

Implementing Advanced Access in a Family Medicine Practice: A New Paradigm in Primary Care

John B. Anderson, MD, and Carlos A. Sotolongo, MD

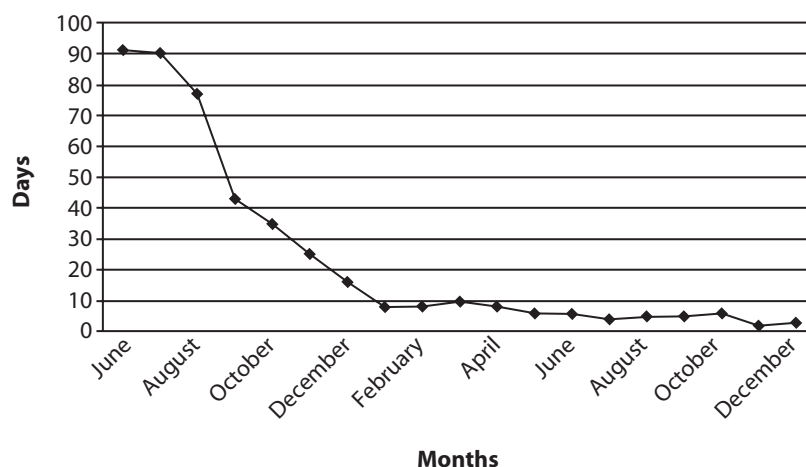
Triangle Family Practice is a family medicine group that has been part of the Duke University Health System since 1995. There are eight physicians and three physician assistants/nurse practitioners in the group that is located in suburban Durham. Growth in this area of Durham has resulted in a significant influx of new patients to the practice. In 2001, the practice was seeing almost 300 new patients a month. The wait for an annual physical appointment was an average of 90 days, with one provider booked out to 180 days (see Figure 1). Patients were unhappy because they were unable to see their usual provider, the staff was dissatisfied at having to continually bargain with patients over appointments, and the providers were struggling to keep up with the demand. Everyone realized that something had to be done, as this had become an untenable situation.

We became aware of the concepts and principles of Advanced Access scheduling after attending an Institute for Healthcare Improvement meeting and realized that this approach could address the issues we were having at Triangle. Advanced Access is based on the premise of doing “today’s work today” and that it is not necessary to make patients wait, either for appointments or while they are in the office. The old paradigm is that we can create capacity in today’s schedule by pushing work into the future.¹ The result is that all the routine or non-urgent requests are scheduled out for weeks hoping to make space for those patients who need to be seen today. Our schedules end up full with last month’s work, and patients have to convince the staff they are sick enough to be seen today. Patients are often unable to see their usual provider, they have to wait for preventive

and chronic illness care, and they routinely miss appointments that are scheduled weeks and months into the future. The practice’s financial performance suffers because of the high no-show rate and the large number of low-acuity visits. Patient and staff satisfaction are also poor as a result of the constant haggling for appointments and inefficiencies in the office.

The decision was made to use Triangle Family Practice and Butner-Creedmoor Family Medicine as pilot practices prior to implementing Advanced Access across all the practices that make up Duke’s primary care network, Duke University Affiliated Physicians (DUAP). What follows is a description of how we implemented these concepts at Triangle from the spring of 2001 until spring of 2002. The group participated in a Breakthrough Learning Series Collaborative sponsored by the Institute for Healthcare Improvement on Advanced Access and

Figure 1.
Wait Time for Physical Appointment (Practice Average):
Third Next Available, June 2001-December 2002



John B. Anderson, MD, is the Medical Director, Duke University Affiliated Physicians and an attending physician at Oxford Family Physicians. He can be reached at ander054@mc.duke.edu or 2200 W. Main Street, Suite 1050, Durham, NC 27705.

Carlos A. Sotolongo, MD, is an attending physician at Triangle Family Practice. He can be reached at 6020 Fayetteville Road, Durham, NC 27713.

Office Efficiency with other primary care practices from around the country. The collaborative approach was helpful in that we learned from expert faculty, but also were able to share experiences and strategies with other practices.

Implementing Advanced Access Scheduling

The challenge that confronted Triangle was how to take the “high-leverage” changes, outlined elsewhere in this Journal and in the literature, and apply them to their own situation.^{1,2} The decision was made early in the process to close the practice to new patients so as to allow the providers to work down their “backlog” of patients that were scheduled out into the future. This process can take anywhere from six weeks to six months, but is a crucial step in the process of creating capacity to see patients on a same-day basis. We also began to examine several long-standing policies regarding the way our schedules were managed. There were rules in place as to how many physicals could be scheduled in a day and multiple appointment types structured in an attempt to “manage” the demand from patients for visits. Providers were scheduled as “walk-in” doctors so they could see acute care patients. Scheduling providers on a walk-in basis disrupts continuity and further restricts the physician’s availability to see his or her own patients. In addition, the practice had no idea of what the demand for appointments was and no idea of what individual provider panel sizes might be.

