us toward open access scheduling for our visits."
- **Advanced access scheduling.** Stout says no-show rates dropped to 14% when the clinic adopted a patient-centered approach to scheduling. "We did open access, but really it was advanced access. In true open access, you never make appointments ahead of time. We set aside 25%–30% for long-term scheduling, which our elderly patients often prefer. We needed to remain flexible to our patients' culture and needs," says Stout. An added benefit to the advanced access scheduling has been freed-up staff time. Stout says front desk staff can now engage in proactive outreach to the community.
- **Shared medical appointments.** This initiative also began by surveying patients. "We asked our diabetic patients what they needed, and they said they wanted to know other patients. They wanted support with their chronic illness," says Stout. So CHA Revere created a diabetes group visit, which included medical management. "We do things like go to the supermarket with a nutritionist with patients; it has been very effective in lowering A1cs. Seeing all these patients together was empowering for them," Stout says. The clinic has also started drop-in groups with specific providers. By using a team approach the clinic can see 12–15 patients in 90 minutes instead of six patients, a help in a clinic that has space limitations.

CHA Revere's take-away from their new initiatives? "Always go back and ask your patients," says Stout. "That methodology has been the most important thing we have done. We need to do it practically every day. And look at data. When you try something, measure it, and if it's not effective don't keep doing it."

Add Same-Day Access

Prioritizing regular, daily same-day access is a profound change for most practices. The schedule template and how staff think about demand must change.

In most practices, staff fear that providing same-day access invites a catastrophe from pent-up demand. Typically these fears are not realized, as practices can take steps to systematically address the natural demand from a panel of patients and provide same-day access at the same time.

In addition, there is often a misperception that moving to advanced or open access means never pre-scheduling visits. However, an advanced access schedule reflects the mix of patients' needs with some pre-scheduled appointments but enough open capacity to see today's demand today. An advanced access system is patient-centered because it is designed to respond to the needs and preferences of patients. Patients who prefer a same-day or next-day appointment can get care in real-time and patients who prefer to have a pre-scheduled appointment can schedule out. The proportion varies by practice type and must to be discovered by each practice as same-day capacity is increased over time to meet daily demand.

An advanced access system is patient-centered because it is designed to respond to the needs and preferences of patients. Patients who prefer a same-day or next-day appointment can get care in real-time and patients who prefer to have a pre-scheduled appointment can schedule out.

Steps to Take

Use Coleman Associates' Simplified Patient Scheduling (SPS) to increase same-day access. SPS is implemented as follows:

- In a setting where a provider with 15-minute appointment slots schedules four patients per hour, SPS recommends trying to book the first slot in the hour with the most complex case, then two other slots with more routine appointments, and leaving the last visit in the hour block open for same-day use. Each hour the provider and care team has a chance to get back on track if delays occur. The day starts with some slots open throughout hours of operation.
- As you add same-day slots to schedules, let patients know that same-day appointments are available and ensure that appointment schedulers know how to use them. Monitor use of the same-day appointments to make sure the practice has a sufficient number available for each provider each day.
- If same-day appointments go unused on a regular basis, there may be too many in the schedule or they are not being offered to patients. However, if requests for same-day appointments consistently exceed the supply, adding more same-day appointments to the schedule may be necessary
- Over time, study daily demand for service and adjust the number of same-day appointments as needed based on the demand. To learn more, see the Primary Care Practice Telephone Tracking Log on page 21 of the Outpatient Primary Care Dartmouth Clinical Microsystems Greenbook.
- To test the addition of same day capacity, start with one ready and willing provider and apply the Plan, Do, Study, Act (PDSA) rapid-cycle testing approach. To learn more about PDSA cycles, see the Quality Improvement Strategy Part 1 Implementation Guide.
- Testing the SPS approach, which can generate a lot of concern among a practice's providers, allows improvement to begin and produces results to share with others.
- Adding same-day appointments to the schedule each day allows a practice to use the principle of pulling today's work to today in order to preserve tomorrow's capacity for tomorrow's demand.

Simplify Appointment Types

Queuing theory suggests that a provider is more likely to see patients on time when there is one appointment type with a fixed duration that is matched to the provider's typical time with patients.

A practice that can simplify its appointment types to a single type will find it easier to schedule appointments and will have more success in using all of its daily capacity.

Steps to Take

- To minimize the pain of interrupting long-standing daily routines, use small rapid-cycle tests of change to discover what works then use the results to help implement and spread the change throughout the practice.
  - One family medicine practice started by focusing on the appointment type for "well woman exam with Pap test" which was a 30-minute visit. There was a six-month delay for this visit type when the work was started. They decided to test allowing these visits to be scheduled into any 30-minute appointment slot on the schedule. This gave schedulers and patients more options, improving patient and staff experience. Within a short period, the practice was able to reduce the delay for these visits to six weeks. Later they were able to bring the delay down to a couple of weeks.
- Establish the duration for the appointment type and build the schedule around that type and time. (Complete this step after team-based care is implemented in the practice, which will impact how providers work.)
- Start by combining appointment types of similar duration—30 minutes of work is 30 minutes of work regardless of the label or assessment of urgency. Early success with this change should begin to open the path to the ultimate goal of a single appointment type and duration for the practice.

Work More Efficiently

Human interaction in complex settings like primary care practices is prone to communication errors, overly complicated processes, and policies with unintended negative consequences leading to long cycle times, unfinished work, re-work, significant staff burn-out, poor morale, and low satisfaction.

Increasing efficiency is a key to unlocking the potential of the care team to:

- Pull work to today.
- Anticipate and prepare for tomorrow's work.

