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Advanced Access and Contingency Plans

What is Today?

The most important contingency plan in an improved access approach wherein we will offer an appointment today for any problem is obviously a decision about what is the definition of "today." In a saturated model, "today" is over before we start. The schedules are full and demand is either forced into an already filled schedule or sent to another venue of care. This is not acceptable to our patients, especially when they are ill, sick and vulnerable. They want to see their see their own provider.

Thus, we need to make a conscious and intentional decision about "today." Just as ending the day before we start is not acceptable, so is working each night until midnight.

To resolve this, some groups make a decision to see all patients who declare that they can arrive before a specified "cut-off" time. This can be 4 or 4:30 PM, for example. In this way the patients, and their ability to arrive at the practice, determines the care. This is not a decision based on whether or not the schedule is full. In practices where there are evening hours, there is often an afternoon "cut- off" for the providers working in the daytime and another one (7:30 or 8:00 PM) for those working the evening hours.

Post Vacation Schedules

One of the constant difficulties of practice is the amount of work and appointment demand that occurs during a vacation period and then becomes overwhelming immediately post-vacation. Successful practices have utilized the following method as a post vacation contingency plan:

- If a provider plans a single week vacation, block his/her schedule for two weeks (the week he/she will be away, and the week he/she returns).
- On the first day the provider is away, open the mornings of the week he/she returns. This allows accumulating demand to fill the mornings on that week.
- When the provider returns, open the afternoon of each day in sequence (day by day), allowing the schedule to fill up on each day.

This creates a carve-out model (holding appointments) in the middle of an Advanced Access approach. Patients who call during the planned week of absence no longer have to wait until the end of the long routine queue, or have to see another provider. The wait time is no longer than a week. This tends to increase the continuity for the absent provider since many patients will wait to see their own provider, and this also tends to preserve the schedules of the providers who are present, allowing them to see their own patients and not having to see patients of the absent provider.

This approach results in increased patient satisfaction due to shorter waiting times, better continuity, increased provider satisfaction and the “space” to be able to do the work when the provider returns from a vacation. None of this is possible except in Advanced Access since carving out in any other approach just extends the wait time for the routine queue. With reduced backlogs and the commitment to do all the work today, the practice is in a good position, and holding appointments in the first post-vacation week has little adverse effect.

“T” Appointments

In Advanced Access, appointment types are reduced to a minimum number in order to increase scheduling flexibility for patients. In these models, since appointment requests are no longer sorted by clinical condition, but rather by the presence or absence of the provider, there needs to be an appointment designation for personal (present doctor’s own patients) and team (for the absent provider’s patients). Groups have successfully used designations of “P” for personal and “T” for team. Some also use a U designation for either new patients or crossovers from one site to another.

One of the key contingency plans involves the variable use of the “T“ appointments. These appointments can be used in the following ways:

- In general, the “T” appointments should be shared equitably among the providers who are present. In most cases, 50% of an absent provider’s patients will wait for his/her return. The other 505 need to be shared equitably among those providers present on any given day. The key here is to avoid appointing all the patients from an absent provider into the first open space for any provider who is present. This tends to “punish” those with a reduced backlog and same day open schedule.
- If the prediction for the number of “T” appointments is underestimated and these appointments “run out,” then further requests from absent providers’ patients need to be rotated amongst the providers who are present. The rotation, if continued, starts next time where it was left off this time. This is all pre-determined.
- If there are a limited number of appointments left and a provider’s patient makes a specific request for an appointment time on his/her schedule that contains an unfilled “T” appointment, then appoint that patient to that time and trade the “T” appointment for any other unfilled “P” appointment on that provider’s schedule. Continuity takes precedence. At the same time, don’t eliminate the obligation to manage the “T” appointments.
- If a provider is over-paneled, the group can decide to allow that provider to avoid any “T” appointments altogether.

Nurse Practitioners/Physician Assistants

One of the most important contingencies is to develop a planned method of how to work with NP/PAs in the practice. In many systems of care, the role of the NP/PA is to substitute for the physician. In this approach, when a physician’s schedule is “full” and the clinical condition permits it, patients are diverted from their own physician who is present and scheduled to see the NP/PA. This results in a number of adverse outcomes - patient satisfaction is reduced (even

if patients say they “don’t care who they see,” the satisfaction ratings for a non-familiar provider are lower), there are more return visits generated, and the system has lost the opportunity to truly maximize the efficiency of that visit. So what on the surface appears to be a smart plan results in more work and less satisfied patients. In addition, it is much easier for a provider to see his/her own patients – there is less time involved in new relationship building and clinical care starts where the provider left off last time, not as a new event.

The best approaches we have seen involve having the NP/PAs see patients from absent physicians. In this way, the physicians present can provide what they do best: healthcare in the context of their relationship with their own patients. The NP/PA still generally sees patients with acute medical problems but these are patients from physicians who are absent and not from physicians who are present.

In addition, the question is asked “What do the NP/PAs do when all the physicians are present?” First, in most practices of medium to large size, this is unusual and, second, this is the place to have patients choose the NP/PA as a primary provider. In many environments, there is a great desire on the part of patients to have a female provider and, since most NP/PAs are female, this provides an opportunity for patients to choose a female provider. The role then for the NP/PA is to care for that partial panel of patients in addition to the role of seeing patients for absent physicians.

Predict The Expected

There are many events that occur in practices that seem unpredictable: flu season, the demand for school and sports physicals, an admission to the hospital, trauma, laceration, excision, procedure, a visit that takes longer than expected, a mother who brings three children instead of one, etc. We often act like these events had never occurred previously, yet the flu season occurs every year, as do school and sports and school physicals. Unexpected events are just part of office practice. We often respond by restricting access by the development of rigid appointment types or by delaying or deferring the care.

