MMA
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Advanced Access: Part-Time Providers

The critical design elements for Advanced Access are continuity and capacity. A provider's presence in the office (full or part-time status) may have an effect on his/her ability to comply with these design elements. Organizations and practices have different expectations about full-time status. For some, full-time clinical status requires ten half-day sessions per week in the office. For others, there are system expectations and bookable hour expectations that require less than ten half-day sessions (of either 3.5 or 4 hours each) per week .

A provider who is in the office from seven to ten half-day sessions per week can easily work within the principles of Advanced Access, doing today's work today. If the provider takes a full Monday or Friday out of the clinical office then it is more difficult since "good backlog" tends to accumulate immediately following time out of the office. In addition, if there are three consecutive out of office sessions, some difficulty can ensue. Thus, generally, if the clinical out of office sessions can be spread over the week, there is very little problem. In Advanced Access a provider is responsible for the management of his/her patients' needs on the day he/she is present in the clinic. Thus, panel size and expectations commensurate with the amount of time the provider is in the office are crucial. This does not mean that each 7/10 provider needs to manage the same size-adjusted panel. In environments where revenue/salary is allowed to float, then the panel can float since the access standard is set.

A provider with a 6/10 clinical schedule can also do well in the Advanced Access model. However, these providers must spread the work over the week. A schedule of patients on Monday, Tuesday and Wednesday simply won't work. The absolute most successful model is the Monday, Wednesday and Friday model. In this way supply is spread over the week to match demand. Patients who request appointments on Tuesday and Thursday get the choice of waiting a day to see their provider or seeing another provider on that day (T appointment). Since the wait is now only a matter of hours instead of a matter of weeks or months as we have seen in older systems, the likelihood of the patient choosing to wait for his/her provider goes up and the continuity rises as well. With a panel approximately 60% of that of a full-time provider, the work on the Monday, Wednesday and Friday is less, so the demand moved from the off days of Tuesday and Thursday tends to fill the schedule quite well. These providers do have to be more flexible in their attitudes, posture and philosophy.

At a 5/10 clinical schedule, Advanced Access is difficult due to the accumulation of good backlog, which always gets booked sequentially and hence fills the next day first. Any approach built to "protect" that day is a carve-out model. Two providers with 4/10 or 5/10 clinical schedules can be paired to make one. They have to commit that one will be present on all days (within reason), that they are never there at the same time (not enough work to do), that their patients understand and agree to the arrangement, and that they are the same gender. If one of

the providers is male and one female, we have seen that most of the work goes to the female provider.

Providers at or under 4/10 clinical schedule ought to consider either a carve-out model with a commitment to do all today's urgent demand today, and not let wait times for non-urgent go out past seven days. If demand for non-urgent demand goes past seven days, there is no capacity for return patients with semi-urgent problems who need to be checked within a week or so. The other option for these part-time providers is to relinquish their panel responsibilities (they have a demand–supply mismatch problem anyway) and take on the role of a team provider who sees the patients of the providers who are absent.

Part-Time Panel Questions

Regarding panel for a provider in clinic who works less than 20 hours/week, which scenario is better?

Scenario #1:

I am a part-time doctor, working 4 hours in a clinic each week. I get a prorated panel of my own, (perhaps about 200 patients or so) assigned to me. When I am not in clinic, my assigned patients would be seen by a specified full-time provider. When I am in clinic, I see both my assigned patients and the other providers' assigned patients.

Answer: *If the expected panel for an FTE is 1200 you would get 10% of that (4 hours a week is about 10% of a work week) so whatever the FTE panel expectation is, yours ought to be 10% of it.*

Use the equation:

Panel size X Expected visits per patient per year (you can get this from past activity) = Number of visits you offer per day X Number of days per year you work (an FTE is usually 210).

If you use this approach, then your patients will need to wait for 9.5 sessions per week for the .5 session you "attend." So there will be a wait.

If your partner has a full panel, then he/she faces a 1.1 panel size each day - that is, 10% more workload than an FTE. If you "cover" for him/her, you get 1.1 panel size at your session. Generally patients will wait for you, so the pressure really moves to the single session you are available each week.

You would have to accommodate all your sick patients that day and unless you carved out for "same day sick" you would be continuously at risk for overflow.

If you did carve out, you are at risk for saving too much space. Variation on both sides - up or down - can hurt you.

The advantage is that you get to keep some relationships, but do so at the expense of wait time and risk of variation.

Scenario #2:

I not have any patients assigned to me. When I'm in clinic I act as a "helper provider" for another provider who has an assigned panel. I see just his/her patients when I'm in clinic.

Answer: *In this scenario, your 200 or less patients have to be absorbed by others within the practice. This is a zero sum game. The other providers will have to divide your 10% panel and actually go over 100% panels but what they get is your help to relieve them of seeing patients when they are not in the clinic. So the sessions you work, you see patients from absent providers and "protect" your partners' time so they can see their own. If you work the same session each week, you could be benefiting some providers more than others dependent on scheduling.*

Keep in mind that your schedule (by the nature of the work) will fill that day. You may have a few pre-scheduled patients when you know the provider is gone and the patient needs follow up that specific day. But for the most part the work is generated that day from absent providers. If you work AM it will be hard to fill - so work PM. Generally one provider can cover the absences for two but you work only a half day so that cuts this in half.

Conclusion

I understand the sentiments but my preference is for Scenario 2. I just think it works better. You might have to change PM "shifts" dependent on needed coverage for absences. So you may need to be flexible.