Workflow analysis helps to identify opportunities for simplification and efficiency which will boost the care team's capacity for meeting patient demand. One Denver-area safety net clinic analyzed their front desk workflows and implemented a Patient Welcome Center to great success. (See case study.)

Patient Perspective

"When I visit my doctor's office I want it to be well organized, efficient, and not waste my time."

Steps to Take

- Identify a workflow or other process that is not working well in the practice. Examples include:
  - Typical patient visit, from patient's arrival to departure.
  - Preparation for the day's schedule.
  - Coordinating care.
  - Processing prescriptions refills.
  - Completing forms and paperwork for patients.
  - Tracking tests and referrals.
  - Reaching out to patients for population health management.
  - Carrying out the work of planned care visits.

- Target inefficient processes by 1) tracking patient visits to identify bottlenecks or other process problems or 2) choosing a process that has received patient complaints.
  - See the Patient-Centered Interactions Implementation Guide for ways to get feedback from patients on the parts of the practice that they would most like to see improved and start there.
- Use the process analysis and improvement tools from the Dartmouth Green Book, the Improvement Guide, and/or the Institute for Healthcare Improvement (IHI) website.
- Start the day with a huddle to give the care team an opportunity to anticipate and prepare for the day. Huddles are a very effective way to leverage a small amount of time for large gains in the team's ability to manage daily work more effectively.
- One way to increase efficiency is to have the tools you need available when and where you need them.
  - Many practices have taken the step of stocking and labeling tools and other materials needed in the exam room and instituting a process for regular stocking of rooms, a task typically assigned to medical assistants.
  - The most successful practices have also set up each exam room in an identical manner that makes it easier to have providers and teams work in any room efficiently.
- Ensure that each provider has a minimum of two exam rooms (three is even better).
  - Use as much of the practice "real estate" for the business of the practice: seeing patients. If there are rooms used for vital signs or offices, consider how to convert these to exam rooms. Get vital signs in the exam room instead of a room set aside for this single purpose. Create a workflow that allows the patient to go to the exam room and stay there. Have the team come to the patient. Don't assign rooms to specific providers and leave them empty when they are not in the practice seeing patients. Use all of the space as a resource for ensuring efficiency in meeting the daily demand.
  - Shift schedules to level the number of providers working during each session. It is not uncommon for there to be large variations in the number of providers scheduled across a week's worth of sessions. Some days there are so many providers there is barely one room per provider while on other days there are enough rooms for each provider to have three or four rooms.



Case Study:
Redesigning Front Desk Workflow Results in More Patients Seen, Fewer Billing Errors

Metro Community Provider Network, Inc., Denver, Colorado (2010)

Metro Community Provider Network, Inc., a Denver, Colorado-area safety net clinic averaging about 20,000 patient encounters per year, noticed patient cycle times were growing and front desk staff was overtaxed while trying to meet the diverse needs of new and returning patients.

In January 2010, the clinic redesigned its front desk workflow, creating a Patient Welcome Center adjacent to the front desk, which is the first stop for patients when they arrive at the clinic. The Welcome Center has a sign with a list of services it offers to patients, including answering general questions, medication pick up, message center for providers, and financial screening registration.

"We wanted to free up the two front desk staff persons to focus only on medical needs," says Nikki Brezny, Regional Clinic Operations Manager at Metro Community Provider Network, Inc. "We assessed our cycle times and found that back office procedures, like taking vitals and rooming patients were not a problem, and the flow worked well. We only changed the part that was slowing down total cycle time and limiting access for our patients," Brezny says.

By staffing the Patient Welcome Center with an experienced financial screener already employed with the organization, the clinic instantly offers its patients a wealth of information the minute they walk through the door, while increasing patient satisfaction and reducing cycle time for patients. The clinic provided customer service training for the staff person to augment the skills she already had.

Patients should be cared for from the moment they walk in. Patient-Centered Medical Home is about treating the individual with respect.

The change has resulted in several positive changes:

- Reduced waiting time. "We managed to reduce our cycle time by 20 to 30 minutes on average," says Brezny.
- More patient visits. A 14% increase in patient encounters per clinical FTE provider.
- Increased patient satisfaction. "The majority of our repeat medical home empanelled persons enjoy talking with her and they know her," says Brezny.
- Reduced claims processing error rates and less re-work.
- Improved payer mix. With experienced and qualified staff handling financial intake from the beginning, 5% more patients have been screened and found eligible for Medicaid.

Brezny says she dreams of a day when her clinic can offer a "concierge" attending to the waiting room patients' needs on the floor. "Patients should be cared for from the moment they walk in. Patient-Centered Medical Home is about treating the individual with respect."



Adopt Innovative Forms of Access

Primary care has historically relied on one-to-one, face-to-face visits between a patient and provider. Both the shortage of primary care providers and today's more complex patient needs have led practices to look to other ways to deliver the care patients need and maximize their ability to provide service. This section includes detailed information on group visits. Other innovative forms of access include e-mail visits and telehealth, discussed in more detail earlier in the Guide.

Offer Group Visits

Not only do group visits use capacity efficiently and improve access, they also provide a means to manage the demands of patients with complex care needs. Patients typically enjoy group visits and the support they receive from their peers.

Group visits have been around for decades and research has shown that they help to improve access and quality goals in safety net hospitals and health systems, and can be modified to fit the needs of an organization, providers, and patients.[5]

A group visit typically includes 15 or more patients and their caregivers (as appropriate) in a 90-minute session. The session might include didactic presentations plus group discussion and self-management support accompanied by peer support. Most commonly, practices have used group visits for chronic care patients, obstetrics/pre-natal care, and new patient orientation. Some practices have also used group visits for well-child appointments. One Colorado family health center successfully conducted a total of 850 group visits, covering a wide range of topics, in a single year. (See case study.)

