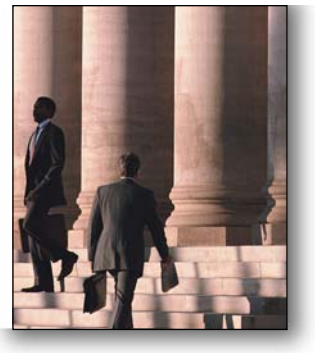
PRACTITIONER FORUM

Michael R. Spieker, MD, CAPT, MC, USN



Reducing Delays in DoD Health Care

Is Open Access Appointing the Answer?

Like many health care systems nationwide, the military health system (MHS) is grappling with the problem of extended wait times for patients seeking appointments and resulting delays in care. In a May 22, 2003 memorandum, Assistant Secretary of Defense for Health Affairs William Winkenwerder, Jr., MD extolled the virtues of the "open access" model of patient appointing and directed that military medical treatment facilities (MTFs) move toward this standard to improve patients' overall access to care.[1]

Civilian medical practices that have been successful in implementing the open access model of patient scheduling report such benefits as improved patient satisfaction, increased patient volume and billing, and decreased hours worked by providers.[2–4] The open access paradigm, however, is not a magic bullet. As Dr. Winkenwerder himself has acknowledged, open access "is simple in concept but can be difficult in execution."[5] Its success depends upon certain practice conditions, which may be difficult to control or modify.

CAPT Spieker is the program director of the Family Practice Residency at Naval Hospital Bremerton, Bremerton, WA.

Before open access appointing is implemented universally across the MHS, therefore, DoD leaders and hospital commanders need to ask critical questions that address the chances of success given certain conditions encountered in MTFs. Will this strategy reduce overutilization or invite patients to overrun an already overutilized system? Will there be adequate support (in the form of nursing, clerical, and medical records staff) for providers to address the necessary change in practice style? Will this approach solve current access problems or simply create different problems for patients and providers? Are the data available to perform assessments necessary to ensure success? In short, MTFs that attempt to implement open access appointing face significant obstacles that civilian practices do not—and if lightly regarded, these obstacles are likely to result in a troublesome implementation.

NUTS AND BOLTS OF OPEN ACCESS APPOINTING

Open access appointing—also known as advanced access appointing or open-office scheduling—describes a process that shifts the focus of appointing from "when the doctor is in" or "what the doctor has available" to "what the patient needs." The fundamental tenet is to "do today's work today" by eliminating the backlog of patients waiting for future appointments.

Adherents of the process describe two features crucial to successful implementation.[2] The first, provider-patient continuity, refers to the ability to schedule patients to see their own provider.[2] This type of continuity tends to boost not only patient satisfaction but also provider satisfaction and efficiency. Capacity, the second key feature of successful open access appointing, describes the ability of the provider to maintain a block of time each day (often at the beginning of the day) for same-day appointments rather than delaying that work to a later date.[2] Advocates warn that open access is not sustainable if patients' demand for appointments permanently exceeds providers' capacity to offer appointments.[4]

Reducing the backlog or "appointment debt" is the biggest challenge a practice faces in implementing open access appointing. Essentially, the only way to achieve this is to work extra hours. Proponents admit that, in the early

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phase of implementation, physicians face "double duty" while they see both previously scheduled and same-day patients. Often, it's necessary to see more patients per day or work additional shifts for six to eight weeks—or sometimes more.

There are tactics that can facilitate implementation of open access appointing by freeing up physicians' schedules and reducing patients' wait times. For example, practices can decrease the number of appointment types included in appointment templates (in order to make providers' schedules more flexible) and hold group visits or nurse examinations (in order to reduce unnecessary physician visits).

APPOINTING CHALLENGES FOR MILITARY PROVIDERS

Several obstacles unique to the MHS are likely to derail the best efforts of well intentioned DoD administrators and providers and decrease the likelihood of successful open access implementation in most MTFs.[3,4,6]

First and foremost among these challenges is the instability of DoD provider assignments. MTFs host a hyperdynamic personnel nightmare of gapped billets caused by permanent change of station (PCS) moves, deployments, and new contracts. These activities typically occur without the use of temporary replacement staff and create an environment that does not foster provider-patient continuity. Because such continuity is vital to the open access model, this issue alone is powerful enough to undo any chance for success. Even proponents of the open access model acknowledge the vulnerability of practices in which the provider base is unstable.[4]

In addition to patient care, many MTF commanders must address multiple, competing missions such as graduate medical education (GME) and military training and contingencies. These additional missions frequently take providers away from the practice environment—one of the most complex situations to manage in the open access model.

By its very nature, GME requires primary care residents to train outside their usual clinics and staff physicians to provide direct supervision, which cuts into the time these providers can spend with their patients. In an open access appointing system, this loss of continuity would have to be addressed in such a way that would reduce the benefit of the model.

