Access Management in Primary Care

Perspectives from an Expert Panel

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Preface

This report aims to serve as a resource for health care organizations as they undertake initiatives to improve access to primary care. Ensuring timely primary care access has become a major focus for health care organizations as they take responsibility for providing care to large patient populations across multiple care settings. National clinical guidelines or standards for tracking and managing primary care access do not yet exist. This report documents the results of an expert panel that included health care consumers, providers, payers, purchasers, researchers, productmakers, and policymakers from several health care systems as these panelists reviewed evidence, deliberated, and came to consensus on primary care access management definitions, priorities, challenges, and recommendations for achieving results in each priority area.

The Veterans Health Administration (VHA), as the largest single health care system in the United States, faced a crisis in providing access to care that came to a head in early 2014. The front line of the crisis was the southwestern United States, an area that had seen rapid growth in its veteran population without concomitant expansion of local VHA service availability. The numerous access management failures documented in this region, including use of inaccurate or falsified data and long delays before new patients could access an initial appointment, led to the recognition of the many ongoing access challenges across the VHA system. Furthermore, evidence from research or from the experiences of other health care systems provided information on access itself but only limited relevant guidance on approaches to access management across a health care organization.

Prior to initiating this report, VHA implemented numerous initiatives to improve veterans’ access to needed care, including identification of high level group practice managers with a focus on access at all VHA facilities. Some panelists had extensive experience with these initiatives. Achieving better access for patients involved myriad decisions and trade-offs, such as whether and when to prioritize speed of access to any primary care provider over access to a personal primary care provider, or how to manage different forms of access such as telephone, video, email, or face-to-face visits. These different contact types are further complicated by the frequent need for clinical assessment prior to matching a patient to an appropriate service. Deciding how to most effectively deploy clinic personnel, resources, and processes to achieve timely access across widely divergent urban and rural local contexts remains a major challenge for both VHA and other large health care systems.

Although VHA experiences provided the impetus for this report, there is no evidence that access to primary care in the VHA is worse than in many or most other health care environments. Indeed, information on the quality with which any particular health care system’s enrolled patients can access primary care is sparse. Such information as waiting times for new patient appointments, utilization of care modalities that are not face to face, and patient experiences of
access to care at a given care location are largely unavailable to the public. Furthermore, the ongoing challenges inherent in managing access are universal and require ongoing, uninterrupted access management. The development of appropriate access leadership and team structures, as well as meaningful measurement systems, is essential.

This report aims to inform health care organizations by bringing diverse, key stakeholder perspectives to bear on access management challenges in the areas of management structure, processes, and outcome measurement. The report integrates perspectives from experts with direct access management experience in VHA, Canada’s provincial health care system, a nonprofit health maintenance organization, and Medicare or Medicaid primary care. In addition, it provides information from peer-reviewed and non-peer-reviewed literature (e.g., national health services manuals on access from other countries). The resulting primary care access management milestones are intended for use by health care organization executives and by middle and frontline managers as a tool for prioritizing needed improvements and for learning what experts and the literature offer as approaches to undertaking the prioritized improvements. Although this report was developed from the viewpoint of large accountable care and managed care organizations, other types of health care organizations may well find much of the included information to be applicable.

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Summary

Effective access to primary care is critical for ensuring population health. Health care organizations aim to identify access management approaches that achieve and sustain optimal access. This report is directed at health care organization executives and middle and frontline managers and aims to assist them in designing and implementing evidence-based access management improvement initiatives. The project addressed definitions of access and access management, established access management priorities, and resulted in access management recommendations and suggestions.

Methods

The project began in 2016 with the goal of moving from a focus on access to primary care as a singular measurable attribute to a focus on access management approaches for achieving the best possible access within health care organizations. The project was funded by the Veterans Health Administration (VHA); however, rather than focusing on the prior VHA access crisis and the specific issues that characterized it, as had been accomplished in prior reports, the work presented here aimed to identify principles applicable to VHA’s future and to the broader needs of population-based health care systems in general. Our effort was supported by expert panel input and evidence review. We used written surveys to collate individual stakeholder input and to assess the level of consensus independent from potential group pressure. We reviewed transcripts of the meeting to inform needed revisions to pre-panel material. In addition, we conducted qualitative content analyses, analyzed word frequency data to validate themes, and visually inspected word clouds to compare subpanel results on access management definitions. The final summary documents were reviewed by the panelists for approval.

To carry out the modified Delphi expert panel, we recruited, based on a systematic panelist identification frame, 20 diverse stakeholders with potentially competing interests. Panelists included health care consumers, providers, payers, purchasers, researchers, productmakers, and policymakers.

Based on research literature and organizational experience, we identified 85 areas of potential access management actions. These were rated by the panelists prior to an in-person panel meeting. This written survey also elicited responses to vignettes of access management scenarios.

Meeting materials and presentations at a two-day face-to-face meeting incorporated results from a systematic evidence review and a qualitative study of VHA access management pilot sites commissioned by our research team. The meeting included group discussions, small group work in breakout groups, and a process involving five parallel subpanels. The group discussions
concentrated on areas of disagreements identified in the pre-panel survey. Small breakout groups focused on solutions for different access management scenarios shown in the vignettes. We set up five subpanels that formulated definitions, and we reviewed convergent ideas across subpanels. The 20-person stakeholder panel was supported by local panel guests with expertise in access management.

A post-panel survey established panel consensus on access management priorities that are both important and urgent. Following this process, we invited panelists to develop recommendations for achieving the consensus-identified access management priority actions. To develop the recommendations, we used the priority actions as themes. We then extracted information relevant to each theme by reviewing transcriptions of panel discussions and the previously assembled panel evidence sources (systematic review articles, qualitative data results, additional hand-searched reports). Using these data sources, we developed initial recommendations and suggestions for implementing them in relation to each consensus-supported priority. Panelists reviewed and commented on the resulting document through two virtual panel meetings and document review with revision by our research team.

Results

The process resulted in consensus around definitions of access management, optimal access management, and optimal access; these definitions are presented in Figure S.1. Subpanel deliberations highlighted that definitions of access to care within health care delivery organizations should be patient-centered, but they also should take into account clinically appropriate needs for access (e.g., based on initial clinical assessment or discussion of a request) in addition to patients’ perceived needs (e.g., their needs prior to accessing clinical assessment or triage). The definitions of optimal access management and optimal access balance a variety of considerations rather than attempting to define access in absolute terms.

**Figure S.1. Final Consensus Definitions of Access Management, Optimal Access Management, and Optimal Access**

- *Access management* encompasses the set of goals, evaluations, actions and resources needed to achieve patient centered healthcare services that maximize access for defined eligible populations of patients.

- *Optimal access management* engages patients, providers, and teams in continuously improving care design and delivery in order to achieve optimal access.

- *Optimal access* balances considerations of equity, patient preferences, patient needs, provider and staff needs, and value.
The modified Delphi panel work on priority actions for access management improvement resulted in consensus around eight priorities rated by panelists as both urgent (critical to accomplish within the first year of a primary care access management improvement initiative) and important for achieving optimal access. Panelist ratings refined these priorities from among an initial 85 identified in the pre-panel survey; most of the items were rated as important, but only eight were also consistently rated as urgent. Panel discussions also identified framing considerations that were based on pre-panel survey results and were important for shaping how the priority actions would be implemented.

The eight priority actions address the following:

- **organizational structure:**
  - identifying clinical and administrative leaders for each site with authority to support access management priorities
  - establishing a clearly identified group practice management structure

- **process improvement:**
  - routinely evaluating and managing patient telephone calls to schedule appointments
  - maximizing systematic approaches to contingency staffing
  - maximizing registered nurses’ opportunities to manage demand through care coordination
  - proactively managing demand by optimizing provider visit schedules

- **outcomes:**
  - assessing the quality of patient experiences of access
  - assessing provider and staff morale in relation to access mismatch.

Framing considerations address the following:

- primary care access initiative targets
- types of primary care access requiring management
- types of access management organizational contexts to consider.

Figure S.2 shows the framing considerations and the eight consensus-based priority actions within a structure-process-outcomes framework.
Recommendations for achieving the access management priority actions are presented in Table S.1. For each recommendation, we specify the appropriate management level for initiating improvement based on that recommendation (i.e., the improvement must be initiated by the executive level or can be initiated by midlevel managers, including unit managers, primary care site leaders, or care team leaders). The table is ordered by panel agreement.
### Table S.1. Recommendations for Achieving the Access Management Priority Actions