Steps to Take

- An important part of the preparation for using group visits in your practice will be to determine if and how you can bill for them. As payment systems change in response to healthcare reform and the PCMH Model of Care, there will be more opportunities to receive payment for group visits and other alternative visit types. If the local payers in your area do not support group visits at this time, consider meeting with the local health plan to discuss a pilot to demonstrate the effectiveness of group visits in your practice.
- Begin with one provider offering one group to a small group of patients (five to seven). As the practice works out the moving parts of group visits, it can then expand to larger groups and groups with different focus.
- Implementing group visits will require:
  - Adopting one model.
  - Finding an appropriate space for the group.
  - Choosing a consistent meeting time.
  - Scheduling the group visit and the staff to support it so they are available to fully participate and focus on the group visit.
  - Planning carefully for the group visit, the content, and staff training.
  - Ensuring all the materials and equipment that will be needed are available.
  - Supporting providers and staff who will recruit patients for the group visits. Patient attendance improves when the patients' provider invites patients to participate, tells them why they think it would be useful, and explains how it works.

To learn more about group visits, refer to the Improving Chronic Illness Care's Group Visit Starter Kit.

Case Study: The Benefits of Group Visits

Clinica Family Health Services, Colorado (2010)

Clinica Family Health Services serves 34,000 patients across its four sites in Colorado, with its Pecos site treating nearly half of the total patient population (more than 16,000). Amy Russell, VP of Clinical Services says that the Pecos site was struggling to see all patients that sought care, and so began experimenting with group visits as a way to enhance access in the late 1990s, beginning with diabetic patient groups. In 2001, the clinic recognized an additional need in the community for prenatal visits, and began applying principles from two group visit models, the Centering Pregnancy and the model of Kate Lorig, MD, to craft one that worked for its patient population.

"We saw that women weren't getting in early enough in their pregnancy, so we started groups to improve access," says Russell. "History taking, education, and routine labs all occurred in group format and patients liked that." Then as the prenatal groups grew, the clinic started having a higher demand for newborn visits so they began continuity groups where new moms would continue with the same groups to get bilirubin checks, PKUs for newborns, and contraception for themselves.

Addressing Community Care Needs

"All those women delivered and wanted to stay in groups, so we moved to parenting groups that managed well-child care. Patients join a group in pregnancy based on gestational age and stay with it through the first two years of life," Russell says.

Judy Troyer, Pecos Clinic Director, says that while they started groups because of the need to improve access, a key byproduct was improved outcomes. Clinic patients who participated in the continuity groups had lower C-section rates and fewer low-birth weight and pre-term births.

In addition to the continuity groups, Clinica offers access groups for patients who are seeking a specific service. For example, diabetics might all come in at once to get their retinal photo or flu shot.

"You want to look at access groups when you have high demand, limited capacity. It works well when people have a common educational need," says Russell. "Our diabetes outcomes are better for patients who participate in groups—we see more improvement for those who enter groups than those who are not in groups. We think it's a better model for care."

Russell and Troyer have learned many lessons in the process. "First, you have to put effort into planning groups. Group care can be chaotic. If you have 10 or 12 patients in a room and things don't go well, it could be detrimental to improving access," says Troyer.

Provider Enthusiasm for Groups

For providers at Pecos, there is great enthusiasm for participating in group care. "We have providers who fight over doing the next group visit. For our continuity groups, the same provider and support staff manage the group throughout. We went to a model of assigning groups based on FTE status; someone who works more gets more groups."

Clinica motivated providers by sharing data:

- Initial group visit leaders saw better patient outcomes with groups than individual care.
- Patient satisfaction data also showed that patients preferred the format.
- During group visits, providers have been 41% more productive, on average.

"We have been working on this for 10 years," says Russell. "After five years, we couldn't meet the demands of the providers to do all the groups they wanted to do. At first we struggled to get it going, it was small scale; and then it took off."

"Of the four Clinica sites, Pecos, which conducts the most group visits, also has the lowest staff turnover rate. In 2009, it was 13%, versus 25% for all sites. Staff members have more opportunities to gain experience through groups," Troyer says.

Troyer advises that clinics dedicate staff time to managing groups. "You cannot just implement and then let it go off the radar. Staff time is needed for managing room assignments, scheduling, notifying and reminders, and planning for future groups. You also need a cross-functional group of people. Groups impact all staff from check-in to billing to provider."

"We have enhanced access because we are seeing more patients in the same time frame," says Russell. "Our Pecos site ran 850 groups in 2009."

Shift Supply to Cover Gaps

Both supply and demand will vary over time. Patient demand can be shifted to a small degree, but typically not enough to create the capacity/demand balance that is needed to ensure reliable access on a daily basis.

Focusing on changes in how the practice anticipates and responds to patient demand is a much more effective and sustainable approach. Shifting schedules to more efficiently use the supply of providers and appointments will increase capacity.

Practice leaders and managers should develop plans to proactively address both ad hoc gaps and recurring imbalances.

Ad Hoc Gaps

Ad hoc gaps can occur due to unanticipated spikes in patient demand or supply shortfalls (e.g., if a provider is ill).

