Introduction

Enhancing access for patients, regardless of their ability to pay, is a fundamental concept of Patient-centered Medical Home (PCMH) transformation. A practice can have the most patient-centered approach to care, yet if patients cannot access their care team, the model doesn’t work. This implementation guide offers some specific recommendations to help practices take steps to increase capacity to address patient demand, ensuring access for all.

Enhanced Access is more than just providing patients with the ability to schedule same-day appointments. Like most of the Change Concepts presented by the Safety Net Medical Home Initiative (SNMHI), the principles of Enhanced Access require changes in how practice site clinicians and staff work. These changes, while challenging to implement, will result in reducing or eliminating the barriers to care that patients sometimes experience.

Elements of Enhanced Access

- 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.

The goal of the Safety Net Medical Home Initiative (SNMHI) is to help practices redesign their clinical and administrative systems to improve patient health by supporting effective and continuous relationships between patients and their care teams. In addition, SNMHI seeks to sustain practice transformation by helping practices coordinate community resources and build capacity to advocate for improved reimbursement. The SNMHI is sponsored by The Commonwealth Fund and is administered by Qualis Health and the MacColl Institute for Healthcare Innovation at the Group Health Research Institute.
**Change Concepts**

The following eight Change Concepts for Practice Transformation (Change Concepts) comprise the operational definition of a patient-centered medical home for the “Transforming Safety Net Clinics into Patient-Centered Medical Homes” Initiative. They were derived from reviews of the literature and also from discussions with leaders in primary care and quality improvement. Over the course of the “Transforming Safety Net Clinics into Patient-Centered Medical Homes” Initiative, we will cover each of these change concepts in turn. An implementation guide will be prepared and made available for each concept. This implementation guide is focused on Enhanced Access, a critical element of the medical home, and one we think must be addressed early on, as its principles are overarching.

1. Empanelment
2. Continuous and Team-based Healing Relationships
3. Patient-centered Interactions
4. Engaged Leadership
5. Quality Improvement (QI) Strategy
6. Enhanced Access
7. Care Coordination
8. Organized, Evidence-based Care

Implementing Enhanced Access is best accomplished when Empanelment and staffing models are in place. Before tackling Enhanced Access, practices should implement patient-provider panels and ensure that high-functioning care teams are in place. Empanelment makes it possible to measure, predict, and schedule according to demand, and to improve provider continuity; which in turn, reduces demand for unnecessary visits.

**Message to Readers**

SNMHI implementation guides are living documents. Updates will be issued as additional tools, resources, and best-practices are identified. This implementation guide provides an introduction to the three elements of the Change Concept “Enhanced Access:”

- Promote and expand access by ensuring that established patients have 24/7 continuous access to their care teams via phone, e-mail 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.

Transformative change relies upon knowledge sharing and transfer. The partner clinics and Regional Coordinating Centers participating in the SNMHI are members of a learning community working towards the shared goal of PCMH transformation. This learning community produces and tests ideas and actions for change. The Initiative celebrates the contributions and accomplishments of all its partner clinics and Regional Coordinating Centers and, in the spirit of collaborative learning, implementation guides often highlight their work. This guide includes resources from Clinica Family Health Services (Colorado), Metro Community Provider Network, Inc. (Colorado), Cambridge Health Alliance Revere Family Health Center (Massachusetts), Harbor Health Services (Massachusetts), and Multnomah County Health Department (Oregon). Editorial support was also provided by the Massachusetts League of Community Health Centers.
Background

When patients face waits or delays in receiving care they are more likely to skip appointments. 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. The human and financial costs of inaccessibility are therefore substantial.

Studies in the United States demonstrate improved outcomes and lower costs of care in regions served by a higher proportion of primary care when compared to those with lower proportion of primary care. Studies show that enhancing patient access, particularly providing access to 24-hour advice, and to the patient’s provider of choice, improves outcomes, experience of care, and reduces the costs of care.