<table>
<thead>
<tr>
<th>Priority Action Area</th>
<th>Recommendations (Listed by Strength of Panel Endorsement)</th>
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<tbody>
<tr>
<td><strong>Telephone access</strong></td>
<td>Ensure that the set of telephone management metrics incorporates four key principles:</td>
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<td>• following calls to resolution</td>
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<td>• accounting for both call center and primary care team roles in telephone management, promoting substitution of telephone</td>
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<td>management for in-person management whenever appropriate</td>
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<td>• promoting metric availability at local site levels to support targeted telephone management improvement initiatives</td>
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<td>• incorporating patient preferences and experiences into metric development and interpretation.</td>
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<td></td>
<td>Ensure that appropriate telephone management strategies are focused on four key principles:</td>
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<td>• enabling links to each patient’s usual primary care team (i.e., to the patient’s continuity physician, nurse practitioner,</td>
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<td></td>
<td>or physician assistant and team) whenever possible and appropriate</td>
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<td></td>
<td>• enabling telephone calls to access available non–primary care resources appropriately, comprehensively, and accurately</td>
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<td></td>
<td>• facilitating local health care system and site improvement based on data</td>
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<td>• using best available technology for incorporating patient preferences into telephone answering protocols.</td>
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<td>Ensure that telephone management initiatives target call center and primary care team staff satisfaction and stability by</td>
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<td>prioritizing:</td>
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<td>• appropriate staffing</td>
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<td></td>
<td>• incentives for high-quality performance.</td>
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<td>Ensure that patients with hearing loss or difficulty attending face-to-face visits are accommodated through telephone</td>
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<td>adaptations, print materials, or other virtual technologies.</td>
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<td><strong>Patient access experience</strong></td>
<td>Regularly assess patient access experiences at the primary care site patient population level, using a reliable and valid</td>
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<td>survey.</td>
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<td></td>
<td>Regularly collect real-time data in primary care sites at the time of visits.</td>
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<td><strong>Group practice management structure</strong></td>
<td>Identify a group practice manager position at a high enough level to report effectively to executive leadership while</td>
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<td>connecting executive leadership and relevant middle managers with frontline primary care practice–level access-related</td>
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<td>activities and concerns.</td>
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<td>Identify and document the specifics of a group practice management program and team, including key stakeholders in the</td>
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<td>team’s success, and ensure that the team is trained in (a) how to promote stakeholder engagement, including frontline staff,</td>
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<td>and (b) how to access and use data for improvement.</td>
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<td><strong>Identification of primary care practice site leaders</strong></td>
<td>Ensure that the inter-professional structure of team-based care models, such as the patient-centered medical home, is</td>
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<td>reflected in strong integrated inter-professional governance at the primary care practice site level, including explicitly</td>
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<td>identified site-level physician, registered nurse (RN), and administrative leaders.</td>
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<td>Ensure that inter-professional primary care practice leadership is trained in problem-solving approaches and in how to</td>
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<td>teach these to providers and staff.</td>
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<tr>
<td><strong>Development of contingency staffing approaches</strong></td>
<td>Analyze demand data and use that information to anticipate upcoming needs for contingency staffing either from internal</td>
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<td>staffing resources (e.g., local or regional primary care teams) or from external sources (e.g., contracted temporary staffing).</td>
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<td>Contingency staffing is a work-force method in which staff members are hired as and</td>
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<tr>
<th>Priority Action Area</th>
<th>Recommendations (Listed by Strength of Panel Endorsement)</th>
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<tr>
<td>RN demand management and care coordination role</td>
<td>when needed for limited periods of time.</td>
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<td>Provider experience</td>
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| Maximization of the ability to manage demand | | Train primary care site leaders and teams in four key principles of proactively managing demand, including:  
  - analyzing site-level data on past demand to plan short-term supply (i.e., workforce) adjustments  
  - enabling providers to achieve needed same-day continuity visit availability by right-sizing their panels and by using advanced access principles  
  - integrating patient preferences into all aspects of access management  
  - using data resources to track site-level and team-level access (e.g., through dashboards). |

For each recommendation, we also specified evidence-based implementation suggestions. We designed a tool ready to use for quality improvement (see Appendix E).

In summary, the modified Delphi expert panel established a parsimonious set of action-oriented management priorities for guiding initiatives aimed at improving primary care access management. The priorities were translated into recommendations and suggestions for implementation.
Acknowledgments

We thank our distinguished panel of experts:

- David Aron, MD: director, Clinical Program Research and Education, Louis Stokes Cleveland Department of Veterans Affairs Medical Center, Cleveland; professor of medicine, Case Western Reserve University School of Medicine; adjunct professor of organizational behavior, Case Western Reserve University Weatherhead School of Management; leader of the VA Quality Scholars Fellowship Program, a training program in quality improvement
- Paul Brynen: patient representative, Care Coordination Quality Enhancement Research Initiative Strategic Advisory Group, Los Angeles
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- Carolyn Clancy, MD: executive in charge, U.S. Department of Veterans Affairs
- Joan Clifford, DNP, RN: medical center director, Edith Nourse Rogers Memorial Veterans Hospital
- Angela Denietolis, MD: executive director, Office of Primary Care, VHA
- Stephan D. Fihn, MD, MPH, FACP: director, Clinical Systems Research and Development, VHA; professor, Department of Medicine and Health Services, University of Washington
- Clinton (Leo) Greenstone, MD: deputy executive director, Clinical Integration, VHA
- Karey Johnson, DNP, RN: Office of Primary Care, VHA
- Peter Kaboli, MD: investigator and hospitalist, Comprehensive Access Delivery Research and Evaluation Center, Iowa City VA Healthcare System
- Tara Kiran, MD: family physician and quality improvement program director, Department of Family and Community Medicine at St. Michael’s Hospital, University of Toronto, Ontario, Canada
- Thomas Klobucar, PhD: acting executive director, Office of Rural Health, VHA
- Jia Li: associate director, San Francisco VA Medical Center
- Storm Morgan, MSN, RN, MBA: clinical program manager, Office of Nursing Services, VHA
- Michael Eugene Morris, MD: assistant area medical director, Fontana Medical Center, Kaiser Permanente
- Greg Orshansky, MD: lead physician, primary care, West Los Angeles VA Medical Center
- Ashok Reddy, MD, MSc: senior adviser, Centers for Medicare & Medicaid Services (CMS) and CMS Innovation Center; core investigator, Center of Innovation for Veteran-Centered and Value-Driven Care; staff primary care provider, VA Puget Sound Health Care System; assistant professor, Department of Medicine, University of Washington
- Bob Rubin: patient representative, Care Coordination Quality Enhancement Research Initiative Strategic Advisory Group, Los Angeles
Christopher Ruser, MD: internist, Veterans Affairs Connecticut Healthcare System-West Haven
Ali F. Sonel, MD: chief of staff, acting chief medical officer, VA Pittsburgh Healthcare System.¹

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¹ Job roles reflect positions at the time of the expert panel.
### Abbreviations

<table>
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<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tr>
<td>ESP</td>
<td>Evidence-Based Synthesis Program</td>
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<tr>
<td>GPM</td>
<td>group practice manager</td>
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<tr>
<td>MD</td>
<td>medical doctor</td>
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<tr>
<td>NP</td>
<td>nurse practitioner</td>
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<tr>
<td>PA</td>
<td>physician assistant</td>
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<tr>
<td>PACT</td>
<td>Patient Aligned Care Team</td>
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<tr>
<td>PCOR</td>
<td>patient-centered outcomes research</td>
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<tr>
<td>QI</td>
<td>quality improvement</td>
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<tr>
<td>RN</td>
<td>registered nurse</td>
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<tr>
<td>SD</td>
<td>standard deviation</td>
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<tr>
<td>VA</td>
<td>U.S. Department of Veterans Affairs</td>
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<tr>
<td>VHA</td>
<td>Veterans Health Administration</td>
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<tr>
<td>VISN</td>
<td>Veterans Integrated Service Networks</td>
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Achieving the goals of population-based health care delivery requires active access management directed at the goals, evaluations, actions, and resources needed for optimal use of health care services by defined eligible populations of patients. The concept of access encompasses both the ability to obtain health care services and the timeliness with which services are obtained. The Institute of Medicine (which is now the National Academy of Medicine) identified six fundamental aims for health care—that it be safe, effective, patient-centered, efficient, equitable, and timely (Institute of Medicine, 2001) —and notes that timeliness is, in some ways, the least well studied and understood (Institute of Medicine, 2015). Timely access to primary care is of particular importance to integrated health care systems because of the assessment, triage, and long-term continuity follow-up function that primary care health care providers serve (Bhat, 2005). Primary care is or should be the point of first contact for most patients for most issues, thus enabling specialty, emergency, and hospital services to deliver appropriately focused care.

Access is often looked at as the outcome of a “black box” that encompasses unidentified policies, influences, and activities and is often measured simply in terms of waiting times for new appointments or availability of appointment slots. This perspective, however, provides little assistance in terms of showing how a health care organization can achieve and maintain optimal access. Questions about how to manage access require, instead, knowledge of the management structures, processes, and outcome measurement approaches that are most likely to support optimal access across an eligible population. This report aims to provide guidance about how to improve access management, looked at in terms of the Donabedian structure-process-outcomes framework (Donabedian, 1988) and a logic model derived from relevant literature but refined by expert panel deliberations.

Prior literature identifies a variety of tested approaches for promoting timely access; these approaches, however, do not address the full range of management considerations. Advanced access tools, such as open access scheduling, can enable patients to see a health care provider at a time and date that is convenient for them (Mehrotra, Keehl-Markowitz, and Ayanian, 2008). E-health technology can enable prompt virtual patient-provider interactions (Fortney et al., 2011). Better utilization of nonphysician clinicians, such as in patient-centered medical homes, has also been prominently recommended (Institute of Medicine, 2015). Reducing the backlog of patients waiting for appointments, using fewer appointment types, and setting access goals are common approaches aimed at improving access. Integrating these approaches within overall organizational access management, however, has proven challenging, and evaluations of these approaches do not show robust evidence of effectiveness (Miake-Lye et al., 2017). Although
open access scheduling, for example, can promote access under situations in which the supply of care services can be right-sized relative to patient demand or need, they provide less help when primary care sites are confronted with fluctuating or expanding patient populations that overwhelm existing care resources (Mehrotra, Keehl-Markowitz, and Ayanian, 2008). Yet such situations are common and inevitable across health care systems.