Steps to Take

- Examine the data for larger trends. Many unexpected events that interfere with daily workflow are actually predictable when viewed from this perspective.
- Develop contingency plans for the full range of typical events within a practice, such as coverage during a provider's illness or other unexpected absence, or how to adjust the day's schedule when patients are late for visits.
- As a team, agree on the nature of triggers and clarify which contingency plan to use in which situation. This will allow staff to quickly identify the need for, and the means to activate, "Plan B."

Recurring Imbalances

If a practice is not measuring and responding to supply/demand fluctuations, gaps can occur on a regular basis. For example:

- Friday afternoons may experience particularly heavy patient demand yet have the least amount of provider availability.
- In a residency training practice, specific sessions during the week, e.g., Tuesday mornings and/or Wednesday afternoons, may have excess providers and trainees. There may be too few exam rooms and other resources to allow for efficient workflow. This imbalance may lengthen cycle time, resulting in patient complaints and staff stress.
- Typically, winter is both a time of high demand (due to the prevalence of influenza and other respiratory syndromes) and of low supply (as staff take time off to coincide with holidays and school breaks).

Steps to Take

To ensure a baseline level of coverage to meet expected patient demand at all times:

- Revise weekly schedules so that more staff are on duty during busy periods (e.g., demand increases with flu season, camp physicals, school physicals) and fewer during slower periods (e.g., summer vacations, school breaks).
- Arrange for coverage during planned absences.
- Adjust scheduling to accommodate demand for post-vacation providers.
- Develop vacation policies and require advance notice for schedule changes.
    - Some practices have adopted the policy that time-off requests that miss the advance notice window must come with a one-for-one replacement (i.e., if a provider needs an afternoon off they must come with the name of the provider who will take that afternoon schedule).
    - Multnomah County Health Department provides an excellent example of a provider staffing policy that includes specific productivity and scheduling targets for new and established providers, available here.
- Develop procedures to proactively address patient needs **before** providers take a scheduled absence.
- Monitor demand to uncover variations by day of the week.
- Formalize "when today ends" to allow staff to do today's work today.

How advance planning and scheduling accommodations might work

Example 1: Provider Out Following Delivery

An obstetrical provider (Provider A) is out for the day following a delivery. This is a common, relatively predictable event in family medicine practices and OB/GYN practices.

Rather than the old mode where front desk staff had to use almost all of the next week's same-day appointments to accommodate the bumped patients, the practice manager implements "Plan Stork" (pre-approved in staff and provider meetings):

- Prior to the due date, Provider A has been extending herself to make sure her backlog is zero.
- Provider A reviews the schedule for those patients whose needs might be met via email or a call from nurse.
- Work that is not time-sensitive (e.g., a meeting) is postponed.
- Providers B, C, and D each extend their patient sessions to take on a proportionate share of the patients.
- Provider A's next patient session is extended to catch up with the backlog.



Example 2: Provider Vacation

A common occurrence in any primary care practice is a provider going on vacation. Because the provider is out for a week or maybe two, a backlog for an appointment can develop, and when the provider returns, he/she can be overwhelmed with demand.

Advanced planning can help a provider:

- Meet urgent patient needs before vacation.
- Ensure patients who need urgent care during the provider's vacation get it.
- Return to practice with enough capacity in the schedule to address any pent-up demand without a week of late nights and missed lunches.

These methods allow the provider and care team to continue to care for the panel of patients by anticipating needs for care before, during, and after the provider's vacation. Applying these strategies can make a world of difference for the provider, care team, and patients. These strategies also make clear why an advance notice policy for vacation is so important for a practice that wants to be a medical home for its patients.

The following steps can will help a provider, care team, and the practice as a whole plan for a vacation and quickly get back on track with matching supply and demand after the vacation. They can also be used by a provider going on maternity leave, although the time periods for planning and return will need to be extended.

1. Two to three weeks prior to the scheduled vacation, the provider reviews the panel of patients using registries to ensure that patients who need for a service that is due while the provider is on vacation (and which can be met prior to the vacation) are scheduled to receive the service prior to the provider going on vacation. This reduces the need for patient to see another provider and avoids a patient missing or falling behind on an important service.

continued on page 26

2. Depending on the level of same-day availability in the provider's schedule and the time-sensitivity of the needs of the patients in the panel, a provider may seek to add same-day capacity to the schedule for the two to three weeks prior to vacation to be able to bring patients with service needs in before vacation without needing to overbook appointments.
3. The provider and care team may look to make more capacity available for patients with time sensitive or complex care needs by not scheduling non-time-sensitive services like annual physicals during the pre-vacation period to reserve as much capacity as possible for seeing patients who may have care needs that **are** time sensitive and would come up while the provider is away on vacation.
4. Several weeks before the vacation, the provider's after-vacation schedule is adjusted to add additional same-day capacity for the first day or two back. This allows the provider to have capacity to meet the demand that is typical upon the provider's return from vacation. It also builds in time for the provider to catch up with the care team and the covering provider(s) about patients who needed service during the vacation.
5. Prior to vacation, the provider should meet with the care team to determine the work the team can do to manage as many patient requests for service as possible and to complete tasks related to population health management, including identification of patients who need to be contacted about specific care needs that can be scheduled.
6. In the week prior to the vacation, the provider should also meet with or talk to the provider(s) who will be covering during the vacation period to see patients who have urgent needs for service. By identifying the providers in advance, the patients and care team know who they will be seeing or communicating with in the vacationing providers absence.

Applying these steps will require a practice to discover what works. It is a good idea, as with all changes, to test it with one provider to see how it works, learn from that and share that learning with other providers and care teams.