TABLE 1: Benefits and Outcomes Associated with Enhanced Access

<table>
<thead>
<tr>
<th>Stakeholder</th>
<th>Benefits / Outcomes</th>
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<tbody>
<tr>
<td>Patients and Families</td>
<td>Convenience</td>
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<tr>
<td></td>
<td>Get to see their provider of choice</td>
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<td></td>
<td>Problems addressed in a timely manner</td>
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<td>Providers</td>
<td>Greater continuity</td>
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<td></td>
<td>Less chaos and more control</td>
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<td></td>
<td>Better satisfaction</td>
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<tr>
<td>Clinics</td>
<td>Potential increase in RVU billing</td>
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<tr>
<td></td>
<td>Reduced no-show</td>
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<td></td>
<td>Improved staff satisfaction</td>
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<td></td>
<td>Fewer patient complaints</td>
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<tr>
<td>Communities</td>
<td>Reduced emergency department use</td>
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<td>Reduced hospitalization rates</td>
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Access and Primary Care

Access to primary care is a defining variable of high-performing health systems and is therefore a defining component of initiatives aimed at improving outcomes and lowering cost. Medical homes can improve quality, reduce errors, and advance societal health. Medical homes enhance access by helping people clear financial barriers to care, eliminating unintended practice barriers to care, extending access to include multiple channels of communication, and expanding access to encompass 24/7/365 care needs.
Research Review: Access as Infrastructure
Having an FQHC as a regular source of care can significantly reduce the likelihood of hospitalizations and ED visits for ambulatory care sensitive conditions (ACSCs). For example, in one study, Medicaid beneficiaries receiving outpatient care from FQHCs were 27% less likely to be hospitalized and 5% less likely or seek ED care for ACSCs than a comparison group.5

Access to services associated with medical homes:
To assess the impact of medical home assignment on uninsured individuals enrolled in a medical assistance program, Orange County California tracked enrollees receiving care from practices functioning as medical homes (employing case management, team based care, enhanced access). Enrollees with longer time periods in medical home practices were less likely to have any ED use or multiple ED visits.6

Community Care of North Carolina (CCNC) supports local networks of providers with money to adopt improvements in care and access consistent with medical homes (enhanced access with 24 hour on call coverage). As of 2008, CCNC is saving the state $160 million annually.7

Furthermore, studies show that patients who have care needs met by a personal primary care provider (PCP) are more likely to have good outcomes, a good experience of care, and their overall care will cost less than those who do not. The goal of enhanced access is to improve the probability that patients have their care needs met by a personal PCP.8

This goal is easier to achieve when a practice:
• Has a process for overcoming finance as an obstacle to care.
• Minimizes barriers for patients seeking appointments:
  • Eliminates delays for appointments
  • Streamlines the appointing process
  • Eliminates in-office waits and delays
• Makes every possible accommodation for continuity of care with the PCP.
• Has expanded office hours.
• Provides access to good health advice when the office is closed.

In order to enhance access, a practice must first address inconsistencies with supply and demand. In many cases, practices are using traditional solutions which may seem to address patient needs, but have the unintended consequence of bogging down the practice and denying patient-centered care. Table 2 compares traditional solutions to accommodate patient demand to the PCMH solutions covered in this guide.

The resource section of this guide provides tools for practices that want to formally measure capacity (provider time available to deliver direct patient care) and demand (patient need for direct patient care). Presuming that this gap exists for most practices, we next discuss methods to close the capacity/demand gap.

TABLE 2: Comparative Responses to Patient Demand

<table>
<thead>
<tr>
<th>Traditional Response</th>
<th>PCMH Response</th>
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<tbody>
<tr>
<td>Double or triple-booking urgent need appointments with those scheduled weeks before.</td>
<td>Use open access scheduling so that patients with immediate needs can be seen the same day.</td>
</tr>
<tr>
<td>Develop complex appointment scheduling patterns to accommodate providers’ preferences.</td>
<td>Use one appointment type that meets the needs of providers and patients.</td>
</tr>
<tr>
<td>Offer patients the first available appointment with any available provider.</td>
<td>Ensure continuity of care with PCP and care team so that acute needs and ongoing care are addressed by the same team.</td>
</tr>
<tr>
<td>Nurses triage all calls and requests.</td>
<td>Train one nurse as a health coach to assist patients. Empower nurses to handle care questions over the phone (e.g., medication refills, etc.).</td>
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Methods of Increasing Capacity

The most obvious means of increasing capacity is hiring more staff and providers. This may be a difficult option for many reasons, so this guide will focus on other ways to increase capacity: working more efficiently through using workflow analysis, simplifying appointment types, implementing simplified patient scheduling, creating contingency plans, reducing no-shows, and listening to patients.