The most efficient practices respond to that unexpected demand by planning that it will occur. Information flows freely from the receptionist to the care team. Rooms and procedures are planned “just in time” by standardizing rooms and equipment as well as having all necessary tools and equipment ready for use. Staff are cross trained and flexible to share the work, and a communication plan (huddles) helps the practice to anticipate these needs.

In a practice operating with Advanced Access, the schedules are not filled far in advance and the day starts with maximum flexibility and capacity. A standard appointment length sets the rhythm of the practice but does not mandate rigidity. Since the practice team works together and patients see their own providers more often than in the past, process steps can be rearranged or reversed in order to maximize the patient’s experience and reduce the delay.

The process of each task is broken down to see what the work is and who needs to do the work.

Scripting For Common Occurrences

In our practices some events or processes occur frequently. Often we look upon the occurrences as new events and reinvent the response each time they occur. One of the more valuable contingency plans involves the development of scripting for common recurrent events. For example:

- When we change the appointment types to reflect the presence or absence of the provider (PTU) rather than the clinical nature of the visit (urgent/routine), we can potentially lose the transfer of clinical information to the assistant working with the provider. In addition, we want the assistant and the provider to be prepared for the visit. Thus, we may make the appointment and then develop the following script (after the appointment is made) *"Your appointment is for today at 2 PM. In order to be prepared for your visit today, your provider and his/her team would like to know why you are coming in."* Even though the visit issue has often been already declared, this allows us to screen for emergency issues (to be sent to the ED) and allows us to gather information to prepare the rooms and/or equipment for the visit.
- When a provider is absent we need to give our patients the opportunity to either wait for him/her return or be seen today. The script would look like this: "*Your provider is out of the office today. He/she will return in two days. I can make an appointment for you with him/her in two days or, if you wish, I can make you an appointment with his/her practice partner today."*
- While working in an Advanced Access model, we often have to allow for some supply side variability, that is, sometimes we will have to see an "extra" patient in order to do all of today's work today. We may have to script for that: "*Your provider wants to see you today. He/she has been busy (don't say overbooked) and can see you at 4 PM. There may be a wait but probably not more than 15 minutes. She also has appointments tomorrow morning. I could also appoint you at that time."*
- We recognize there is often a great demand for the late afternoon appointments. On occasion, those appointments will fill and there will be "holes" in the schedule earlier in the day. We can use a script to try to pull the work towards the appointments earlier in the day. When a patient leaves one appointment and makes a required follow up appointment, we can say: *"Your provider has an appointment open at 8:30 next Thursday. Would that work for you?"* If the patient declines, we then offer the 8:45 appointment and so on. In addition, when a patient calls, we first offer the earliest open appointment and attempt to fill sequentially. If the patient requests a later appointment, we provide that.
- On occasion, in Advanced Access, there will be a day when demand is greater than supply and we will have to make more appointments than exist in order to do today's work today. The best way to manage this is to prepare in advance how each provider or how we as a group will manage this situation. If our "what is today?" cut off time is 4:30, we are not saying that if we are out of appointments then we won't see the patient but that if the patient can get here by 4:30 we will see him/her. Thus, if the 4:30 appointment is filled and we have more patients to see, the cut off time is 4:30 but the appointed time may be later than that or even earlier than that if we have a pre-arranged commitment to see all our patients today. The 4:30 question just defines for us whether we have committed to see that patient "today." This puts a boundary on what is today from the patient perspective but does not put a

boundary on the number of appointments or the time of the visit which may actually occur at 4:45. In order to avoid confusion for our patients who can get here by 4:30 but we can't see them until 5:00 PM instead of asking: "Can you get here by 4:30? "and then appointing them at 5:00, we may ask a more open ended question: "When can you get here?" and if the answer falls before 4:30 we appoint them to the first opening which may or may not be 4:30. If the answer is after 4:30, we make other arrangements even though the provider may be still seeing appointed patients at 5:00 PM.

Plan For Demand

In an access model wherein the task is to complete today's work today, a key determinant of daily success is the correct prediction of demand. Demand is often incorrectly measured by looking at past activity (i.e. if we saw 125 patients on our practice on a specific day, we conclude that the demand for service was for 125 appointments). This actually measured the supply of services that we offered rather than the true demand for service on that specific day. To determine the true demand for service on any specific day we need to add the following externally created sources of demand:

- All those patients calling for and getting an appointment, regardless of the day to which they are appointed. (We assume that those who decline today and accept tomorrow will be equal to those who declined yesterday and accepted today.)
- All those patients who walked in instead of calling in
- All those patients who were appointed by other means: fax, email, direct from the ED, add-ons, etc.
- All those who were deflected from care in the practice and went, instead to the urgent care centre or ED

In addition, we need to calculate internally created demand:

- All return visits generated today and appointed today as the patient left the practice.

The sum of these components gives us a measure of the true demand for our services. We need to measure and monitor this over time to begin to see the patterns. We then need to plan to meet this demand with the correct supply of services. At first we need to create time off policies that assure enough daily supply to meet this predicted demand. When patterns emerge that demonstrate a predictable variation in demand (i.e. there is more appointment demand on Monday than Friday or more demand for prescription refills on Friday) we then need to flex the supply over the week to meet these patterns.

In addition, there are unpredictable variations in demand. A crucial contingency plan is to be prepared to meet these unpredictable variations on a daily basis. Those practices that anticipate these variations, monitor the demand continuously over the course of the day, and stay ahead of demand fluctuations, tend to have less "crises."