Decrease Unnecessary Demand

When attempting to balance a practice's supply with patient demand, it is as important to reduce unnecessary demand as it is to increase capacity. To start, try these options:

- Foster continuity.
- Max pack visits.
- Extend revisit intervals.
- Provide alternatives to traditional face-to-face provider visits.

In most practices, some proportion of patient demand reflects the options available to patients to obtain needed care or services. If options are limited (e.g., the practice is only open and available to patients during traditional business hours and for in-person visits) access barriers may increase unnecessary demand.

Examples of unnecessary demand include:

- Patients are scheduled for an office visit to receive normal, routine test results instead of receiving this information by letter, phone call, patient portal, or secure email communication.
- Patients are given follow-up appointments with shorter intervals than needed because providers are attempting to keep close track of patients through face-to-face visits instead of a tool such as a registry.

Foster Continuity

Continuity of care—where patients are nearly always seen by the same care team—improves work processes in a practice[6] and can increase patients' trust. Patients who trust their providers are more likely to follow through on recommended screening tests.[7] This can reduce the need for follow-up calls or visits.

Max Pack Visits

"Max packing" encourages care teams, which will be familiar with the patient's overall history, to explore issues beyond the immediate presenting problem. If documented correctly and delivered appropriately, max packing will not only decrease demand but also (in fee-for-service models) increase per-visit payments.

Steps to Take

During a huddle or scheduled planning time:

- The care team identifies patients on the daily schedule with unmet care needs beyond the stated reason for the visit.
  - To do this well, the team will need to quickly scan charts for care gaps while keeping huddles short.
  - Patient-specific registries or care summaries can be very helpful with this process.
- The care team determines who is the most appropriate team member to handle each issue
- For example, a continuity provider can ask, "Now that we've taken care of your cough, I'd like to talk with you about your blood pressure and how that is going and also talk about getting you an appointment for a colorectal cancer screen for which you are due. Is that OK with you?"
- Teams that have begun to work on patient-centered interactions will be skilled in how to offer the patient the opportunity to provide care today that avoids a later visit.

"Max packing" encourages care teams, which will be familiar with the patient's overall history, to explore issues beyond the immediate presenting problem.

Extend Revisit Intervals

Extending revisit intervals opens up appointments for other patients.

Providers develop habits in training and in practice that strongly influence how much time they allow between revisits for patients with chronic conditions. There is very little—if any—science behind these habits. One study demonstrated significant reductions in ED use and hospitalization, and increases in patient satisfaction, when patients were rescheduled at twice the typical interval with telephone follow-up visits in between.[8]

Steps to Take

To gain provider support:

- Review evidence-based guidelines to determine and standardize the revisit interval for specific patient populations. Compare the guidelines for appointment frequency to each provider's revisit patterns to identify and understand variation.
  - Address providers' concerns.
  - Use the results of your investigation into guidelines and provider-specific patterns as a starting point for exploring the concept and its use in the practice.
  - Concerns from providers often revolve around losing track of patients. A well-designed and actively used registry, combined with a care team taking a population health management approach, is a highly effective solution.
- Suggest to a willing provider that this method be tried with one patient one time. Start by extending the typical return visit interval by one month or one week.
- After achieving success, extend this approach to other providers.

To gain patient support:

- The care team should explain the reasoning behind longer intervals.
- The care team may need to reassure the patient that they will make themselves available if anything comes up during the interval. Keeping the promise to patients when they call for advice or for their next appointment at the end of the longer interval is imperative. Practices with reduced appointment delays can expect less patient resistance.

To monitor access:

- On an ongoing basis, track whether patients are able to get appointments at the desired intervals.

Provide Alternatives to Traditional Face-to-Face Provider Visits

Group Visits

Group visits reduce unnecessary demand on appointment slots by serving multiple patients simultaneously. They also help increase capacity, as discussed in more detail in the previous section, Offer Group Visits.

Nurse Follow-Up Visits

An important strategy to help reduce unnecessary visits to the provider, and to take full advantage of the care team's skills, is to have nurses conduct appointments for needs requiring follow-up attention but not a full visit with the primary care provider (e.g., blood pressure and INR checks).

Some practices use trained medical assistants to provide blood pressure checks using a protocol that enables them to know which patients need to be seen by a provider. Patients can be scheduled or the practice can set aside a block of time to see patients. Any patients with results warranting a check-in with the provider are given time to be seen that day.

To learn more about the role of nurses in care management, see the Organized, Evidence-Based Care Implementation Guide Supplement: Improving Care for Complex Patients: the Role of the RN Care Manager Implementation Guide.

Use the Phone or Secure Email to Provide Follow-up, Clinical Advice, and Support to Patients

In situations where a patient check-in is good practice, but a face-to-face visit is not required, the phone or secure email can be used. (See implementation details in Adopt Innovative Forms of Access.)

For example, providers or a member of the care team can check on patients who have set new self-management goals or have been prescribed a new medication. By offering timely clinical advice via phone or secure email on a 24/7 basis, providers and the practice can help patients take any steps needed to avoid an unnecessary visit to the practice or the emergency department.

Patient Portals

Patient portals are an efficient way for patients to make requests for appointments, referrals, prescription refills, or paperwork and to receive test results.

Patients must be taught how to use the portal and the practice must develop workflows that efficiently process the requests received through the portal. To learn more about patient portals, see Appendix A: Enhanced Access and Health Information Technology.

Clear the Backlog

At the outset of an enhanced access initiative, most practices are burdened by a backlog of demand.

Without a very low backlog (0–3 days), practices will continue a daily struggle to meet demand. The investment made in reducing the backlog pays off when the practice can focus more time on serving their patients than struggling to tame the demand.