1. Work more efficiently

Efficiency is one desired effect of strong care teams. Human interaction in complex settings like community health centers is prone to communication errors, overly complex processes, and policies that have unintended negative consequences. Workflow analysis in the context of a coordinated care team can help identify opportunities to gain efficiency and simplify work.

Tools to analyze workflow include the Patient Walk-Through Tool, spaghetti diagrams, cycle time analysis, and more. Each can help a practice identify opportunities to reduce the number of steps in a process, the number of feet walked by staff and patients, unnecessary waiting and delays. If the goal is to have a positive impact on patients, consider using a patient experience measure as marker of improvement: “When I visit my doctor’s office it is well organized, efficient, and seldom wastes my time.”

Recommendation: Use process analysis tools from the Dartmouth ‘Green Book’ or any other process analysis to unmask opportunities to simplify patient and information flow.

2. Simplify appointment types

Set the goal of each provider having only one appointment type of a fixed duration based on the average amount of time that provider takes to see a patient. Trying to predict how long individual appointments will take often results in frustrations and delays.

Example: A primary care practice had a six month delay for a well woman exam with a Pap test. When the practice permitted schedulers to put this appointment type into any 30-minute slot, the delay dropped immediately to six weeks. Queuing theory suggests that a provider is more likely to see patients on time when there is one appointment type with a fixed duration matching that provider’s typical time with patients.

Recommendation: 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 should begin to open the path to the ultimate goal of a single appointment type.

Redesigning Processes in Action

Mountainview Pediatrics in rural western North Carolina suffered from too many repeat phone calls from parents asking, “Has the refill been called in?” The response “Your provider checks messages at the end of the day” wasn’t satisfying the callers. Recognizing that approval of a refill request only took the provider about 10 seconds, they tried a new process in which the nurse would present one to two refill requests as the provider left one exam room to go to the next. The nurse would then immediately call the pharmacy and notify the patient. Call volume dropped by 60% within four months.
3. **Implement Simplified Patient Scheduling (SPS)**

This is a stepping-stone strategy to reduce delays for appointments. Some practices have difficulty moving directly to full advanced/open access but can still make headway reducing appointment delays with this technique developed by Coleman Associates. A practice able to simplify down to one appointment type per provider can easily implement the technique.

**How it works:** 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 simple cases and leaving one open for same day use. Each hour the provider and care team has a chance to catch-up and get back on track if delays occur. And, the day starts with some slots open throughout the hours of operation.

**Recommendation:** Use SPS as a stepping-stone to reduce appointment delays if advanced/open access is too difficult or daunting. See SPS articles in the resource section for more details.

4. **Align capacity with demand**

Many practices learn through measuring their own supply and demand that there are gaps that might be filled by shifting capacity. Friday afternoons may be particularly busy but have the least amount of provider availability; or President’s week may have the lowest provider availability due to holidays but have highest demand time due to influenza season in pediatrics. Information on measuring supply and demand is available [here](#).

Shifting capacity to meet patient demand means asking people to change their schedules or vacations. Practice managers can start the conversation by gathering data on capacity and demand and demonstrate the gap at provider meetings, asking the group for ideas to close the gaps.

Gap closing techniques used by practices include creating minimum staffing policies that require advance notice for schedule changes. Some centers 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 is available [here](#).

**Recommendation:** Adopt a time-off policy based on minimum staffing needs and based on analysis of demand.
5. Create contingency plans to deal with sudden gaps

Variability in patient demand and unpredictable supply shortfall (e.g., a provider is ill) can create sudden gaps. Maintaining good access and patient flow is easier if a practice has a list of contingency plans that can be implemented quickly. Prior agreement on the nature of the triggers and ordered list of contingency plans used is important.

Many of the unpredictable events that interfere with the flow of the day become predictable when viewed from the big picture. A provider out for the day following a delivery is relatively predictable; there is a rough idea of the patient’s due date and impact of having a provider out for a full day.

Example: Provider A delivers a baby and has the next day off. Rather than the old mode where receptionists had to use all future same day slots to accommodate the bumped patients, the office 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 schedule for those patients whose needs might be met via email or call from nurse.
- Non time-sensitive work (e.g., a meeting) is postponed.
- Providers B, C, 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.

Recommendation: Create contingency plans based on frequent unpredictable events that disrupt supply or create demand surges.

