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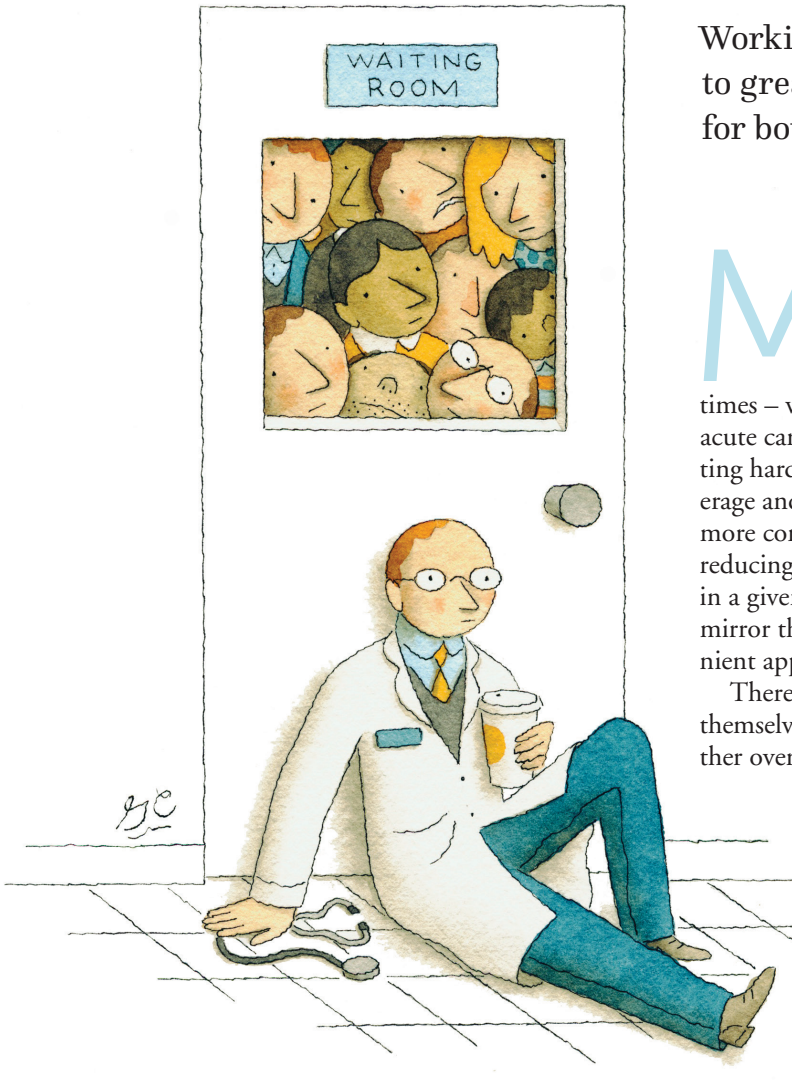
How to Provide MORE ACCESS Without Working More Hours



Working differently can be the key to greater access and satisfaction for both you and your patients.

Meeting patients' needs for access to care is one of the most frustrating challenges family physicians face. Physicians generally want to provide care for their patients at all times – when they are sick and when they are healthy, for acute care or for routine check-ups – but doing so is getting harder. As more people gain access to insurance coverage and the population ages, medical care is becoming more complex, lengthening visits, and in some cases reducing the number of patients that physicians can see in a given day. Additionally, many patients' work hours mirror those of their physicians, making mutually convenient appointment times difficult to come by.

There are several ways that family physicians can make themselves more available to their patients without further overextending their practice's resources. And access must not always mean face-to-face contact; physicians can make the resources of their practices available even when they themselves are not. No one solution is best for all physicians or practices. By determining the most appropriate changes, physicians can help avoid common access problems, improve patient satisfaction, and hopefully preserve some of their own sanity.

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Appointment scheduling

Traditionally, access is considered the availability of face-to-face office visits. These visits are what drive physician reimbursement in most payment models and are the form of care that patients value most. During such visits, physicians can best assess their patients' physical status and build close working relationships. For this reason, patients typically have a persistent, if unrealistic, desire to see their physicians whenever needed.

Insurers are pushing for greater appointment access too. Some now require that participating physicians have appointments available to patients within a certain number of days. In some cases, being able to create more access, and thereby reducing the length of time patients must wait for an appointment, may be the difference between meeting the terms of the insurance agreement and facing penalties or exclusion.