The reality is that short-term pushes to clear backlogs must often be undertaken at the same time as the longer-term process changes are introduced to balance supply and demand. A combination of work-smart and work-hard strategies is required to eliminate backlogs.

Work Smart

A good place to start is to "comb the schedule."

- Start by having one willing provider and one clinical support team member review the provider's schedule for the upcoming two to three weeks; determine the reason for each appointment.
- Identify situations in which the patient's needs could be met in ways other than an office visit with the provider. (See example situations in the text box on the following page and ideas for alternative forms of access in the previous section.)
- Contact the patient to discuss the proposed alternative. (If the patient asks to keep her appointment, keep it and continue to build the patient's trust and understanding of alternative access options.)
- Repeat these steps every week until the backlog, as measured by third next available appointment (TTNAA), is reduced to no more than a few days. See the corresponding tool to track and measure Time to Third Next Available Appointment.
- Apply this tactic to include every provider's schedule.
  - Ultimately, the schedule review and patient calls can be done by a medical assistant and/or nurse.
  - The provider makes the final decision on whose needs can be met in ways other than a face-to-face visit.

"Working smart" usually results in the ability to free up some appointments, which should be designated and held as same-day appointments (even if you are using SPS already; by this time you are probably ready to add more same-day capacity to your schedule).

You may also find patients who need an appointment sooner than scheduled. Use any freed-up appointment slots to work them into the schedule as soon as possible.

This approach does require time but can be a very effective way to reduce the backlog and to learn how—and for what reasons—patients are scheduled. The reviewers will come to understand which appointments make sense and which patients could benefit from another approach.

More information on the "work hard" and "work smart" strategies pioneered by Tantau and Murray is provided in a case study of the Advanced Access Learning Collaborative.[9]

Examples of patients to consider for alternative follow-up:

- A patient who walked-in to the practice last week and who has an appointment for next week but doesn't need anything further that requires a face-to-face visit.
- A scheduled patient who has not had lab work done, or is coming in for testing results, or has a tracking appointment scheduled without any obvious clinical or social need.
- Appointments for services that can be handled without a visit such as forms, medication refills, advice that could be given over the phone, follow-up for self-management, blood pressure check.
- Patients not assigned to the PCPs panel. These patients should be rescheduled with their assigned provider and care team.
- Patients with multiple appointments in a short period of time for whom it may be possible to handle all needs in one visit.

Work Hard

Another strategy for reducing backlog is to temporarily add appointment slots throughout a specific period of time (e.g., one or more weeks).

The "work hard" approach is best tackled only after the care team has used most of the system redesign strategies described in this section. The other methods can be employed more easily and teach a team sustainable and flexible ways to manage demand for the long term.

When employing this strategy, ensure that the slots are only used by the particular team's patient panel. If the additional appointments are used to take the overflow from another team, it defeats the purpose of clearing the team's own backlog, generates dissatisfaction, and causes a loss of morale for the care team that is "working harder" to reduce its backlog.

Conclusion

Enhanced access is about more than managing the daily schedule in a practice. Enhanced access is about providing reliable and barrier free access to the care patients need, when they need it and in ways that are patient-centered and efficient.

Providing enhanced access begins with a commitment to 24/7 care through extended office hours and coverage systems when the practice is closed. These two changes alone have been shown to improve patient experience of care and outcomes of care in measureable ways. To support the essential goal of 24/7 access, a practice will also need to focus on system redesign related to ensuring that capacity and demand can be balanced on a daily basis to allow optimal access for patients when they need care.

Improving access is substantial but satisfying work. Enhanced access improves patient care and also makes available to patients all of the other improvements of PCMH. Enhanced access reduces the time care teams spend on phone calls, messages, triage, rescheduling, and other forms of re-work. This allows all team members to focus on clinical care, population health, and overall practice efficiency—and in turn, improves provider and staff satisfaction, returning joy to staff in their daily work.

If patients can't get access to care when and how they need it, the benefits of all of the other improvements the practice makes as a part of PCMH transformation (e.g., self-management support, evidence-based care) will remain out of reach.

Additional Resources

Videos

Group Visits
This video from Clinica Family Health Services highlights group visits (22 minutes).

Shared Medical Appointments
This video from the University of Virginia Health System discusses shared medical appointments from the provider and patient perspective (5 minutes).

Tools and Presentations

American Academy of Family Physicians
The AAFP offers many resources including a Guide for Group Visits for Chronic Conditions Affected by Overweight and Obesity.

Center for Accelerating Care Transformation
The ACT Center website, developed by Kaiser Permanente's Washington Health Research Institute, offers many resources and practical guidance.

Articles and Books

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Appendix A:
Enhanced Access and Health Information Technology

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Traditional primary care practices depend almost entirely on prescheduled office visits and ad hoc telephone calls to link patients to the healthcare system. Patient-Centered Medical Home (PCMH) practices offer patients expanded options for interacting with their care teams. PCMH care teams and their patients interact through at least five distinct access modalities, each of which is more appropriate for some clinical situations than others offer:

- Office visits.
- Telephone visits.
- Asynchronous messaging (ASM) (email).
- Direct feeds from patient-controlled technology.
- Mail.

Health information technology (HIT) plays two important roles in expanding access:

- Supporting efforts to match care team capacity with patient demand for access.
- Supporting optimized workflows in each of the access modalities.