While access itself can be analyzed in terms of supply and demand, management of access occurs within health care organizations. Organizations are complex adaptive systems in which the results of management actions will always be subject to uncertainty (Braithwaite et al., 2017), partly because of trade-offs between competing goals and strategies. The same actions that improve access in the short term, for example, can lead to increased demand that worsens access in the longer term (Mehrotra, Keehl-Markowitz, and Ayanian, 2008). The positive effects of open access on wait times may not translate into improved patient satisfaction (VanDeusen Lukas et al., 2004). Patients may value being seen on a day of their choice or by their continuity provider more than they value being seen quickly (Salisbury, Goodall, et al., 2007). Practitioners have voiced concerns about unintended consequences of open access models (Kiran and O’Brien, 2015; Rosen, 2014). Maximizing timely access and continuity of care, for example, can be incompatible goals (Phan and Brown, 2009; Salisbury, Montgomery, et al., 2007). Determining which aspects of access management should be considered first is therefore a critical step toward a successfully implemented access improvement initiative.

There is little evidence regarding the level of primary care access achieved by U.S. health care organizations in general, and waiting times for primary care appointments for new patients are long in many communities; however, the Veterans Health Administration (VHA)—a federally monitored system under the U.S. Department of Veterans Affairs (VA)—has often served as a national bellwether for upcoming health care issues. A backdrop for the panel results reported here was the access crisis in the VHA (Buell, Huckman, and Travers, 2016). By 2014, VHA enrollment had increased to 9.1 million, and the capacity of the system to deliver care in a timely fashion had come under scrutiny (Wong et al., 2017). The issues came to attention in a region (the southwestern United States) that had experienced a large migration of veterans from northern states, as well as an influx of veterans from recent wars. In the context of overall system stress, a culture of denial, including false data reports, existed in some places (Hussey et al., 2015). Poor management decisionmaking occurred at multiple levels and likely resulted in harm to patients. By the time of the access crisis, achievement of open access scheduling had already been a major focus for many VHA sites. The VHA system, however, soon realized that the issues of variations, fluctuations, and disparities in access across the system were a broader problem that would require a more holistic management approach.

To begin to address the broader issues, the VHA, under congressional mandate, supported investigations into approaches for improving access and initiated a new focus on group practice management, including creation of the group practice manager position as part of each local VHA health care system’s management team (Hussey et al., 2015; Institute of Medicine, 2015).
The Veterans Access, Choice, and Accountability Act of 2014 (the Veterans Choice Act) both addressed the issue of the need for contracting outside the VHA for some care and specified the group practice manager position as an executive-level role. These steps provided a basis for improvement; however, they also uncovered the need for management approaches that were responsive to local environments and standardized at a system level.

To understand access management processes better, we developed a flow chart to conceptualize patient access to primary care. The chart shows different ways for patients to get access to primary care in person or by telephone, ranging from scheduled appointments to walk-ins. It also depicts the system and patient characteristics featured in literature as affecting flow. To view the flowchart, see Appendix A.

In addition, we developed a logic model that guided the project (Figure 1.1).

**Figure 1.1. Access Management Logic Model**

The logic model shows more-detailed patient, provider, site, and regional or organizational characteristics as inputs, or preexisting conditions that might shape an access improvement...
The initiative’s outcomes. The Primary Care Access Management Initiative box identifies the types of levers mentioned in literature for use in improving access, while the Types of Primary Care Access to Manage box lists the different types of access targeted by improvements. The Access Management Initiative Outcomes span the structural and process-change initiatives aimed to achieve, the access outcomes tested, and the unintended consequences monitored.

This project aimed to develop and validate access management strategies for health care organizations that reflect both the positive and cautionary findings from existing literature and to integrate those strategies with expert opinion. The Access Management Expert Panel process aimed to garner and synthesize information to support a broader approach to access within VHA as an evidence-informed learning organization—and to do so in a way that made use of the experiences of other health care systems and informed them as well. In doing so, the project built substantially on an evaluation of the Veterans Choice Act conducted by RAND (Farmer, Hosek, and Adamson, 2016), specifically on Finding 1 summarizing the mismatch or misalignment of access demand, resources, and management structures and processes. The project also built on findings from the Institute of Medicine (2015) and the British National Health Service (King’s Fund Commission on Leadership and Management in the NHS, 2011). In addition, the project sought to engage panelists from several health care systems in several countries and to use a published expert panel identification frame to span multiple relevant and potentially conflicting roles (patients, providers, policymakers, purchasers, and payers of health care services).

Rather than aiming to promote specific policy changes, this report aims to provide guidance to health care organizations as they consider access management improvement initiatives that may span a range of improvement targets and may involve multiple structural or process-of-care changes. We postulated that a diverse, experienced expert panel, armed with empirical information on access, could help primary care organization executives and middle and frontline managers by identifying key access management priorities and approaches for achieving them.

Objectives

Specifically, the project addressed three objectives:

- Define key features of access management and of the outcomes it seeks to achieve in health care delivery organizations.
- Establish core priorities for action among the many potential access management elements that might help achieve the desired access outcomes.
- Develop access management improvement recommendations and evidence-based suggestions for implementing them that would support achievement of each identified core access management priority.
This report describes results of an expert panel process with multiple components. Beginning in July 2016, we initiated an expert panel process supported by systematic evidence review and qualitative data collection and analysis on VHA’s new access manager approach. In January 2017, panelists participated in an in-person modified Delphi expert panel process with pre- and post-panel voting to identify the most-urgent and most-important aspects of access management improvement to put into action (priority actions). Once panelists reached consensus on the top priorities, panelists completed a second panel process involving two teleconferences held in February and March 2018. This process identified recommendations and suggestions for implementing them to accompany each priority action. The timing of the major project elements is as follows:

1. Prepare an evidence base (systematic review and qualitative access management study) (1st and 2nd quarter, 2016).
2. Recruit expert panel members (3rd quarter, 2016).
3. Develop panel materials and agenda (4th quarter, 2016).
4. Conduct and analyze in-person stakeholder panel (access management definitions, priority actions) (1st and 2nd quarter, 2017).
5. Develop recommendation materials and the agenda for formulating access management recommendations (3rd and 4th quarter, 2017).
6. Conduct and analyze the recommendation panel process (recommendations for achieving priority actions, suggestions for implementing the recommendations) (1st and 2nd quarter, 2018).

The project was supported by panels of content experts and pertinent stakeholders. All participants signed nondisclosure agreements and agreed to treat all information as confidential to enable meaningful discussions. The project was assessed by the RAND Human Subjects Protection Committee, found to be of minimal risk, and determined to be exempt (original assessment October 5, 2016, ID2016-0610; reassessed November 16, 2017, ID2017-0911).

Stakeholder Panel Recruitment

We used a framework-based approach, informed by the access flow chart (Figure A.1) and logic model (Figure 1.1) to determine the panel composition for the main stakeholder panel supporting the project. We followed a structured recruitment strategy by applying a patient-centered outcomes research (PCOR) framework, the “7 P PCOR” framework (Concannon et al., 2012). The “Ps” stand for patients, providers, purchasers, payers, policymakers, productmakers, and principal investigators, representing major stakeholder groups in health care. We then
identified additional areas of needed expertise based on the patient flow chart and access management logic model.

We recruited individuals to represent the identified stakeholder groups. Table 2.1 shows the represented stakeholder groups in relation to the framework.

**Table 2.1. Access Management Stakeholder Panel Composition**

<table>
<thead>
<tr>
<th>7P PCOR Framework Stakeholders</th>
<th>Expertise Represented Within Each Stakeholder Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients (consumers)</td>
<td>Patient representatives from the Care Coordination Quality Enhancement Research Initiative Strategic Advisory Group, Los Angeles</td>
</tr>
<tr>
<td>Providers</td>
<td>Provider types: Physician, nurse</td>
</tr>
<tr>
<td></td>
<td>Continuity of care, team care</td>
</tr>
<tr>
<td>Purchasers</td>
<td>Centers for Medicare &amp; Medicaid Services (CMS) and CMS Innovation Center</td>
</tr>
<tr>
<td>Payers</td>
<td>Kaiser Permanente</td>
</tr>
<tr>
<td></td>
<td>Veterans Health Administration</td>
</tr>
<tr>
<td></td>
<td>Canadian National Health Service</td>
</tr>
<tr>
<td>Policymakers</td>
<td>National, regional, and local primary care operations</td>
</tr>
<tr>
<td></td>
<td>Rural care</td>
</tr>
<tr>
<td></td>
<td>Contracted care (e.g., through the Veterans Choice Act)</td>
</tr>
<tr>
<td>Productmakers</td>
<td>Call center manager</td>
</tr>
<tr>
<td></td>
<td>Group practice manager</td>
</tr>
<tr>
<td></td>
<td>Quality improvement measures, tools for clinical decision support and training</td>
</tr>
<tr>
<td>Principal investigators</td>
<td>Primary care models</td>
</tr>
<tr>
<td></td>
<td>Access assessment frameworks</td>
</tr>
<tr>
<td></td>
<td>Implementation research</td>
</tr>
<tr>
<td></td>
<td>Identification of unintended consequences of primary care policies</td>
</tr>
</tbody>
</table>

NOTE: N = 20 stakeholders; some stakeholder groups were represented by more than one panelist (e.g., the panel included two patient representatives).

The panel composition included patients and the public (i.e., consumers of health care), health care providers (with an emphasis on primary care), purchasers (responsible for underwriting the costs of health care, such as CMS), payers (e.g., insurance companies responsible for reimbursement of medical care, such as Kaiser Permanente), policymakers (represented by key VHA personnel), productmakers (represented by the most frequent “point of entry” for primary care within VHA: the call center), and principal investigators (researchers with key contributions to advancing access management). Each of the seven PCOR stakeholder groups included between one and three members, for a total of 20 panelists.

