



Transitioning to an Advanced Access Model

The transition to an advanced access model can be difficult. “Good access” is the opportunity for our patients to see their own provider at the time that they choose. To develop an operational model that can deliver this is difficult. The critical design elements in designing such systems require us to address the continuity and capacity (flexibility) issues. There are only three ways that systems have attempted to address these. We describe these approaches as the traditional model, the carve-out model and the advanced access model.

In a “traditional model” of access the schedules are saturated with demand created from the past. In these systems, we stratify demand into “urgent” and “routine.” If the patient has an urgent need and can prove it, we will see him/her today. If not, he/she is sent to the end of the queue. These systems attempt to solve the urgent continuity issues by over-filing an already full schedule (“you can see your own provider if you can prove you have an urgent need and if you are in luck and your provider has an opening”) and attempt to solve the routine (non-urgent) continuity issue by making patients wait. There is simply not enough capacity, and the capacity problem is solved by over-filing the saturated schedule, making patients wait or sending them to someone else or somewhere else. Most healthcare systems moved away from this model some time ago.

In a carve-out model, the need for appointment capacity is predicted and saved, preserved, reserved and/or frozen for same day needs. The urgent continuity issue is solved hopefully by having enough appointments saved on a daily basis for each provider, and the routine (non-urgent) continuity issue is addressed by having patients wait. In a carve-out model, depending on how much capacity is carved out, the wait time for routine appointments extends and hence for these patients we have made the access problem worse. Capacity is gained by saving space. But because of the stratification of demand into urgent and routine, when we look past today’s carve-out and into the future, it is either filled with routine appointments to the extent of the now extended wait time, or it is filled with saved/frozen appointments. There is no available capacity. This leads to some very specific problems. What do we do with those patients we see today and who need a follow up that is less than the wait time for the extended routine visits? What do we do with those patients who have an urgent need yet can’t get here today, or for whom there are “no more appointments?” And what do we do with those patients who don’t fit the criteria for urgent yet can’t wait until the end of the queue? What we have seen is that we either tell these patients to call back on the day they want to be seen or we steal the frozen appointments for non-urgent pre-booked appointments. Our predictions for how many carve-out appointments are needed then becomes inaccurate and we carve-out more than we need, extending the wait time even further. We have just made the access problem worse.

The only other way to truly solve this access conundrum (continuity and capacity, and urgent and routine) is to eliminate the distinction between urgent and routine, to offer an appointment for all requests today. In this way, the continuity issue is addressed by assuring a panel size commensurate with a provider's time in the office so that he/she can see all of his/her patients today. He/she does all of today's work today. The capacity issue is solved by reducing backlog and pulling the work toward today. The past paradigm is that in order to protect today (which is saturated now or at least threatens to be saturated) we need to divide the work into urgent (we have to see these patients) and routine (they can wait). Thus, we push a good part of today's work into the future. This stratification, by necessity, creates a carve-out model with all its drawbacks. In advanced access models (do all of today's work today) the paradigm shifts to one of protecting the future by doing today's work today.

The transition to an advanced access model is difficult because we have to give up some preconceived notions and assumptions. In carve-out models, we stratify the demand because, clinically, our routine patients can wait (this assumes we don't make any mistakes in "triaging") and because most patients who don't perceive their need as urgent will be "satisfied" with having to wait. But this totally misses the point. This is an operational issue, not directly a satisfaction issue or even a clinical one. When we stratify, we create a carve-out model that simply doesn't work. It is better than the traditional model, but is really built for us (so we can protect ourselves) not for our patients.

Transitioning is difficult due to the necessary paradigm shift. We need to see the operational world differently. And we need to overcome our fears of insatiable demand and "how can I do all the work today since my schedule is already so full." In fact, if we have a system where the demand for a non-urgent appointment is stable at a month, what we are saying is that the demand coming in and the supply being delivered are in equilibrium, but just a month late. If the demand and supply are not in equilibrium (if demand is greater than supply) we have another related but distinct problem. This is not an access flow problem but a demand–supply mismatch issue and needs to be solved in other ways. In addition, if we have a stable wait time and we are doing last month's work today what we really have is a backlog problem.