Matching Capacity to Demand

Different patients will find some access modalities preferable to others. Finding the optimal mix of patient access modalities in a PCMH is largely uncharted territory and will likely vary depending on the panel of patients and the innovation of care team members. As enhanced access modalities are added, the care team will need to "feel its way," learning as it goes while comparing demand to supply. The goal of the PCMH is to gradually move portions of the panel's care needs to patient-centered and appropriate, but less resource intensive, access modalities (e.g., shifting some office visits to phone calls). Office visits with providers can be used predominantly for diagnostic issues, for patients with multiple or complex chronic conditions, and for care transitions. Because the optimal appointment mix will likely be different from panel to panel, the best tactic is to begin by opening up a new line of access, such as nurse visits to manage hypertension and glycemic control on a limited basis, and then slowly increase supply to match demand. A similar approach will work for scheduled telephone encounters. Likewise, optimizing the number of same-day appointments held for provider visits is best done empirically by holding a small number of same-day appointments until 24 hours prior to the appointment then expanding the number until they begin to go unfilled. HIT plays a crucial role in monitoring the effect of increasing a particular type of access. These innovations may prove challenging for care teams and patients alike. Implementation of new technology, even on a relatively small scale such as this, requires testing all components and assuring adequate provider and staff training both prior to using the technology but also during "go-live" when both the need and the learning potential is greatest. It also is important to actively seek patient input during in the planning process and to use their input in creating messaging for the panel on how to best use these types of expanded access.

- Use electronic health record (EHR) reports to identify sub-populations suited for different access modalities. Patients started on antidepressants can often be followed up within several weeks using a telephone visit to adjust medication dose based on symptom severity scores and side effects. Often no office visit is required.
- Set up office visit schedules for nurses and medical assistants to see patients for monitoring specific

disease parameters including protocol-based medication adjustment for blood pressure, asthma, or diabetes management. Protocol-driven nurse visits can also be used in same day access for common uncomplicated acute conditions, such as urinary tract infections and upper respiratory infections. A nurse can provide care, after which the provider briefly reviews the care plan and signs orders for the visit. Overall care team visit capacity can increase while freeing up resources for longer scheduled provider visits.

- Use reports to identify members of subpopulations with chronic conditions who would benefit from structured planned-care visits or group visits.
- A standard way to measure wait times is to monitor the time to the next first and third available appointment. The first available appointment is the soonest a patient could be scheduled (often due to a sudden cancellation) without double-booking. The third available appointment shows how far into the future the schedule opens up. Monitoring the number of unfilled appointments is also important. Use these reports to modify capacity for each access modality. Demand for some visit types (particularly SDAs) may vary by day of the week. Design access reports accordingly.

Using HIT to Support Enhanced Access

Office visits

Office workflows frequently suffer from inefficiencies that cumulatively reduce the amount of time available during an office visit for patient care. HIT can improve office visit efficiency, thereby reducing the burden of administrative tasks. These resources can be redirected back to patient care in several ways:

- Allowing patients to directly schedule appointments online, including same-day appointments, can reduce time and effort spent processing appointment requests.
- A streamlined check-in process, in which patients swipe an electronic card with demographic, registration, and insurance information, can reduce time and effort spent checking in patients at the front desk.
- A new technology called real-time location systems (RTLS) can let front desk staff send a patient directly into an open exam or procedure room, reducing patient waiting and eliminating the need to maintain costly waiting room space. These systems are relatively expensive, and although they are considered promising for improving efficiency, evidence to support their widespread use lower healthcare costs is lacking.[10]
- RTLS also lets care team members easily identify the location of other team members, patients and crucial equipment, such as ECG or nebulizer machines, thereby eliminating time wasted looking for people and things.
- Vital sign devices can transmit data directly into the EHR reducing work and data entry errors. However, validity of data must be monitored.
- Proximity badges can automatically unlock and log care team members into computers, reducing time wasted repeatedly typing passwords.
- Hyperlinks within the EHR to commonly used external data sources can reduce time spent looking for information. Examples of high-value data sources accessible through health information exchange (HIE) include virtual patient records, records in affiliated hospitals or specialty offices, regional registries for immunizations, and state registries for controlled substance prescriptions.
- Clinical Decision Support Interventions (CDSI), when properly configured to support the work of every care team member, can reduce time spent finding and organizing information.
- A huddle, a short 5–10 minute care team meeting at the start of the day for rapid chart review of every patient on the schedule, is a chance to gather information prior to the visit and address care gaps. Huddles can greatly increase efficiency by preparing the practice team for the visit. HIT can help support huddles. For example, by providing a snapshot view of the chart with problem list, medication list, and the status of evidence-based preventive and chronic disease measures, as well as easy access to the most recent chart note.

- Modular EHR charting templates allow flexibility, for example, when it's discovered during a care visit for a chronic problem that a patient has symptoms that require a diagnostic evaluation. Likewise, patients scheduled for a diagnostic issue can have preventive and chronic care needs assessed. Modular templates (in which an acute evaluation can be nested into a chronic disease template) may minimize changeover work.
- Use of real-time drug formulary checkers can eliminate the re-work of phone calls from the pharmacy to authorize medication substitutions.
- An EHR feature that allows the charts of multiple patients to be open at the same time on the same computer workstation can reduce processing waste during visits with multiple family members and during group visits.
- Access to community resource databases can help care teams help patients without insurance identify reduced or no-cost services (e.g., free mammogram screening) and reduce the chance that patients will be denied needed care.

Group visits and shared medical appointments

Select patients, especially those with chronic illness, can benefit from participation in group visits and shared medical appointments because they often spend more time with their provider, less time in the waiting room, and they learn from questions, comments, and solutions offered by other patients. Patients often leave these visits with new relationships and social support.