By design, we included panelists meeting one or more of the criteria in Table 2.1 who also had particular expertise in the needs of rural populations. This ensured that the complexity of access to care in rural areas was considered, including lack of providers and unfilled positions. We also included in the panel an expert on contracting out-of-system care whose expertise was based on implementation of the Veterans Choice Act, legislation intended to improve veterans’ timely access to care outside of the VA health care system. Choice Act programs complement
existing programs, such as Access Received Closer to Home and Patient Centered Community Care programs, and have intensified the need to solve issues concerning arranging, coordinating, and reimbursing care within facilities outside of VHA. Although the term provider is often used to refer to physicians, nurse practitioners, or physician assistants, we included staff nurses as providers within our framework. Nurses carry out a variety of critical access-related roles, such as providing care management, refining scheduling and preserving access (e.g., follow-up with patients for rescheduling), and providing telephone appointments and after-hours phone care. We included national, regional, and local policymakers. We included a non-U.S. health care system (Canada) to ensure representation outside the United States, particularly for reflecting lessons learned in large national managed care systems. To ensure that the panel considered wanted and unwanted consequences of policies, the panel represented the perspective of frontline continuity of care expertise and of other issues potentially resulting from “uncoordinated access,” including access to providers that are not a patient’s usual or continuity care provider and access to contract care outside of the system in which the patient is enrolled. To include a perspective on access measurement for quality improvement, several stakeholders were involved in tracking, analyzing, and improving access measures. While all aspects of access measurement are important, for the purpose of this project, a representative specializing in quality improvement measures to improve access was determined to be critical.

All panelists contributed to identifying priority actions. Nineteen of the 20 panelists attended the face-to-face panel meeting described in the next section. Seventeen panelists contributed to the procedures aimed at developing definitions of access management.

Fourteen of the panelists engaged in a subsequent panel activity directed at developing recommendations for implementing the identified priority actions. These subpanelists were recruited from the main panel and included panelists who were available for the additional work and indicated that they were willing to commit to additional work formulating specific recommendations. These panelists represented six of the PCOR stakeholder groups (patients, health care providers, purchasers, payers, policymakers, and principal investigators). The members of the recommendation panel participated in interactive web conferences and provided input before, during, and after web meetings.

**Other Participants**

The in-person panel meeting was also attended by interested VHA staff with content expertise in access management. These participants attended one or both meeting days as observers and included physicians and doctorate-level health services researchers (see Acknowledgements). These panel guests provided the technical experts with VHA-specific content information where requested, but, unless asked, they did not speak outside of two designated activities (the definition-focused subpanels and the vignette-focused breakout session). These guests did not participate in the formal consensus activities.
Preparing an Evidence Base

The panelists’ work was supported by empirical evidence. We began the first step in the expert panel process by reviewing prior reports on VHA (e.g., Hussey et al., 2015; Farmer et al., 2016), as well as reports and manuals from other major health systems, including Canada’s and Great Britain’s (Kiran and O’Brien, 2015; Rosen, 2014). The literature informed meeting materials, such as the pre-panel survey.

Systematic Review

In addition, the project was supported by a systematic review of the access management literature performed by the VA Evidence-Based Synthesis Program (ESP). The ESP has been established to provide timely and accurate syntheses of targeted health care topics of particular importance to clinicians, managers, and policymakers. The ESP report (Miake-Lye et al., 2017) is based on a systematic review of the literature and aims to summarize research on access management to identify successful evidence-based approaches from international literature.

One of the key questions addressed by the systematic review was what definitions and measures of intervention success are used, as well as what evidence supports use of these definitions and measures. The report identified 53 relevant publications. It concluded that, in the identified studies of management interventions to improve primary care access, the third next available appointment was the most commonly used measure of success. The authors identified no empiric data linking this choice to any health outcome. The next most commonly used measure was continuity, followed by patient satisfaction. Many publications that discuss access management do not include a definition of access. A second key question addressed what samples or populations of patients are studied, including eligibility criteria. The review identified 19 relevant studies addressing this key question. The authors concluded that patients who have been included in published studies of access management in primary care have not been described in detail. In general, study samples are likely typical of adult patients attending family medicine clinics (Miake-Lye et al., 2017).

A third review question in the ESP report addressed the salient characteristics of studies of local and organizational contexts. The 19 studies contributing to this question suggested that little is known about the local and organizational contexts of practice sites included in published studies of primary care access management interventions (Miake-Lye et al., 2017). Many sites in the included studies were academically affiliated clinics, part of the British health care system, or part of the VA. The 19 studies also contributed to the fourth key question, which aimed to determine key features of successful (and unsuccessful) interventions for organizational management of access. The review authors reported that all interventions were described as advanced access or open access, with 15 of the 19 studies including these phrases in the publication title. The most common intervention components were reducing the backlog of appointments, using fewer appointment types, and producing regular activity reports. The final
review question determined whether there are relevant, tested tools, toolkits, or other detailed material available from successful organizational interventions. The review authors identified a systematic review that included online tools and resources to support organizational improvement in primary care (Janamian et al., 2016). The ESP report included five tools or guides for improving primary care access: one from a VA or a UK setting, two from the Institute of Healthcare Improvement’s advanced access group, and one Canadian study.

The systematic review began in September 2016 and was completed prior to the in-person meeting in January 2017. We used the results to inform the project materials, and the results were made available to panelists both in summary form prior to the meeting and in a meeting presentation and discussion. Panelists could access the articles themselves in an online article repository.

Qualitative Data Collection and Analysis

We anticipated that, in addition to the systematic review, additional information on VHA’s access management initiative would be helpful as a working example of an improvement process. VHA had initiated funding for qualitative evaluation of the implementation of high-level group practice managers and teams in mid-2015; implementation was congressionally mandated to occur in each of the local VHA health care systems (Rubenstein, Sayre, and LeRouge, 2016).

The qualitative evaluation (Rubenstein, Sayre, and LeRouge, 2016) involved interviews with 56 key informants from five VHA health care systems that were designated prototype sites piloting a clinical practice management model. The interviewees included leadership, group practice managers, midlevel managers, schedulers, providers, analytics and data management personnel, and trainers within the VA. Data were analyzed using iterative deductive and inductive context analysis. The results emphasized three key tasks of clinical practice management model implementation: (1) Mobilize a clinical practice management culture (challenges related to engaging staff with data analytics, managing process flow, and change management), (2) shore up data analytic structures (challenges related to the data analytic tools and resources), and (3) leverage key response resources (resources and mechanisms identified as facilitating improved access) (Rubenstein, Sayre, and LeRouge, 2016).

The evaluation was completed prior to the in-person panel meeting. The evaluation’s report was available to panelists, and key results were summarized during the meeting.

Additional Literature to Support Recommendations

Supported by the RAND Evidence-based Practice Center, we also established a literature collection relevant to potential recommendations and suggestions for implementing those recommendations. The literature collection was not limited to empirical research studies included in the ESP report. It included panelists’ suggestions for resources and results of targeted literature searches. We looked specifically for gray literature from U.S. managed care
organizations on access management or group practice management. This informal literature review relied on snowball queries and online searches.

The literature collection was made available online to panelists prior to the in-person meeting. We formally screened the literature collection to draft the recommendations (see later discussion).

Procedure

We used the logic model, flow chart, and assembled literature and qualitative evidence to design a modified Delphi expert panel process. This included a pre-panel survey and materials, an in-person panel meeting, a post-panel survey, and two virtual panel meetings.

The central activity, a face-to-face panel meeting, was convened in February 2017 at the RAND Corporation’s headquarters in Santa Monica, California.

This complex project had multiple components, and each component followed a tailored methodological approach. The following sections outline the methods employed to establish definitions, identify priorities, and formulate recommendations and suggestions.

Establishing Definitions of Access and Access Management

To determine whether there is a universally accepted definition of access, we established five stakeholder subpanels at the in-person expert panel meeting. The subpanels worked in parallel, and all received the same instructions. This procedure enabled us to review definition components and themes across subpanels. Subpanels enable determining which components are panel-unspecific (see Khodyakov et al., 2011) and which are highlighted across different subpanels with different panel compositions and interactions.

Subpanels included up to six participants. Sampling was purposefully designed so that the subpanels had to include a similar proportion of technical experts from the main access management expert panel and observers (as noted, the in-person panel meeting was also attended by interested VHA staff with content expertise in access management). The total number of panelists had to be similar across subpanels, but, generally, participants were free to join subpanels of their choice. Project staff ensured that both panel sample conditions were met. Seventeen technical experts and 14 observers contributed to the access definition subpanels.

Each subpanel had the same set of instructions and materials. To facilitate discussions, the participants received a handout outlining the objective, our working definition of access management, and a published definition of health care access. The published definition of access had been developed by VA staff and was based on expert consensus:

Access to care represents the potential ease of having virtual or face-to-face interactions with a broad array of health care providers including clinicians, caregivers, peers, and computer applications.
Actual access to care represents those directly-observable and objectively measurable dimensions of access.

Perceived access to care represents those self-reported and subjective dimensions of access. (Fortney et al., 2011, p. 641)

The five stakeholder subpanels were instructed that they could choose to adopt the published definition of access, and the decision to not change the existing definition would be a valid outcome of the panel discussion. A member of the team that had developed the published definition was present in the room and available to facilitate discussions or respond to questions. After parallel within-subpanel discussions in the five dedicated subpanels, each subpanel presented its conclusions to the main group. After the session, each speaker emailed his or her subpanel’s discussion summary points and revised definition (if changed) to our project team.