A key transition strategy is to develop and implement a backlog reduction plan. A key component of this plan is to add daily capacity. In order to reduce the backlog, a practice must do more work daily than is generated on that day. This is the only way to "drain the lake" – the reservoir of backlog. The temptation is to look ahead into the future schedule and bring patients in earlier than scheduled. This ought to be avoided. The most effective strategy is to loosen the criteria for a "same day" appointment and bring more work into the daily schedule. Thus, instead of sending the patients away, appointing them with an unscheduled provider or pushing them to the end of the queue, these patients should be seen on the day they call. To do this, daily capacity has to be added, either during the current workday, or by adding extra workdays. While providers need to have input into the times and the total numbers for the extra appointment capacity, it is best to have a single plan for the times and numbers of extra patient appointments. This standardizes the

backlog reduction process and makes the process easier for the staff who can get confused with multiple and changing plans during this transition.

It is crucial to add enough capacity so the backlog can be reduced in a reasonable amount of time. This is a difficult process and there is a limit to how long a practice can go through the transition before they get discouraged. During this time, measurement of backlog reduction should be calculated and displayed, so everyone involved can see the progress being made.

Over time, as fewer patients are put to the end of the routine queue and more of the “smart strategies” for backlog reduction are fastidiously employed, holes start to open in the schedule. As this occurs practices need to loosen the criteria for “same day” even more, ultimately reaching the point where any patient with any problem can be seen today. During this period it is crucial to have the engagement of the entire staff. They need to know that the final philosophy will be to do all of today’s work today. Practices have to avoid the final deflection of backlog - the temptation that when backlog is reduced to a certain level to relax and say “a few days wait is good enough,” thus avoiding the push to eliminate the final two or three days of backlog.

Transitioning to an advanced access model is also difficult because as we reduce the backlog, we see a lot of patients for “physicals.” This is a particularly common experience in pediatrics. It is “physicals” that primarily make up the backlog so it is logical that as backlog is reduced this is the type of visit we see. The key here is to persist through this period of time. It will end! If it does not, then look to see if demand greater than supply. Pushing the physicals to the future, which is the overwhelming temptation at this point (old habits die hard) simply won’t work in a scenario where demand is greater than supply. It will only make the access problem worse.

The next difficulty is what we describe as the “final deflection of backlog.” We get close to getting the backlog reduced to zero and we see open appointments within a few days reach. We ask ourselves: “How can I see one more physical when I have so many open appointments in just a few days?” Again, the temptation is overwhelming but if we push that part of the work out “just a few days” then we will be stuck in the transition forever.

Another difficulty occurs when, usually due to an ill-conceived backlog reduction plan, instead of adding capacity slowly to work down the backlog, the schedules are opened into the future and filled with the routine work we are trying to pull forward. But we don’t offer to do that work today and it fills the future. When we get to the future it is filled and we are right back in a traditional model wherein the patients with urgent needs are either squeezed into an already full schedule or sent away. This type of transition is particularly messy and requires an understanding of these systems to find a way to solve it. A carve-out can be used as a temporary transition strategy, but to avoid the problems of carve-outs, we must move intentionally beyond that. This again is particularly challenging since the mindset is that we already do today’s work today. The definition of today, in this case, is unfortunately “if you are sick enough to be seen today.”

The key here is to control what we can control. The demand we are in control of is the return demand and the other component of good backlog (those patients who choose not to accept an offer for an appointment today). We should offer return visits and good backlog visits at times where we want to move the demand, specifically to the morning schedule, and later in the week (traditionally the appointment slots that are harder to fill). We preserve the capacity in the afternoon by consciously guiding demand away from that time not by preserving or reserving the time. When we preserve the time, our patients just learn to “call back at 12:00 when those appointments open up.”

When stuck in these transitions, develop a conscious and intentional plan to work down backlog, to transition to an advanced access model, to add enough daily capacity to pull the work to today, to find and promote champions for this work, to involve leadership, and to imbed and communicate these improvement goals to all the staff involved.