- Use the EHR to find patients with similar conditions and similar demographics.
- Create scheduling blocks so all staff know when group visits are occurring.
- Reach out to patients using EHR-generated letters and distribution lists to invite and/or remind patients about visits and any possible "pre-work."
- Create templates for these types of visits and consider using a scribe to document in each patient's chart as the care team interacts with the patients.

Telephone

Telephone advice calls can be used during clinic and after hours. When patients use the telephone to access the care team for clinical advice, the two most common sources of waste are telephone tag and having the patient talk to someone who cannot answer the question. Technology can be used to the reduce waste of telephone advice calls in a number of ways:

- Use telephone log reports to identify the temporal pattern of advice calls, and have providers and nurses available to answer clinical advice calls during times of greatest advice call frequency.
- Make sure non-clinical personnel are available to solve non-clinical problems in real-time and limit provider resources to addressing clinical issues.
- Ensure that all charting functionality—including charting templates, computerized provider order entry (CPOE), and Clinical Decision Support (CDS)—are available within telephone encounters.
- Allow providers, nurse triage lines, and emergency/hospital personnel to access the EHR 24/7.
- Document telephone encounters in the EHR so patients do not have to retell their story with subsequent calls and during follow-up.

Scheduled telephone visits

Most scheduled telephone visits can be completed in a fraction of the time required for an office visit. Scheduled phone visits should be prepared for in the huddle and have a consistent structure to ensure the visit is of greatest possible value to the patient.

- Screen views of the daily schedule should make all visit types visible on a single screen with access to a "snapshot" chart overview for each visit type.
- Text messaging can be used to give the provider and patient an "alert" 10 minutes before the scheduled phone meeting. A text alert allows both parties to be sure they are on time for the appointment and offers an opportunity to reschedule if one party is running behind. Such a text alert can also include a message for patients to prepare for the visit by signing into the patient portal or finding their medication list.

Asynchronous Secure Messaging (ASM) (also known as email)

Asynchronous secure messaging, or email, is an effective, flexible, and time-saving form of communication. It is not appropriate for all types of interactions (e.g., urgent issues or nuanced clinical decision-making). To protect patient privacy, the patient or caregiver must be issued a username and password to log in through a portal to view portions of the EHR. Using this communication modality, patients can ask questions of the care team, review a visit summary, view test results, look up relevant educational material, schedule appointments directly, request prescription renewals, and enter information into their own chart. The willingness of patients to set up and use this technology is often dependent on how clearly their provider articulates its importance for communicating with the care team. This technology can be optimized by a number of HIT features.[11]

- Receipt notification informs the care team that the patient has read an outgoing message. This can reduce errors caused by false assumptions that a patient received a message.
- Individualized guides that explain whom to contact, how, and for what situations. This can reduce errors that patients make in trying to communicate with the care team or when scheduling appointments.
- Integrating messages into the EHR so that all charting tools are available in the notes, and all communication between patients and the care team auto-populates the clinical record, reduces the risk that information from asynchronous messaging will be lost or difficult to find.
- Clinical decision support (CDS). CDS can reduce the amount of processing work and errors, most of which result in added work for providers. CDS that prompts care team members to check completeness of allergy and problem lists when processing patient requests for medication renewal can reduce the burden of information errors in the EHR.
- Patient portal links to reliable medical knowledge databases make it easier for patients to find information and can reduce the risk that patients will be confused by irrelevant or erroneous information.
- Key information including demographics, problem list, medications, allergies, and family history. When this information is made easily visible through the portal, patients can quickly identify and report information errors in their record of which the care team may not be aware.
- Provider messaging to patients that diagnostic test results will be available on the patient portal as soon as they are reviewed can dramatically cut down on phone calls to the clinic and reduce unnecessary office visits.

Direct feeds from patient controlled technology

Text messages. The privacy and security details of text messaging have not been sufficiently examined to allow protected health information (PHI) to be transmitted. Text reminders that do not include PHI can still be very useful for communicating with patients.

- Appointment reminders can be configured to contain no clinical information.
- Functionality that allows sending text messages directly from the EHR or from patient lists generated within the EHR for general reminders reduces the work required to send messages to remind vulnerable populations to get evidence-based interventions such as influenza vaccine.
- Patients with specific conditions who have not been seen in the clinic within a given time period can be sent text messages asking them to make an appointment, reducing the chance of a care gap.

Home monitoring devices

Patients increasingly use home devices to monitor daily weight, blood pressure, blood sugar, or peak expiratory flow. The value of this information depends on how well patients and their care teams use it to guide clinical decisions. Increasingly, information from these devices can be transmitted to the care team and auto entered into the patient record with a mechanism to alert the care team to dangerous trends, such as weight gain in patients with heart failure.

Mail

Mail is not generally considered HIT but will likely continue to be important for sending test results and reminders to patients lacking Internet access. Letters are an important back-up modality for contacting patients who are not picking up messages or cannot be contacted by phone for follow-up. The EHR should be configured to streamline letter writing through use of templates and batch processes for reminder mailings. The care team may also receive printed communication from patients and other providers participating in a patient's care. If deemed important, these messages can be scanned for later reference.

Telemedicine

Care teams are increasingly taking advantage of the convenience and availability of telemedicine. Given adequate training, most members of the care team can use this technology. This tool is particularly useful for behavioral medicine and addiction medicine by allowing more frequent communication and support for these patients, many of whom struggle during intervals between office visits. Patients with multiple chronic diseases often have difficulty keeping appointments or coming to an office visit. Leveraging telemedicine is an innovative way to enhance access for a fragile patient population.

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