For the five parallel subpanels, the deliberations, presentation, and subsequent discussion were recorded and transcribed. We conducted qualitative content analysis of textual data submitted by each subpanel, which consisted of the transcripts from group discussions and the revised definitions of access that emerged from each subpanel. Two researchers (a content expert and a qualitative analysis methods expert) independently developed lists of emerging themes found in the subpanel discussions, combined the lists, and reconciled discrepancies by consensus. Using the same approach, the two researchers then analyzed the final revised versions of the definitions that were produced during the in-person panel meeting. We also analyzed word frequencies and visually inspected word clouds based on transcripts to compare results across the five parallel subpanels. Word clouds excluded common English words (e.g., you), stop words that do not convey meaning (e.g., there), and words with fewer than three characters (e.g., on) using “wordcloud: Word Clouds,” R package, version 2.5. The analysis aimed at identifying converging aspects of definitions of access. The merged word cloud highlights the key themes that emerged across the subpanel discussions.

Access Management

In preparation for the in-person panel meeting, all access management expert panelists received a survey that asked about access management from the point of view of primary care. The survey included the following working definition of access management, which we had developed based on the existing literature:

Access management encompasses the set of goals, evaluations, actions, and resources needed to achieve optimal use of health care services by defined eligible populations of patients. Optimal access incorporates considerations of equity, patient preferences, patient needs, and value.

Panelists were asked whether they had any comments on the working definition.

We collated survey responses from individual panel members and documented suggested changes to the working definition, with emphasis on similar changes requested from two or more independent panelists. We reviewed editorial changes, including nomenclature or terminology changes, as well as conceptual changes. We collated the answers and discussed any proposed
changes to the definition on the first day of the expert panel meeting. During the meeting, the moderator discussed the changes and established a revised definition of access management.

**Identifying Priority Actions**

The main expert panel established priorities for optimal access management. The procedure adhered to central principles of consensus methods: anonymity, iteration, controlled feedback, and statistical group response (Jones and Hunter, 1995). We used private voting to avoid dominance group processes, used multiple rounds to allow panelists to change their opinions after discussions, presented feedback before and after panel meetings, and presented central tendency and dispersion measures across panelists.

**Pre-Panel Meeting Survey to Identify Areas of Disagreement**

Prior to the in-person panel meeting, we sent panelists a survey to identify areas of agreement and disagreement that should be discussed further. The survey content was informed by the logic model and the existing evidence. The survey addressed five content areas:

1. patient populations, service and practice contexts
2. evaluating and managing supply and demand in primary care
3. promoting successful group practice management
4. managing demand: identifying and managing complex or challenging patients
5. access management outcomes.

Panelists rated between six and 39 items per content area. Items consisted of potential characteristics (e.g., “Difficulty getting to clinic [i.e., is home bound, transportation difficulties, lives far away from nearest primary care practice, is homeless]”) in each content area (e.g., “Patient demographic or social characteristics that may interfere with use of key access resources”). Panelists rated the priority for taking account of the characteristic in assessing or managing access. The response mode used five categories, ranging from very low priority to very high. Participants were explicitly instructed to use the very high category sparingly to identify top priorities that would be critical to address within the first year of an access management improvement initiative. The survey is included in Appendix C.

We computed reviewer-adjusted (Rubenstein et al., 1990) means and the modal value for each item. We analyzed the central tendency (i.e., how was the priority rated across all panelists) and the proportion of panelists who selected the fifth category (“very high priority, must be addressed this year”) to determine agreement. We identified potential high-priority items as those with an adjusted mean exceeding 3.75 (on the scale of 1 [very low priority] to 5 [very high priority]) and for which more than 50 percent of panelists rated the item as very high priority. In addition, we identified items with substantial disagreement using a standard deviation (SD) cut-off of more than 0.85.
In-Person Panel Meeting to Discuss Access Management Priorities

The two-day in-person panel meeting combined presentations and panel discussions. The meeting was attended by the access management panelists and local stakeholders. The objectives of the in-person panel were to foster discussions, review areas of agreement, and resolve disagreements identified in the pre-panel survey. The in-person meeting followed a structured agenda, alternating topics and activities.

At the panel meeting, we presented pre-panel survey items that panelists agreed represented high-priority areas of access management. We also discussed items with substantial disagreement in detail. An experienced moderator facilitated the meeting with the intent to differentiate true and conceptual disagreements from simple misunderstandings, disagreements due to terminology ambiguities, or differences in defining elements that may have led to a differential interpretation of the item. We carried out several online anonymous polls during the meeting to assess and sharpen our understanding of panelist opinions and conducted two small-group breakout sessions.

All panel discussions were recorded and later transcribed. Transcriptions were deidentified and stored in anonymous form.

Vignettes to Foster Meaningful Discussions

The pre-panel survey also included six vignettes of difficult access-related situations that were discussed in detail at the in-person panel. The vignette descriptions acknowledged that one of the reasons access can be classified as a “wicked” problem is that there is no one-size-fits-all recommendation regarding most of its aspects. We presented six vignettes in total. All were short descriptions of difficult access-related situations that had been reported to the investigator team during site visits at health care facilities or were based on patient experiences.

Five vignettes were presented as part of the pre-panel meeting survey that asked one or two prompting questions to address the issue of access management. One vignette was sent to the access management panel by email in preparation of the in-person meeting. We asked panelists to respond in an open comment field to one or two prompting questions about how to address the issue of access management.

At the in-person panel meeting, we presented the different vignettes and the initial panel responses to impromptu formed groups during a breakout session. The groups were asked to review and discuss the responses and to come up with possible ideas for solutions. Both panelists and local stakeholders participated in the groups. After 40 minutes of deliberation, a group speaker reported back to the larger group. No further instructions were given for the report, and speakers were free to structure the recommendations according to their preference. Some speakers responded directly to the pre-panel survey prompting questions, and others summarized their group’s discussion more broadly. All presentations were followed by a brief panel discussion. Each workgroup submitted a summary of its discussions and recommendations by email to the project team, either at the meeting or within a week after the meeting.
Post-Panel Meeting Survey to Identify Priority Actions

We mailed a post-panel survey to all panelists to assess consensus on a parsimonious set of access management priorities as the basis for early action. The post-panel survey aimed to determine which of the items that panelists had identified as high priority in the pre-panel survey were both important and urgent after the in-person panel discussions. Some items incorporated changes in wording to address issues identified by panelists. In addition, the panelists rated four new items derived from panel discussions. The survey included 30 items in total. We grouped the items into categories that followed a Donabedian structure-process-outcome framework (Donabedian, 1988). The categories were organizational structure (to determine specific areas within the access management organizational structure that should be targeted), process improvement (to determine specific areas that improvement in access management processes should address), and outcomes (to assess access management success).

Panelists were asked to assess whether items were both important and urgent by endorsing one of three answer categories: (1) Improvement toward this goal is important and urgent (i.e., should be undertaken this year); (2) improvement toward this goal is important but not urgent; or (3) improvement toward this goal is not important. Endorsement from more than half of respondents that improvement toward this goal is important and urgent was considered consensus on a critical near-term access management priority.

Panelists (but not guests) reviewed, commented on, and approved the resulting priority actions.

Formulating Recommendations

We used transcripts of the panel discussions and information from the published literature to translate each established priority action into recommendations and suggestions for implementing the recommendations. We screened the collection electronically for key words to identify relevant information related to priority actions established by the panel. We used the Google Drive platform to search the content of more than 100 sources (see Appendix B). A literature reviewer screened the full-text search and extracted relevant information using a standardized format.

Fourteen of the 20 access management panelists participated in this process. The panelists reviewed recommendations in preparation of two interactive web conferences. The panelists discussed and voted on the recommendations during moderated two-hour web meetings. The web meetings used a built-in voting function to instantly capture panel consensus. The project team revised the draft recommendations based on panel input. A third feedback round asked for approval of the final recommendations.
Chapter Three

Results

This chapter summarizes results of the preparatory evidence review, definition, prioritization, and recommendation components of the project.

Definitions

The project addressed access and access management and resulted in definitions of access management, optimal access management, and optimal access.

As outlined, during the in-person panel meeting, five parallel subpanels worked on a definition of access. Figure 3.1 summarizes the discussions across all subpanels as a visual overview in a word cloud.

Figure 3.1. Access Definition Discussion Word Cloud

The words mentioned most frequently (more than five times) across panel discussions were access \((n = 41)\), patients \((n = 31)\), care \((n = 18)\), need \((n = 18)\), needs \((n = 15)\), contact \((n = 14)\), definition \((n = 12)\), management \((n = 11)\), first \((n = 9)\), group \((n = 9)\), actual \((n = 8)\), health care \((n = 8)\), response \((n = 8)\), when \((n = 8)\), defined \((n = 7)\), ease \((n = 7)\), subjective \((n = 7)\), system \((n = 7)\), timely \((n = 7)\), perceived \((n = 6)\), self \((n = 6)\), use \((n = 6)\), veterans \((n = 6)\), and clinical \((n = 6)\). Although it is not surprising that access was the most frequently mentioned word, it was very closely followed by patients and need or needs, reflecting a lively discussion around patients’ needs.