The timing of a physician's next available appointment is a common metric used to determine whether access is adequate. However, it can over-estimate availability in some cases. For instance, a physician might be able to provide an appointment on the day the patient calls to request one, but if the appointment became available only because of a cancellation and appointments for the next 10 days are full, the physician's true availability to patients is much more limited. Looking at the third next available appointment, as some insurers do, provides a truer assessment of a patient's ability to access care.

Whatever the metric, all too often, when patients call their physician's office for an appointment, they are disappointed. In general, most family physicians make appointments easily available for acute needs, but patients seeking appointments for chronic care maintenance, well visits, or other nonacute reasons face longer wait times.

Much has been published on various scheduling models. Each model has specific advantages and disadvantages affecting the ability of patients to get an appointment when they want one.

Some practices carve out a number of daily appointments for last-minute needs. However, they typically set aside these appointments for providing acute care, not for managing chronic care needs. Patients with chronic conditions who have difficulty planning in advance (due to work scheduling issues, for instance) may still be unable to access needed care.

Our scheduling model is a form of "advanced access" that combines traditional and same-day scheduling while minimizing the drawbacks of each. My institution makes part of each day's appointments available at set intervals ahead of that date. For instance, a portion may be opened a month in advance, another portion opened a week in advance, and the remainder opened on the same day. Patients may schedule these appointments for any reason, which reduces the risk of unused appointments and makes it more likely patients can get the care they need at the time they desire.

Some pitfalls that our practice faced when implementing this included explaining the model to patients and keeping exceptions to a minimum. Because the model runs contrary to how patients typically understand appointment scheduling, it can be confusing. But, over time, our patients came to understand that they will be more likely to be seen when they want to be seen – and by their own physician.

We also found that well-meaning staff members have a tendency to override the scheduling model, filling appointments that are not technically available at the time of scheduling. When this happens, we lose immediate availability for patients who need timely follow-up for chronic care but don't schedule it until the last minute. If schedule overrides of this type happen frequently, it usually indicates that the practice is attempting to care for too many patients. Options for dealing with this situation will be addressed later. We have continued to counsel our staff to respect the limits placed on providers' schedules to help maintain availability, and we monitor this issue regularly.

Nontraditional office hours

Appointment slots are helpful only if they are at times when patients can use them. Traditional office hours may not be sufficient for the increasing number of households in which all the adults work during the day or for people holding two or more part-time jobs. Additionally, the patient-centered medical home model encouraged by many payers values practices having these additional hours. However, most family physicians would like to keep more traditional schedules. Harmonizing the needs of our patients with our own desires is challenging but possible.

Many patients cannot attend workday appointments except during their lunch hour. To better accommodate them, a multiple provider office could stagger midday breaks or a solo physician could take his or her midday break an hour earlier or later than normal. This change can significantly increase access without adding cost or increasing work hours. ➤

About the Author

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Physicians can even try shifting their daily schedule to start earlier or end later to increase their availability to patients who work more traditional hours. For example, in our practice, physicians alternate between a noon start time and a morning start time on a weekly basis. This allows us to make evening appointments available. Although being open for longer hours increases staffing and facility costs, patient satisfaction has increased, and because the evening appointments are so well used, they have increased our revenue beyond what traditional appointment times would typically produce.

The scheduling model used in the author's practice allows patients to schedule future appointments as well as same-day visits.

Many of our patients have asked for Saturday appointments, and we plan to add them in the future. First, we must solve challenges with staffing and building availability and then carefully assess the financial implications.

Staggering midday breaks to open up lunchtime appointments or altering start or end times to open up appointments before or after traditional work hours can improve access for working patients.

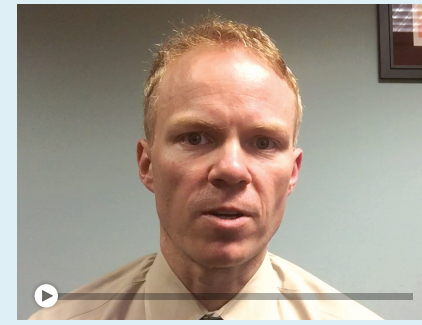
Clinical staffing

Patients ideally should receive all of their primary care from their own family physician. But it is sometimes necessary for patients to see other providers both inside and outside the physician's office.

Physicians in a large group, for example, may have urgent care centers in their network that can facilitate continuity of care by making referrals and sharing of medical records easier. Good communication with these urgent care providers can ensure that patients receive the same high-quality care they would receive in the physician's own office.

Many family physicians, especially solo family physicians and those in small practices, don't have this option. However, if an urgent care facility in the community keeps hours that complement a physician's own, practices may find it useful to directly contract with these facilities. The terms of such a contract may include communication expectations and follow-up arrangements.