6. Reduce no-shows

Patients fail to keep appointments when they feel they have been treated disrespectfully and/or if there has been too much of a delay between contacting the practice and the actual appointment. In one study patients defined disrespect as “you waste my time in the office and you don’t listen to me.”

The solutions to no-shows therefore include not just the typical reminder systems, but attention to in-office waits, delays, and subjective assessment of “listen to me” by patients.

Recommendations:

- Reduce in-office waits and delays by empowering the care team to improve patient flow.
- Reduce delays for appointments by implementing advanced access or the stepping-stone approach of Simplified Patient Scheduling.
- Consider communication training for providers.
- Consider implementing new patient orientation groups if new patients are particularly prone to no-shows.
- Remind providers to sit down, make eye contact with the patients, and allow the patient to talk without interruption.

In one study, patients averaged less than two minutes of talking before they are done – far less than the endless litanies feared by providers. Avoid looking at a watch, glancing repeatedly at the door or letting the computer become the focus of the encounter.
Case Study: Cambridge Health Alliance Significantly Reduces No-Shows by Enhancing Access

In 2004, Cambridge Health Alliance 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 Dr. Soma Stout, 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, Dr. 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 the 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 1-2 weeks showed a 14% no-show rate; when appointments are 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-aways 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.”
Methods To Decrease Unnecessary Demand

There are several things a practice can do to reduce unnecessary demand for services and therefore open the schedule to better meet patient needs in a timely manner. As discussed in the beginning of this guide, Empanelment leads to improved continuity of care and to better outcomes for patients and can help improve work processes in a practice. Continuity of care improves trust, and patients who trust their providers are more likely to follow through on recommended screening tests. Specific tactics for reducing demand are addressed below.

1. Max pack visits

Max packing is when a provider chooses to explore issues beyond the immediate presenting problem, and is best performed by a patient’s PCP, underscoring again why empanelment and continuity of care help enhance access. For example, a familiar provider can ask, “Now that we’re done with your cough how about we address your blood pressure and the fact that you’ve not yet had a colorectal cancer screen?” If documented correctly, this may lead to a more robust payment for practices operating in fee-for-service mode.

Recommendation: During a huddle, the care team can identify patients on the day’s schedule with unmet care needs beyond the stated reason for the visit. To do this well, the team will learn how to quickly scan charts for care gaps while keeping huddles to five minutes (registries are very helpful here). The team can then extend itself to address those needs, eliminating the need for early follow-up and/or missed opportunity to close gaps in care.

2. Extend revisit intervals

Extending revisit intervals opens up appointments for other patients. Providers develop habits in training that determine how much time they allow between re-visits for patients with chronic conditions. There is very little – if any – science behind these habits and one study demonstrated significant improvement in ED use, hospitalization, and patient satisfaction when patients were rescheduled at twice the typical interval and had telephone follow-up in between visits.

Patients may initially be slow to accept this if they have lost faith in the ability of the practice to grant them timely appointments. Practices that have reduced delays for appointments should expect less pushback by patients. Pushback from providers often revolves around losing track of patients. A good registry (the technology and effective use) should provide reassurance.

Recommendation: Suggest to a willing provider that they try the method with one patient one time, maybe extending by one month the typical return visit interval. The provider may need to reassure the patient that they will make themselves available if anything comes up in the interval.
3. Offer group visits/shared medical appointments

Group visits have recently captured the attention of primary care practices struggling to meet the needs of many patients who have ongoing issues and who are amenable to group formats. Research has shown that group visits help to improve access and quality in safety net hospitals and health systems, and can be modified to fit the needs of an institution, providers, and patients. A group visit might include 15 or more patients and their caregivers in a 90-minute session. The session might include didactic presentations plus group discussion, self-management support accompanied by peer support. With training, planning and support, almost any practice can start a group visit. Common to all models is that patient attendance improves when their own provider makes the pitch.

Implementation typically starts with one provider offering one group. As the practice works out the moving parts of group visits, it can then expand to more groups. The care that is delivered individually to patients and appropriately documented in the chart is often billable under typical E&M codes.

Implementing group visits requires:
- Finding space for the group.
- Adopting a model (see case study and the Group Visit Starter Kit from ImprovingChronicCare.org).
- Choosing a consistent meeting time.
- Freeing up the necessary staff and training in the model.
- Provider and staff learning how to pitch the sessions to appropriate patients.

There are a few group visit models identified in the Resources section of this guide.