Table 3.1 documents the results of the deliberation in each of the five parallel subpanels. The table documents the themes that emerged from the discussions, the subpanel definitions, and the themes that emerged in the agreed definitions.
Table 3.1. Comparison of Definitions of Access

<table>
<thead>
<tr>
<th>Subpanel</th>
<th>Themes That Emerged from Panel Discussions</th>
<th>Agreed Definition</th>
<th>Themes That Emerged from Agreed Definition</th>
</tr>
</thead>
</table>
| 1        | • Actual versus perceived access          | Access management encompasses a set of processes designed to achieve optimal delivery of health care services to our veterans and their families and requires continuous improvement. | • Continuous improvement  
• Health care services for veterans and their families  
• Optimal delivery  
• Processes |
|          | • Ease versus need                        |                  |                                          |
|          | • Facilitate self-management              |                  |                                          |
|          | • Patient access to materials             |                  |                                          |
|          | • Timeliness                              |                  |                                          |
|          | • VA-Community partners hybrid model      |                  |                                          |
| 2        | • Clinical necessity/ appropriateness     | Access is defined as a timely response to patient requests, and incorporates patient preferences and clinical necessity. | • Clinical necessity/ appropriateness  
• Patient preferences  
• Timely response to patient requests |
|          | • Continuous improvement                  |                  |                                          |
|          | • Health care services for veterans and their families |                  |                                          |
|          | • Optimal delivery                        |                  |                                          |
|          | • Patient preferences                     |                  |                                          |
|          | • Timely response to patient requests     |                  |                                          |
| 3        | • Clinical appropriateness                | Opted to keep original definition: Access to care represents the potential ease of having virtual or face-to-face interactions with a broad array of health care providers including clinicians, caregivers, peers, and computer applications.  
• Actual access to care represents those directly-observable and objectively measurable dimensions of access.  
• Perceived access to care represents those self-reported and subjective dimensions of access. | • Actual access is directly observable, objectively measurable  
• Actual access versus perceived  
• Array of providers/caregivers/peers/computer applications  
• Ease of access  
• Perceived access is self-reported and subjective  
• Potential  
• Virtual or face-to-face interactions with providers |
|          | • Defined eligible populations of patients|                  |                                          |
|          | • Ease of getting access to care          |                  |                                          |
|          | • Expressed need                          |                  |                                          |
|          | • Optimal use                             |                  |                                          |
|          | • Primary care versus first contact       |                  |                                          |
|          | • Without ease of access, there can’t be use|                  |                                          |
| 4        | • Access defined by patients              | Access is defined by patients. Varies from patient to patient. | • Access defined by patients  
• Access definition varies from patient to patient |
|          | • Actual versus perceived                 |                  |                                          |
|          | • Comparisons to European example of access|                  |                                          |
|          | • Confidence in follow-up after first contact|                  |                                          |
|          | • Distinction between first contact and access|                  |                                          |
|          | • Hard time with the term potential       |                  |                                          |
|          | • Resolution of access needs trumps first contact|                  |                                          |
|          | • Specific goals                          |                  |                                          |
|          | • Timeliness: first contact to resolution of access needs|                  |                                          |
Panel deliberations highlighted that definitions of access to care within health care delivery organizations need to be patient-centered. Recurrent themes that were identified across subpanels were

- timeliness
- ease of access
- actual versus perceived needs
- importance of the patient perception of access.

One subpanel opted to keep the working definition, and the other four subpanels simplified the definition. A key aspect of the definitions developed in the subpanels were patient preferences, patient needs, and access being defined by the patient.

Despite the recurring themes across subpanels, further discussion in the original access management panel concluded that a definition of access in absolute terms was beyond the scope of the project. Panelists instead chose to focus on developing a broader definition of access management that could encompass the variety of important goals that need to be balanced in health care delivery organizations as they strive to achieve optimal access.

The access management stakeholder panel subsequently worked on a definition of access management. The responses to the pre-panel survey that had asked panelists to comment on our research team’s preliminary definition showed that a quarter of the panelists (5/20) explicitly stated that they had no comments on the working definition, and eight did not add any comments.

Three of the 20 panelists provided general comments, as follows:

- “I believe this is a well-articulated definition for access management.”
- “I think this is a sensible definition although many of these . . . focus solely on the preferences.”
• “Who determines the optimal use of health care services? Is the patient perspective considered, or is the definition based on medical model assumptions?”

Four of the panelists had specific suggestions for changing the definition, as follows:

• “I would add after patient needs: staff needs and capabilities.”
• “Considerations of equity and value may or may not be appropriate to the concept. . . . Perhaps if it was preceded by perceptions [rather than] considerations.”
• “Optimal access also incorporates provider and team engagement along with patient centered behaviors.”
• “Interesting viewpoint, as a manager-type, my brain flips this to ‘optimal organization of health care services or teams for idealized provision of care to populations of patients,’ maybe thinking from the ‘supply’ end rather than the ‘demand’ end. Can we really shape the behavior of patients?”

Pre-panel survey comments showed agreement with the general concepts in the proposed definitions but added a variety of suggested wording changes, suggesting the need for further discussion.

At the in-person expert panel meeting, the moderator presented the survey comments to the group together with a revised definition of access management.

The final edits were completed during the meeting and resulted in the definitions shown in Figure 3.2.

**Figure 3.2. Final Consensus Definitions of Access Management, Optimal Access Management, and Optimal Access**

<table>
<thead>
<tr>
<th>Access management</th>
<th>Optimal access management</th>
<th>Optimal access</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access management encompasses the set of goals, evaluations, actions and resources needed to achieve patient centered healthcare services that maximize access for defined eligible populations of patients.</td>
<td>Optimal access management engages patients, providers, and teams in continuously improving care design and delivery in order to achieve optimal access.</td>
<td>Optimal access balances considerations of equity, patient preferences, patient needs, provider and staff needs, and value.</td>
</tr>
</tbody>
</table>

**Priority Actions**

In the post-panel survey, panelists identified eight items as being both important and urgent (see Table 3.2). Appendix D shows the panel agreement for all post-panel items in addition to the results of the corresponding pre-panel items.
Table 3.2. Key Structure, Process, and Outcome Priorities for Access Management Initiatives

<table>
<thead>
<tr>
<th>Category</th>
<th>Priority Action</th>
</tr>
</thead>
</table>
| Organizational structure priorities | • Identify physician, registered nurse, and administrative leaders for each primary care practice site with authority to support access management priorities within local site contexts.  
• Develop a clearly identified group practice management structure with a designated group practice manager who reports to executive leadership, communicates with individual primary care sites, and can collaborate across roles and service lines (e.g., medicine, nursing, administration). |
| Process improvement priorities  | • Routinely evaluate the degree to which patient telephone calls are (a) answered promptly and (b) routed accurately and appropriately, as judged in terms of patients' clinical needs and preferences.  
• Maximize access managers' routine use or ability to demonstrate systematic approaches to ensuring adequate availability of contingency staffing (i.e., planned minimal excess staffing to cover routine absences, such as those resulting from hiring gaps, vacations, illness).  
• Maximize the ability of the primary care team's registered nurses to prospectively manage demand by leading care coordination for their panels.  
• Maximize primary care team members' ability to proactively manage demand (e.g., alerts, reminders, and telephone contacts from patients on their panels) by optimizing provider visit schedules (e.g., through triage, prospective "scrubbing" of appointments) to the extent appropriate given their training/licenses. |
| Outcome priorities              | • Assess the quality of the patient's experiences of access (i.e., patient-rated access). We expect patient ratings to reflect both in-person and non-face-to-face (e.g., telephone, secure messaging) care.  
• Assess primary care provider and staff morale (e.g., low/high burnout, job satisfaction, or turnover rates) in relation to access mismatch (e.g., panels exceeding recommended size, primary care provider vacancies). |

Panelists agreed on two key organizational structure targets (identifying clinical and administrative leaders for each primary care practice site with authority to support access management priorities; establishing a clearly identified group practice management structure). Panelists agreed on four key process improvement priorities (routinely evaluating and managing patient telephone calls to schedule appointments, maximizing systematic approaches to contingency staffing, maximizing registered nurses’ opportunities to manage care coordination, proactively managing demand by optimizing provider visit schedules). Finally, panelists also endorsed assessing two outcomes as top priorities (assessing the quality of patient experiences of access, assessing provider and staff morale in relation to access mismatch).

The panel endorsed all key priorities as highly important based on the pre-panel survey and in-person panel discussions and voting. In terms of identifying those that were both urgent (to be accomplished with a year) and important, agreement ranged from 53 percent of panelists endorsing the priority as both urgent and important (for the process improvement target of proactive management of demand by optimizing provider visit schedules and for the outcome of provider and staff morale related to access mismatch) to 100-percent endorsement (for the...
The results and discussion highlighted that telephone care is both critical in itself and a major determinant of all other aspects of patients’ abilities to achieve appropriate access. While secure messaging, websites, and other care modalities can reduce the telephone load (particularly for unnecessary calls), the telephone remains the core pre- and post-visit communication modality. Even information technology companies are expected to provide prompt and helpful telephone service for their products. Panel discussions highlighted the patient safety aspects of appropriate telephone answering in clinical settings. Discussions also emphasized the role of telephone calls in avoiding unnecessary walk-ins or same-day visits, such as for a standard medication refill (could be handled by a pharmacist on the phone), a clinical question (could be triaged by a nurse on the phone), or a scheduling question (could be handled by a clerk on the phone). Panelists identified unnecessary walk-ins or same-day visits as costly both to the patient and to the primary care practice site.