Many practices use physician assistants and nurse practitioners to provide acute care or handle "overflow." Other practices



IN THE AUTHOR'S OWN WORDS

Dr. Manard provides additional details on how his practice uses its online portal to increase patient access in a video available with the online version of this article (http://www.aafp.org/fpm/2015/0500/p24.html).

GETTING GOING

QUICK	EASY	CHEAP
Adjust the panel size by eliminating contracts with lower-paying insurers or temporarily closing the practice to new patients.	Customize the practice website to offer patient advice, including both general content and content linked to the practice.	Switch to a form of advanced access that allows same-day scheduling but also opens up dates for future visits.
Provide more acute patient care by phone; some practices use this to treat urinary and upper respiratory tract infections.	Divert acute care, especially in otherwise uncomplicated patients, to urgent care centers.	Manage more chronic care either by telephone or through a patient portal; it saves time, and patients still attend appointments when needed.
Shift office hours a few hours earlier or later on some days to create more appointment availability for working patients.	Have staff answer all phone calls, freeing physicians to focus on seeing patients.	Evaluate the need for additional nonphysician clinicians; used appropriately, they can pay for themselves and free up the overstretched physician.

combine a physician and one of these providers into a dyad that provides all phases of a patient's primary care. The nonphysician provider is able to focus on patient education and coaching, while the physician concentrates on the more cognitive aspects of care. By having each provider perform tasks best suited to his or her level of training, my practice has found that the dyad can deliver higher quality care faster. Further, adding nonphysician providers can be a net financial gain for the practice, because the increase in capacity usually produces revenue that exceeds their salary.

Other clinicians, including licensed practical nurses and medical assistants (MAs), can also help. Practices too often fall into the trap of limiting these versatile staff members to such things as getting patients ready for the physician to see, administering immunizations, or managing telephone calls. While they have more limited training, these team members can be used more fully, leaving physicians free to care for more patients. Some practices, as part of implementing a patient-centered medical home model, have improved care for their entire patient population by using MAs as health coaches, having them perform outreach services for complex patients, and making them accountable for the outcomes.[1]

A final staffing consideration is whether the practice is getting the most efficiency from its current team members, at all levels. If a physician is unable to manage a volume of patients comparable to others in the practice, it may be appropriate to part ways. If other team members are unable to manage phone calls, patient emails, or other patient contacts in a timely manner, it may be time to look for replacements. Of course it's important to provide feedback and support improvement efforts before making such a decision. Terminating an employee can certainly create short-term hardships, but it may be the best long-term solution for a practice and its patients.

Panel size

Almost every family physician will feel at some point that he or she is trying to care for too many patients. Objectively demonstrating this can be challenging, but the right data can help make the business case for making changes.

It has been previously reported that the average primary care physician provides care for 2,300 to 2,500 patients.[2,3] However, to provide adequate care for such a panel, including all recommended preventive services, a physician would have to work more than 20 hours a day.[4] If the physician received help from nursing and other support staff, as described earlier, he or she could provide all of these services for a panel of between 1,400 and 1,900 patients, depending on what tasks are delegated.[5]

In our practice, we have tried to objectively determine the number of patients for whom a physician can adequately provide care. We use this number to determine whether the physician should accept newly scheduled patients or refer patients to other physicians in our practice. Using a previously published formula,[6] we routinely evaluate the number of visits a patient panel is expected to need annually and then compare that with the number of visits a physician would ideally be able to provide. If the former is greater, we close the panel to new patients or restrict the number of new patients. If the latter is greater, we increase the number of new patients seen by that physician. While our process is designed for a group practice, a solo physician could

Partnering with urgent care centers or using other clinicians in the practice can help reduce acute care "overflow."

Practices should consider whether physicians and staff who routinely fall behind can improve or should be replaced.

FPM RESOURCES FOR FURTHER READING

"Same-Day Appointments: Exploding the Access Paradigm," *FPM*, September 2000. (http://www.aafp.org/fpm/2000/0900/p45.html)

"Panel Size: Answers to Physicians' Frequently Asked Questions," *FPM*, November/December 2007. (http://www.aafp.org/fpm/2007/1100/p29.html)

"Envisioning New Roles for Medical Assistants: Strategies From Patient-Centered Medical Homes," *FPM*, March/April 2013. (http://www.aafp.org/fpm/2013/0300/p7.html)

"Three Building Blocks for Improving Access to Care," *FPM*, September/October 2013. (http://www.aafp.org/fpm/2013/0900/p12.html)

"A New Approach to Making Your Doctor-Nurse Team More Productive," *FPM*, July/August 2008. (http://www.aafp.org/fpm/2008/0700/p35.html)

"Making a Case for Online Physician-Patient Communication," *FPM*, May 2008. (http://www.aafp.org/fpm/2008/0500/pa3.html)

"Creating a Successful After-Hours Clinic," *FPM*, January 2004. (http://www.aafp.org/fpm/2004/0100/p39.html)

"Reducing Waits and Delays in the Referral Process," *FPM*, March 2002. (http://www.aafp.org/fpm/2002/0300/p39.html)

If patients are provided ready access to their physician's knowledge, this often meets their needs without an appointment.

apply the same logic, gradually adjusting the number of new patients accepted by the practice (in compliance with payer agreements) to ensure availability for current patients.