Providing Access 24/7

The PCMH standard of care for access sets a high bar: 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. 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 suddenly discover that they have run out of a prescription medication on a weekend, and it is sometimes truly too difficult for a parent or patient to make an appointment during regular business hours.

In an ideal system of care, patients would have 24/7 access to clinicians who know them, and clinicians would have 24/7 access to their patients’ information. The literature supporting continuity of care is deep and compelling, and all systems should make continuous, 24/7 access their ultimate goal.

Movement toward the 24/7 care goal should not be done at the expense of the health care team, providers, or patients. Factors external to the practice may make this goal impractical, but there is much that can be done to improve on the status quo. See the Resources section for more information on 24/7 tactics.

Bare minimum standard: An on-call system connecting patients with a clinician at any time the practice is not open – 24 hours a day, 7 days a week – is a minimally acceptable standard of care in today’s connected world. This on-call system might route calls through an urgent care clinic, a nurse advice line, an answering service that connects to an on-call clinician, or clinical staff in a local hospital system. A nurse advice/triage line in Kansas City reported positive patient experience, reduced ED use, and a return of $1.70 for every dollar spent. Any approach that provides 24/7/365 access to a live person is a step ahead. See Appendix A, PPC 1A 8 On Call Policy for an example.

One step up: A 24/7 call system staffed by the practice’s clinicians is better because it increases the chance that the patient will interact with someone they know, increases access to information, and more effective follow-up.
Case Study: Clinica Family Health Services Reaps Multiple Benefits by Enhancing Access through Group Visits

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, over 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 1990’s, 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 model and Dr. Kate Lorig’s model 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 billirubin 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 participate in the continuity groups had lower C-section rates and fewer pre-term and low-birthweight 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 then 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 through 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.”
IT systems that make patient information securely available to the on-call clinician, and assure that after hours care recommendations get back to the primary team immediately, are a critical component of implementing 24/7 access. Similarly, a minimum standard for effective communication around patient care should include a response that the message was received and accepted, that acceptance signaling that indeed the receiver acknowledges that they are now accepting responsibility for the care of this person for this problem.

There are a number of techniques to expand access to primary care services:

**Expand office hours to cover nights and weekends**
A health center can expand office hours by having staggered shifts or by moving some weekday availability to the weekend. Some centers 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.

Unintended consequences to avoid when creating after-hours clinics:

- Trade-off loss in continuity: These off-hour sessions are usually designed to meet off-hour needs of the entire practice and thus will likely have some negative impact on provider-patient continuity. Since continuity of care improves outcomes, satisfaction, and can reduce unnecessary follow-up visits, this is not an insubstantial concern. As you test expanded hours, watch data on patient experience of care. Non-continuity visits may not fully address the needs of the patient and thus may just add more visits to an over-burdened practice.

- No improvement in overall access: Watch the rate at which patients seen in expanded-hours sessions are referred back to their PCP. If this is happening often, a practice must identify how to better meet patient needs in the expanded-hours sessions.

**Develop coverage networks**
Large practices may have a large enough provider base to share call overtime and avoid burnout. In settings where this is not the case, several practices might work together to create a coverage network in which call is shared between the practices.

**Example:** A network of primary care practices in Colorado opened up their own after-hours clinic on evenings and weekends. Their providers reported a more positive on-call experience and the clinic generated revenue. After-hours and urgent care visits might be billable at an enhanced rate from insurers and this particular clinic network generated additional revenue from insurers interested in supporting work that kept patients from needing to go to ED.16

**Recommendation:** Develop a plan for coverage that satisfies enhanced access standards.
Email access and patient portals

Email is an important tool for enhancing access. Email offers patients the opportunity to contact their care team efficiently and frees up office visits for patients with more complex problems. While email is not currently reimbursed by most payers, if a low RVU visit is done quickly via email and the provider can see a high RVU patient, email may be financially beneficial. Patient portals and secure messaging make it possible for staff to send information to patients without tying up the phones. 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. The telephone option is slower because of the time it takes people to pick up the phone (or the staff member to listen to a message) in addition to the social requirements of conversation.

Recommendation: Check with your EMR vendor for a secure messaging module or try a stand-alone secure messaging system. Find a care team willing to test email use to reduce follow up phone calls (efficiency advantage in all reimbursement models) and if the burden is not great, track call volumes, staff and patient satisfaction. Computer access is clearly an issue but the perception that patients have no online access is greater than the reality. Draft an email agreement based on an example in the Resources section and start asking patients for emails.