Figure 3.3 shows the relationships of the eight priority actions within Donabedian’s structure-process-outcomes framework (Donabedian, 1988).
Figure 3.3. Access Management Priority Actions: A Focus on Structure, Process and Outcomes of Care

Table D.1 (in Appendix D) documents items that were identified as important but not necessarily urgent. This includes items on wait times, evaluation of patient walk-in visits, and support for frontline access-related quality improvement. The table also shows two items for which the panel was divided; that is, an equal number of panelists found the item to be very important and urgent as found the item to be very important but not urgent (i.e., does not need to be addressed this year). These items described (1) routine matching of total health care provider hours committed to clinical primary care, with the clinic sessions booked for providers over the prior month (primary “grid validation”), and (2) the evaluation of services provided outside of the health care delivery organization.
Vignettes

As outlined in the previous chapter, we dedicated a breakout session at the in-person panel meeting to reviewing the six vignettes, discussing the comments and suggestions from the panelists, and finding solutions to how the access management situations in the vignettes should best be addressed. Discussions during the in-person panel meeting emphasized the need to ensure multi-level management focus on

- analyzing root causes of access problems before acting
- differentiating short- versus long-term fixes
- improving team functioning and communication
- making telephone care a strategic health care organizational priority
- focusing on individual primary care provider data, circumstances, and needs
- focusing on enabling individual patient preferences to guide access, including trade-offs between rapid care and continuity care
- applying population management perspectives, including management of vulnerable or complex patients.

Overall, the deliberations emphasized the roles of communication and data. As one panel member stated in the group discussion, “From a group practice management standpoint, our role should [be] facilitating the conversations, and the providers . . . if you show them the numbers . . . are reasonable and they do come in line.”

Recommendations

The project resulted in a parsimonious set of recommendations and suggestions for supporting health care organization initiatives aimed at improving access management in primary care. Recommendations represent the synthesis of published research, organizational evidence (e.g., from published handbooks or manuals), and panel discussion (extracted from the in-person panel meeting transcripts) regarding key steps for improving access management relevant to the priority action. The review of the priority actions and recommendations may be useful to health care organization executive-level or midlevel leaders (including unit managers, primary care site leaders, or care team leaders) aiming to improve access to primary care in their health care delivery organizations.

The research team initially assembled 25 recommendations with accompanying suggestions for implementation culled from panel discussions; an electronic theme search of the project database of systematic review articles; and a hand search of the database of reports, monographs, and qualitative results. Panelists made crucial suggestions during the review and revision process. These included consolidating some recommendations and eliminating others, making wording changes, identifying the organizational level that would be required to initiate the recommended changes, and keeping the references for each recommendation but consolidating them at the end of each recommendation section so that users could consult them for additional
information without being bogged down by too many referenced statements. Panelist input resulted in a short set of recommendations for achieving each of the eight priority actions, as well as evidence-based suggestions for implementing each recommendation.

The suggestions for implementing the recommendations point to appropriate actions that organizations or organizational units may want to consider for achieving each recommendation. The suggestions are based on published literature and/or panel discussions and were reviewed, changed based on panel input, and approved in their final form by the panelists.

To indicate the organizational level associated with the recommendation, we indicate whether the recommendation would typically need to be initiated by the executive level of a health care organization (executive level) or could be initiated at another level (midlevel). However, whatever the level at which implementation is initiated, panelists expected that, throughout any improvement process, communication and decisionmaking will flow up and down organizational levels, including the national level when applicable, and across professional or service lines.

Finally, the recommendations and suggestions were accompanied by references. The references indicate sources for learning more about the basis for each recommendation.

Tables 3.3 to 3.10 document the established resources (recommendations, suggestions, implementation level, and references and further reading) for the eight priority actions. The tables are ordered by the highest percentage of consensus achieved in the post-panel survey to the lowest percentage achieved.

To use the priorities, recommendations, and suggestions, health care organizations and primary care settings should consider (1) engaging patients, system and local site leaders, and frontline staff in inter-professional access management improvement; (2) addressing only one or two priorities at one time by considering organizational and local site contexts and developing relevant, focused improvement projects; and (3) ensuring that access management improvement is an ongoing organizational focus. Appendix E of this report includes a tool that we developed for organizations in a user-friendly format that is ready to be used in quality improvement projects when developing an access management improvement initiative.
Table 3.3. Recommendations for Priority Action: Telephone Access

<table>
<thead>
<tr>
<th>Priority action</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routinely evaluate the degree to which patient telephone calls are (a) answered promptly and (b) routed accurately and appropriately, as judged in terms of patients’ clinical needs and preferences.</td>
<td>Ensure that the set of telephone management metrics incorporates four key principles:</td>
</tr>
<tr>
<td></td>
<td>• following calls to resolution</td>
</tr>
<tr>
<td></td>
<td>• accounting for both call center and primary care team roles in telephone management, promoting substitution of telephone management for in-person management whenever appropriate</td>
</tr>
<tr>
<td></td>
<td>• promoting metric availability at local site levels to support targeted telephone management improvement initiatives</td>
</tr>
<tr>
<td></td>
<td>• incorporating patient preferences and experiences into metric development and interpretation.</td>
</tr>
</tbody>
</table>

Suggestions for implementing the recommendation

**Suggested call center measures include:**
- the average speed of answer by the call center for all inbound calls (e.g., the percentage of calls answered within 60 seconds)
- whether calls are answered more quickly at certain times of day versus others
- 24-hour availability of call answering
- measures beyond electronic data (e.g., record call center calls for quality assessment)
- call-back workload (e.g., the number of call-back attempts to patients per 100 initiating calls from the patient or call center)
- provider satisfaction (e.g., with types of appointments booked through the telephone, and reasons for dissatisfaction; timeliness of patient appointments in the community-based programs).

**Suggested primary care team measures include:**
- average speed of answer to the patient from the final call destination for calls routed from a call center to a medical office or clinic
- number or proportion of potentially avoidable calls (e.g., percentage of patients who call and leave more than one message for the clinic before being able to schedule an appointment; clinician assessments of when and what types of calls could be handled another way)
- average speed of primary care team answers to (a) all inbound calls and recorded messages from the call center, and (b) all inbound patient calls.

**Suggested first call to resolution measures include:**
- measures beyond electronic data (e.g., use provider quality review of a set of medical records to determine whether calls are being routed accurately and appropriately based on the patients’ clinical needs and preferences; survey patients’ satisfaction with their ability to contact their physician or care delivery team with a medical question [see Table 3.4, on patient access experience])
- measures of local primary care site call resolution to provide individual sites with data for improvement
- rates of multiple patient call-backs (e.g., the percentage of patients resolving their problem on a first call, the percentage of patients making a second call, the percentage of patients lost to follow-up after leaving a message, the percentage of patients leaving more than one message before achieving resolution).

**Suggested patient access experience measures** (see Table 3.4, on patient access experience)
| Recommendation Level: Can be initiated by midlevel managers, including unit managers, primary care site leaders, or care team leaders | Ensure that appropriate telephone management strategies are focused on four key principles:  
- enabling links to continuity primary care teams whenever possible and appropriate  
- enabling telephone calls to access available non–primary care resources appropriately, comprehensively, and accurately  
- facilitating local health care system and site improvement based on data  
- using best available technology for incorporating patient preferences into telephone answering protocols. |
| Recommendations for implementing the recommendation | Suggestions to facilitate telephone management contacts include:  
- Identify and document all acceptable methods for linking patient calls to their primary care teams and providers.  
- Identify all resources that are accessible by telephone and make available as appropriate to staff and patients.  
- Develop a plan for regularly updating relevant health resource contact information.  
Suggestions to support ongoing, broad-based telephone management improvements include:  
- Set improvement goals for telephone answering services by engaging key stakeholders, including patients.  
- Engage local stakeholders by sharing metrics results widely (e.g., report them in executive leadership and other staff meetings; post on websites or in newsletters) and celebrating improvements.  
- Identify approaches and mechanisms for initiating improvement initiatives.  
Suggestions for use of technology to incorporate patient preferences in call center protocols include:  
- Inform patients on hold about estimated wait times, and give the patient the option of waiting longer or leaving a message.  
- Use different approaches for patients requesting a medical advice contact versus appointment scheduling contact.  
- Remove such messages as “Voicemail is full; call back another time” from call center or designated primary care site phones.  
- Identify key areas in which patient preferences should guide the call center’s response (e.g., when the call is not emergent and the patient prefers a call or appointment with his or her assigned provider or team rather than a quicker appointment or answer from an alternative) and train call center staff accordingly.  
- Remove performance or technological barriers to responding appropriately to patient preferences.  
- Set improvement goals to increase the frequency of real-time medical advice provided to patients with a medical question by a known and trusted caregiver.  
- Explore technology to connect the call center to the electronic medical records so that incoming calls can be automatically assessed for medical questions and automatically routed directly to the patients’ physician or care team. |
| Recommendation Level: Can be initiated by midlevel managers, including unit managers, primary care site leaders, or care team leaders | Ensure that telephone management initiatives target call center and primary care team staff satisfaction and stability by prioritizing:  
- appropriate staffing  
- incentives for high-quality performance. |
<table>
<thead>
<tr>
<th>Suggestions for implementing the recommendation</th>
<th>Suggestions for call center staffing strategies include:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Assess overall call center staffing and turnover relative to call volumes and “right size” staffing, even if it means limiting the number of practices or clinics served by the call center at a given time.</td>
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<tr>
<td>• Ensure increased call center staff availability during typical high-volume call times.</td>
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<tr>
<td>• Incentivize call center personnel (e.g., ensure appropriate General Services levels for level of responsibility; reward high-quality performance; ensure pathways for advancement).</td>
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<tr>
<td>• Reduce friction and increase positive interactions between call center staff and clinical care teams (e.g., schedule meetings between the call center director and the care teams as needed to get buy-in for call center procedures).</td>
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<tr>
<td>Suggestions for primary care team staffing strategies include:</td>
<td></td>
</tr>
<tr>
<td>• Assess primary care team staffing, satisfaction, and stability in relation to telephone management demand (see Table 3.9, on provider experience).</td>
<td></td>
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<tr>
<td>• Ensure increased primary care team staff availability for responding to patient calls and call center messages during typical high-volume call times.</td>
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<tr>
<td>• Identify standard methods aimed at minimizing demand for telephone access while also minimizing demand for unnecessary in-person visits (e.g., robocall high-volume information, such as flu-shot reminders).</td>
<td></td>
</tr>
</tbody>
</table>