Required military training and deployments—circumstances that have few equivalents in the civilian setting—wreak havoc on any system of patient appointing. The open access model suffers particularly from these planned and unplanned interruptions, which result in a transfer of workload to remaining colleagues. Not surprisingly, civilian practices have reported increased dissatisfaction when providers must absorb extra work in this way (for instance, because of extended provider illness).[2,4]

The lack of rewards and incentives frequently has been overlooked in discussions regarding the application of open access appointing in the DoD. In the civilian setting, individual physicians, group practices, and health care systems choose to deploy the model in order to reduce their working hours and improve their bottom line. As the individual physicians work harder to decrease the backlog of appointments, they are compensated financially for the extra work they do. Even so, as Murray and colleagues note, financial rewards don't always solve the "burdensome problem" of a day without a finite end point.[4]

Even if such incentives and rewards were enough to motivate providers, they currently are not available to DoD providers. Successful reduction of backlog neither increases these providers' financial compensation nor decreases the amount of hours required by their commanders. Furthermore, authors of articles on open access appointing have cautioned—and some physicians involved in implementation of the model have complained—that in some systems, providers who make progress under the open access model and begin to gain capacity in their schedules are forced almost immediately to absorb the overflow from their colleagues who have not yet made such strides. This situation creates a disincentive.[2] At most MTFs, history dictates that any gains made in reducing backlog will be lost quickly when planned (summer PCS moves) and unplanned (deployment) contingencies occur.

Finally, the DoD's patient demographic, patient culture, physician culture, and insurance plans are fundamentally different compared to civilian models. In addition to provider turnover, military practice involves a high level of patient turnover—for much the same reasons (PCS moves, training, and deployments). This further compromises provider-patient continuity.

Such features as universal coverage, 100% transportability, free medications, no copayments, and no insurance forms make TRICARE

Prime the premier insurance program in the United States. They also, however, encourage beneficiaries to utilize the health care system—even when self-care would be sufficient. This phenomenon is readily apparent to MTF providers who already see large numbers of patients for minor conditions not typically seen in civilian offices because of personal cost and copayments. If the promise of a same-day appointment were to provide an extra incentive to use the system excessively, open access appointing actually could end up decreasing overall access and driving up costs by increasing demand well beyond capacity.

Many MTFs have inadequate professional resources, and few have skilled medical management professionals trained in clinic and change management who could engage medical staff and implement open access appointing successfully. Programs initiated without metrics that scrutinize outcomes other than access (including provider-patient continuity and the oft forgotten provider satisfaction) will face uphill challenges. A recent DoD pilot project met with only qualified success that has not been sustainable—despite using one of the preeminent expert consultants on open access and having the full support of the command and navy leadership.[6]

In describing an unsuccessful attempt to implement open access appointing at Naval Medical Clinic Patuxent River, Patuxent River, MD, another author reported many of the obstacles described here. Provider turnover, competing military priorities, seemingly endless work days, and insufficient personnel and other resources were listed as major components in the failure of the open access model in this particular setting.[7]

WHAT WE SHOULD DO

Despite the substantial roadblocks that stand in the way of successful military implementation of open access appointing as it was devised, there are many facets of this model that could be used to improve access without merely creating a different appointing nightmare for patients.[2,3]

First, we can reduce barriers to providers in the following ways:

- Use TRICARE Online and central appointing services for appointment scheduling, in order to give nursing staff more time to spend supporting providers.
- Authorize nurses to fit walk-in patients into providers' schedules at their discretion.
- Allow patients to ask their providers questions at their convenience using free, secure e-mail services.
- Limit the appointment types to no more than three—or better yet, two. This would allow for "on-the-fly" appointing that does not limit patients to certain days or times. Clerks can manipulate the information after the appointment is made to ensure proper accounting.

We also need to make the most of the time providers spend with each patient. This means taking care of as many issues as possible (for example, immunizations, medication refills, and reviews of laboratory test results) while the patient is in the office, rather than having the patient come in again at a later date. Any of these tasks that can't be performed while the patient is in the office could be done later by telephone or with the assistance of nurses and case managers. The idea is to initiate a cultural shift in which intervals between provider visits are determined based on clinical necessity, instead of habit or tradition. Such cultural changes require the support and encouragement of the commander.

To further reduce unnecessary visits, administrators could develop telephone consulting systems, using technologically advanced equipment and highly qualified personnel, to extend provider care into the home. In addition, in cases in which the visit chiefly consists of education (such as vasectomy counseling), holding group visits can maximize efficiency.

DoD providers are a highly motivated group with particular ideals that have drawn them to military service. They deserve to be involved in plans to improve access, so that they can ensure consideration of their personal goals as well as the institution's goals. Furthermore, providers who find innovative and successful ways to improve access and quality of patient care should be rewarded in innovative ways.

A group's ability to do all of today's work today and to hold providers accountable for their own patients depends directly upon panel size. In order to determine the appropriate panel size for an individual physician, you must factor in clinic frequency, panel demographics, and the physician's scope of practice (including teaching and military obligations).[8] To paraphrase Mark Murray and take his thoughts a step further, if physicians are given the right sized panels, they can do anything. But if physicians have panels of 5,000 patients, they will disappoint their patients and

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administrators continually and frustrate themselves.[2]

Open access appointing is a great idea given a particular type of practice setting. Military commanders must be cautious about expectations, implications, and unexpected consequences of its implementation. ●

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