Helping Patients Attain Health Insurance Coverage

Provide eligibility screening and enrollment assistance

State policies regarding eligibility vary significantly. Problems arising from eligibility criteria can add significant expense to the practice. In an effort to streamline eligibility criteria and enrollment with mandated coverage, Massachusetts is exploring policy changes that might be helpful in other states. Below are some techniques used by practices to streamline the work. [See policy article available in the Resources section]

Conclusion

Enhancing access can be achieved by increasing capacity, decreasing unnecessary demand, and modifying scheduling options. Improving access may reduce the time care teams spend on phone calls, messages, triage, scheduling, etc. This allows all team members to focus on clinical care, population health, and overall practice efficiency; and in turn, improve provider and staff satisfaction and patient experience.
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 were 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. This 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.”

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.

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 empaneled persons enjoy talking with the financial screener 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. PCMH is about treating the individual with respect.”

An out-stationed specialist can provide links to community resources as an adjunct to practice resources. Taking on the enrollment process should lead to reduced burden on front desk staff, increased reimbursement for the clinic, and reduced churn, which all can lead to improved health outcomes.

Related Change Concepts

Implementing Enhanced Access is best accomplished when Empanelment and staffing models are in place. Before tackling Enhanced Access, practices should implement patient-provider panels and ensure that high-functioning care teams are in place. Empanelment makes it possible to measure, predict, and schedule according to demand, and to improve provider continuity; which in turn, reduces demand for unnecessary visits.

Enhanced patient access improves a practice’s ability to coordinate care and to provide evidence-based care according to patient need. Specific Change Concepts that rely on Enhanced Access include:

• Patient-centered Interactions
• Care Coordination
• Organized, Evidence-based Care
Additional Resources

Literature


Presentations and Media


Coleman and Associates. Simplified Patient Scheduling. click here.


Methods Toolkit and Workbook. click here.

Shared Medical Appointment Toolkit. click here.

Group Visits Toolkit. click here.

Centering Model Toolkit. click here.

Group Visit Toolkit. click here.

E-Visit Guidelines. click here.

Telehealth methods. click here.
References


Suggested Citation
Appendix A:
Sample On Call Guidelines, Harbor Health Services

Affected Departments: All Clinical
Effective Date: 2/07/2000
Revised Date: 11/8/2000, 2/2010

Policy:
It is the policy of HHSI that there is always a physician on call for patients. Those sites that have pediatric practices will have both adult & pediatric on call physicians. The following delineates the procedure and responsibilities for the On Call Physician.

Procedure:
1. Patients covered – All patients followed at the affiliated health centers are covered. Obstetrical and Gynecological problems not normally cared for by on call physicians and would be referred to the OB/GYN physician on call. Questions that come from institutions other than the Carney Hospital (i.e. Nursing Homes, etc.) are the responsibility of the On Call physician and shall be referred to the identified physician unless such coverage has been separately arranged.

   Some physicians may choose to be “service attending” for a month or more at Carney Hospital. “Service” patients are not the responsibility of this On-Call Group. A “service attending” must cover those patients independently, or make other coverage arrangements. To avoid confusion, if you are on service, please let our on-call physicians know that fact. The on-call physician will tell you if for some reason he or she wants to know any more information about your service patients.

2. Participating Physicians – All physicians by contractual agreement will participate in the On-Call system.

3. Monthly Schedules – One physician will be assigned the responsibility for making up call schedules. Weekday and weekend coverage will be shared fairly between all members of the coverage group. Some members may be assigned less than full coverage responsibilities based on their full time equivalency within their practice these decisions will be at the discretion of the Corporate Medical Director.

   Schedules will be made up for three month periods at least two weeks prior to the beginning of a new quarter. The administrative secretary assisting the Medical Director will be responsible for typing and distributing Corporate Call Schedules.