Some physicians might worry that reducing the size of their panels would hurt their finances. In our practice, we have not found that to be true. We have successfully closed the panels of overburdened physicians, allowing attrition and recommended reassignment during the course of one to two years, with no net decrease in visit volume or billing. In fact, one provider saw an increase in net relative value unit generation with a significant decrease in panel size.

Reducing an overworked physician's panel size doesn't necessarily lead to lower revenues or productivity.

Alternatives to face-to-face care

Most people expect prompt service, including from their family physician. This doesn't always mean a face-to-face visit is necessary, however. If patients are provided ready access to their physician's knowledge, this often meets their needs without an appointment.

Providing patients the information they're looking for remotely may mean that a visit isn't necessary.

When a patient calls your office, how quickly do you respond? Physicians have all had patients who call hour after hour asking staff if the physician has answered their question yet; at the same time, many other patients never make the second phone call to check. Both groups of patients are looking for answers, but they have different approaches. At least one payer, as part of an overall quality initiative, has asked our office to examine how quickly we respond to phone calls. It is important to remember that patients appreciate hearing from their physician personally, but they appreciate a prompt answer at least as much. If practice staff can provide those answers, either working with physicians on a case-by-case basis or using previously established advice and protocols to make independent decisions, patients will generally feel that they have the access they seek.

Communicating with a patient through a portal is often quicker and easier than returning a phone call.

Practices that are struggling to keep up with incoming telephone call volume may want to consider contracting with a triage service to provide telephone advice or with a scheduling service to manage those calls. A practice will need to evaluate whether the additional cost of such a service is worth the benefit to patients, as costs are based on call volume and can be significant.

Using a patient portal, especially when coupled with an electronic health record (EHR), can provide a form of availability. Taking a minute or two to respond to a patient's email through the portal in between appointments is quicker than a phone call and still provides a prompt response. For medicolegal reasons, physicians should limit the advice they provide through the portal to what they would usually provide by telephone. Also, physicians should be cautious using humor or other techniques as emails lack many of the nonverbal cues communicated over the telephone or face-to-face (pauses, laughter, etc.). Even with these limitations, however, patients have generally been satisfied with portals as a way to access their physicians' advice.[7]

Practices can use a patient's health history, stored in an EHR, to send customized proactive messages referring the patient to pertinent online resources and patient education materials. For instance, our practice's system generates a list of patients whose diabetes is poorly controlled and emails them a request to discretely log their blood-glucose values through the patient portal. This can allow us, based on the system's comparison of the numbers to pre-established levels, to make changes to the patient's medication without needing a face-to-face visit. We can also use these portal messages to point patients toward materials on our website or elsewhere that may help with lifestyle changes and better disease management. Customizing these messages based on the patient's medical history increases the likelihood that the patient will pay attention to the content and take action.

Taking the first steps

There is no way to implement all of these changes at once, and some may be inappropriate for your practice. Look for changes that work best with your particular management style. The table "Getting going" on page 26 suggests some first steps to take, while *FPM* articles that offer greater depth on these topics are listed in "*FPM* resources for further reading" on page 27.

Physicians know that in the current health care environment, the need for services will continue to grow. Given that they generally cannot increase the number of hours each day they're available, making the most of those hours is the best alternative. Using some of these techniques, physicians can maintain or improve satisfaction and potentially care for more patients than previously possible. Meeting these goals can help to ensure financial viability and sustainability for years to come. FPM

Send comments to **fpmedit@aafp.org**, or add your comments to the article at **http://www.aafp.org/fpm/2015/0500/p24.html**.

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7. Lin CT, Wittevrongel L, Moore L, Beaty BL, Ross SE. An Internet-based patient-provider communication system: randomized controlled trial. *J Med Internet Res.* 2005;7(4):e47.

An EHR portal can be used to send patients tailored messages and resources based on their health history.

Practices should consider which strategies for increasing access best serve their unique patient population, physician preferences, and management style.