Involving Staff and Providers in the Process

The practice created an internal team that participated in the collaborative. The team met on a weekly basis to plan the necessary changes and to analyze the data collected to measure the impact of these changes. They began to measure their demand for appointments so as to compare it with their capacity to see patients. They also tracked their no-show rate, their cycle time (how long it takes a patient to move through the office), and their patient and staff satisfaction. We use the third-next available appointment for a physical as our measure of access with the goal being able to get this down to same day availability. As mentioned earlier, Triangle’s was out to 90 days. One of the biggest challenges faced by Triangle’s team was convincing the staff and providers of the need to change and adopt this new approach. This was accomplished by involving them in the process, and sharing the data from the practice and testing changes prior to their implementation.

The practice was able to create significant capacity in their schedule by reducing their appointment types to two, 15, and 30 minutes. The scheduling rules, such as only four physicals per day, were removed, and the primary question staff had to

answer when patients requested an appointment was whether the patient’s provider was in the office that day. Once providers began to see their own patients, more could be done at each visit, and patients did not have to be seen as often. We began to employ a concept called “max-packing,” which entailed doing as much as possible for patients when they are in the office and not having them return for another appointment. This frees up the future schedule and raises the acuity level of that visit. Care teams were created in the practice that also included schedulers and medical record personnel. These teams would “huddle” each morning before patients were scheduled to plan the day’s work, synchronizing patient information with

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the appropriate provider. The care teams were geographically co-located to help facilitate real-time communication between nurses, providers, and schedulers on the phone with patients. As appointment availability increased, the need for phone triage decreased, and those nurses could be given other tasks in the office.³

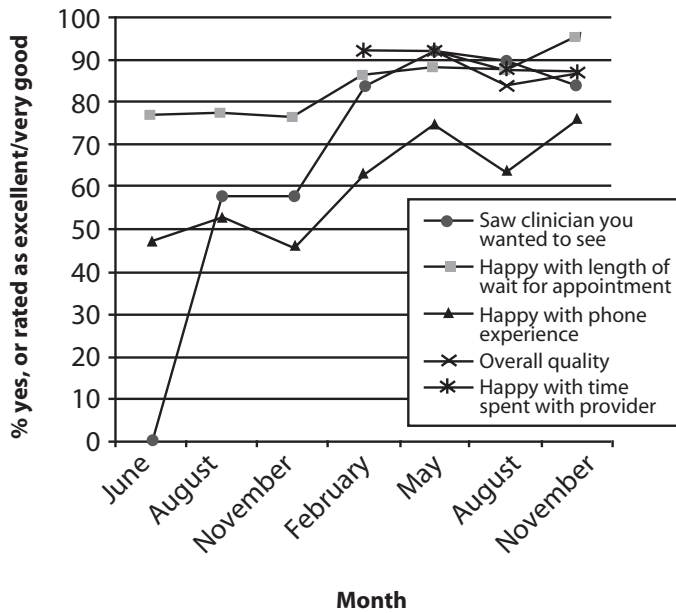
Making Adjustments

Once the practice was able to collect and understand its demand for appointments data, over-paneled providers could shift some of their patients to other providers. We learned that Mondays and Fridays are high-demand days, so we were able to “shape” the demand and book return appointments at less busy times. Patients who needed to return for follow-up were given appointments, but because we had availability, we did not have to schedule patients for “just in case you’re not better” appointments. The practice also developed contingency plans for when providers were on vacation or at times of high demand for appointments. There were some concessions made with the scheduling of physicals due to the high demand for some of our female providers. We did limit this number to six-a-day, and they were scheduled on the hour so as not to occur back to back.

Conclusion

As a result of implementing Advanced Access, the practice can now measure its availability in terms of one-to-two days.

Figure 2.
Patient Satisfaction, June 2001-December 2002



Patient satisfaction has improved dramatically (see Figure 2), the staff finds this a much more satisfying place to work, and the providers feel less stressed and better able to take care of patients. The practice has enjoyed financial success and has been able to grow its market share. The changes associated with Advanced Access cannot be implemented without significant work and effort, but the resulting success has positioned the practice to respond to the changing landscape that lies ahead for primary care medicine. **NCMedJ**

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