   Distribution of the schedules will be to all participating Physicians, the Administrators at each health center, the Clinical Managers, Manager of Operations, the Answering Service, the Emergency Room, and Operator of the Carney Hospital and the Medical Director of each health center.
4. Turnover Times – The start time for answering service coverage will be at 5:00 p.m. on weekday evenings and will go until 9:00 a.m. the following morning. On weekends, coverage begins 5:00pm Friday evening and ends at 9:00a.m. the following Monday. On holiday weekends, coverage continues until 9:00 a.m. the following Tuesday. On non-Monday holidays, coverage would be from 5:00 p.m. the prior night to 9:00 a.m. the next working day. During regular workdays (Mondays through Fridays) it will be assumed that the physician’s site of practice will be responsible for handling phone calls between 8:30 or 9:00 a.m. and 5:00 p.m. The only exception to this will be on emergency days (snow days, etc.) where it will be expected that the physician on call for the following night will be available to triage calls starting at 9:00 in the morning. Should this be necessary it will be the responsibility of the health center to notify the appropriate physician?

The answering service will be instructed to request the physician on call to return the first call to the answering service after change over times to insure that the physician is available. After the first contact, the physician can elect to have patient phone numbers presented to him or her without returning calls to the answering service.

Physicians are expected to be available to return calls on an immediate basis. Routine times between a call being received by the answering service and a call being returned by the physician should not exceed 30 minutes.

At times when absolutely necessary, the physician can request that the answering service hold calls that are non-emergent for periods not to exceed one hour. During this time physicians should always be available to the answering service should emergent calls need a response. The answering service has been instructed to always error on the side of calling the physician when a clinical situation is unclear.

5. Notification Issues – At the start of all weekends, it will be expected that physicians wishing to have their inpatients covered for rounding purposes will be signed out to the weekend on-call physician Friday, preferably after 5:00 p.m. for this purpose. In-patients that are not signed out will be assumed to be covered by the admitting physician.

All patients admitted during On-Call hours will be assumed to the responsibility of the On-Call physician. Patients normally followed by another member of the group for continuity purposes should be transferred to that physician by direct contact between the on-call physician and the continuity physician. This should occur no later that the beginning of the next business day (between 7:00 and 7:30 a.m.). Until direct contact is made, the on-call physician will remain responsible for the patient.

6. Rounding – The covering physician will round on hospitalized patients that have been signed out on Saturdays, Sundays and holidays. It is acceptable to see a new inpatient within 24 hours of the time of admission. If a patient is admitted on a Sunday after the on-call physician has already rounded, the continuity physician can be legitimately notified to round on that patient the following Monday.

7. Consults – On-call physicians occasionally are expected to consult on a pre-op or a psychiatric patient whose continuity provider is in the coverage group. These consults need to be done within 24 hours of the request.

8. Emergency Lab Results – Occasionally the on-call physician will be called by a laboratory regarding a “Panic Value” lab result. If the physician feels this represents a true emergency, the patient must be contacted. Lab results that do not sound serious can be reported to the appropriate continuity physician no later than between 7:00 or 7:30 a.m. the next working day.

9. Narcotics – In general, on-call physicians are not to prescribe narcotics over the phone; individual discretion will occasionally be used in exceptional cases.
10. On-call physicians should record any insurance authorizations given for patients to be seen at a hospital or other facility.

11. Changes in the On-Call Schedule – Any physician needing to make the change in the on-call schedule once it has been distributed will assume the responsibility for finding another member of the call group with whom he/she can change. If changes are made at least 2 weekdays prior to the on-call date, changes should be called in to the medical secretary at Harbor Health Services responsible for the distribution of on-call schedules. It will be his/her responsibility to type up a revised call schedule and transmit it to the distribution list. Any changes that occur within 48 hours of the actual date are the responsibility of the physician making the change to notify each participating health center, the answering service and the Carney Hospital Emergency Room.

12. Physician On-Call Unable to be Found – The answering service has been instructed to expect a call back from the physician on call whenever there is a changeover time. They have also been instructed to notify patients that if they have not received a call within 30 minutes to call back the answering service. When either of these situations occurs, the answering service will try to reach the designated on-call physician by both beeper and by calling his/her home phone. Should they not be able to reach the physician, they have been instructed to contact any other member of the call group that they can reach. Once they reach an alternative physician, that physician is expected to assume call responsibilities until the designated physician can be found.

A list of “potential back-up physicians” will be provided to the answering service, with names rotating every 3 months so that the same physician is not always tried first.

13. Billing – All physicians in the Call Group have the right to bill for the daily care provided to hospitalized patients. By agreement of the group, it will be the physician rounding on the patient who has the right to bill for the daily care of patients they are covering.