References and further reading for the recommendation


<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Ensure that patients with hearing loss or difficulty attending face-to-face visits are accommodated through telephone adaptations, print materials, or other virtual technologies.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level: Can be initiated by midlevel managers, including unit managers, primary care site leaders, or care team leaders</td>
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</table>

<table>
<thead>
<tr>
<th>Suggestions for implementing the recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Identify target vulnerable groups for ensuring telephone access; always include patients with mental health issues and patients with hearing loss.</td>
</tr>
<tr>
<td>• Assess patient telephone access and care experiences among other vulnerable patient groups seeking care at a given primary care site, such as those who live distant from the site; are homeless; are women veterans; are frail elderly; have language difficulties; or belong to ethnic, cultural, or sexual minorities. Institute training, technology, or protocols for ensuring appropriate and effective communication with clinic staff regarding needed care.</td>
</tr>
<tr>
<td>• Assess patient satisfaction with telephone access among each target vulnerable group, and institute training, technology, or protocols for improvement where needed.</td>
</tr>
<tr>
<td>• Ensure prompt availability of local help for mental health problems (e.g., “hot numbers” to primary care and to mental health specialty, or to an appropriately skilled triage, for patients with mental health problems, in addition to national suicide hotlines).</td>
</tr>
<tr>
<td>• Reach out to patients with mental health diagnoses proactively through a hotline.</td>
</tr>
<tr>
<td>• Identify patients with critical hearing loss, and proactively identify technology or alternative communication methods to accommodate telephone access.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>References and further reading for the recommendation</th>
</tr>
</thead>
</table>
### Table 3.4. Recommendations for Priority Action: Patient Access Experience

| Priority action |  
|-----------------|--------------------------------------------------|
| **Assess the quality of the patient’s experiences of access** (i.e., patient-rated access). We expect patient ratings to reflect both in-person and non-face-to-face (e.g., telehealth, telephone, secure messaging) care. |

| Recommendation Level: Must be initiated at the executive level |  
|------------------|--------------------------------------------------|
| Regularly assess patient access experiences at the primary care site patient population level, using a reliable and valid survey. |

| Suggestions for implementing the recommendation |  
|-----------------------------------------------|--------------------------------------------------|
| **Suggested surveys include:** |  
| • the Supplemental Access Items for the CAHPS® Health Plan Survey 5.0 |  
| • Survey of Healthcare Experiences of Patients Consumer Assessment of Health Plans – Patient-Centered Medical Home (SHEP CAHPS PCMH) questions on access. |  
| **Measures of timeliness alone are not sufficient:** |  
| • Assess both urgent/same-day access and routine access for new and established patients. |  
| • Measure timeliness of bonded and matched access (e.g., access to the patient’s assigned site, continuity provider, and team) separately from simple timeliness of access, particularly for nonurgent problems. |  
| • Incorporate the hassle factor in surveys of patient access experience. |  
| • Consider patient focus group input on existing patient survey designs and what the surveys do and do not reflect. |  
| • Consider the access experiences and perceptions of patient family members, who may be carrying much of the access burden for some patients. |  
| • Establish a patient and family advisory council for each primary care clinic to provide feedback to improve the patient access experience. |  
| **Recognize the following in interpreting results:** |  
| • The degree to which a visit met patient choice (e.g., whether, for a specific visit, bonding and matching were more important or urgency and timeliness were more important) will ultimately shape overall satisfaction. |  
| • Different types of patients (e.g., younger versus older, chronically ill versus healthy) have different priorities, as do patients who are anxious, in pain, missing work, or being affected in terms of other daily living activities. |  
| • Non-face-to-face modalities (e.g., telehealth, telephone, or secure messaging visits, particularly with continuity providers or teams) can substitute substantially for in-person visits and affect patient experience measures. |  

<p>| References and further reading for the recommendation |<br />
|-------------------------------------------------|--------------------------------------------------|</p>
<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Regularly collect real-time data in primary care sites at the time of visits.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level: Can be initiated by midlevel managers, including unit managers, primary care site leaders, or care team leaders</td>
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<tr>
<td>Suggestions for implementing the recommendation</td>
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<tr>
<td>Suggested surveys include:</td>
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<tr>
<td>- American Association of Family Physicians questionnaire at each patient primary care in-person contact</td>
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<tr>
<td>- Health Quality Ontario questionnaire at each patient primary care in-person contact</td>
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<tr>
<td>- Institute for Healthcare Improvement and Dartmouth College's &quot;Today's Office Visit Survey Card&quot; at each patient primary care in-person contact.</td>
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<tr>
<td>Suggested additional evaluations:</td>
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<td>- Follow up real-time assessments directly with patients that indicate “poor” or “dissatisfied” ratings, to discover what happened.</td>
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<td>- Conduct patient focus groups.</td>
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<td>- Ask real-time questions via patient kiosks.</td>
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<tr>
<td>- Use a “patient tracer” (i.e., a real or simulated patient) to evaluate the experience of making, scheduling, and undergoing an appointment.</td>
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<tr>
<td>- Carry out spot surveys focused on key site access issues over several weeks.</td>
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<tr>
<td>- Consider the access experiences and perceptions of patient family members.</td>
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<tr>
<td>- Develop a local patient experience template to reflect the key patient experience goals, barriers, and facilitators at the site.</td>
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</tr>
<tr>
<td>References and further reading for the recommendation</td>
<td></td>
</tr>
</tbody>
</table>
### Table 3.5. Recommendations for Priority Action: Group Practice Management Structure

<table>
<thead>
<tr>
<th>Priority action</th>
<th>Develop a clearly identified group practice management structure with a designated group practice manager who reports to executive leadership, communicates with individual primary care sites, and can collaborate across roles and service lines (e.g., medicine, nursing, administration).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recommendation</td>
<td>Identify a group practice manager position at a high enough level to report effectively to executive leadership while connecting executive leadership and relevant middle managers with frontline primary care practice–level access-related activities and concerns.</td>
</tr>
<tr>
<td>Level:</td>
<td>Must be initiated at the executive level</td>
</tr>
<tr>
<td>Suggested</td>
<td>Characteristics of successful group practice managers (GPMs) include that the GPM:</td>
</tr>
<tr>
<td>for implementing</td>
<td>• serves as the point person for helping local primary care site leaders respond effectively to both central and frontline demands</td>
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<tr>
<td>the recommendation</td>
<td>• reports to the executive team, participates in organizational strategic planning, and has sufficient authority to implement needed improvements</td>
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<td></td>
<td>• has both good people skills and data skills, and uses them to enable and monitor access improvement while also managing expectations</td>
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<td></td>
<td>• has oversight for the access management program, including identifying gaps and establishing processes to close them.</td>
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<tr>
<td>Recommendation</td>
<td>Identify and document the specifics of a group practice management program and team, including key stakeholders in the team’s success, and ensure that the team is trained in (a) how to promote stakeholder engagement, including frontline staff, and (b) how to access and use data for improvement.</td>
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</tbody>
</table>
| Level: Can be initiated by midlevel managers, including unit managers, primary care site leaders, or care team leaders | **Suggestions for implementing the recommendation**  
- Create an orchestrated access management team in each facility.  
- Incentivize clinicians and staff members to work in teams to address the issue of hierarchy, which limits sharing of information and experience; clarify roles. Engage team members by providing feedback on improvement measures and how changes are improving the situation for patients.  
- Incorporate flexibility into the access management program to be able to customize the program to unique site and patient needs.  
- Create a group practice management culture that is goal-directed rather than punitive and that focuses on improvement.  
- Identify or develop tools to track and manage patient care, and use the tools to inform executive management.  
- Expect and overcome resistance when decisionmaking crosses professional silos; build psychological safety into improvement efforts to address risk aversion; promote a culture of problem-solving.  
- Display GPM-gathered data in one place (e.g., a dashboard) where the data can be easily reviewed by the GPM and shared with others (e.g., clinic leaders) to identify and solve problems.  
- Ensure that GPM-gathered data are clean and accurate and reflect what is being done to facilitate access to care and enable decisionmaking.  
- Training for group practice managers is critical, particularly regarding acquiring, utilizing, and communicating data.  
- Engage team members by providing feedback on improvement measures and how changes are improving the situation for patients.  
- Engage all team members regardless of hierarchy in understanding the value of data generation and use in improvement and change programs.  
- Ensure that the GPM team is trained in advanced access techniques.  
- Train GPMs in inter-professional shared decisionmaking, such as shared governance (see Table 3.6, on the identification of primary care practice site leaders). |
<table>
<thead>
<tr>
<th>References and further reading for the recommendation</th>
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</table>
Table 3.6. Recommendations for Priority Action: Identification of Primary Care Practice Site Leaders

<table>
<thead>
<tr>
<th>Priority action</th>
<th>Identify physician, registered nurse, and administrative leaders for each primary care practice site with authority to support access management priorities within local site contexts.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recommendation</td>
<td>Ensure that the inter-professional structure of team-based care models, such as the patient-centered medical home, is reflected in strong integrated inter-professional governance at the primary care practice site level, including explicitly identified site-level physician, RN, and administrative leaders.</td>
</tr>
<tr>
<td>Level: Must be initiated at the executive level</td>
<td></td>
</tr>
</tbody>
</table>
| Suggestions for implementing the recommendation | • Consider models of shared governance at the local level. Shared governance is a system of management that aims to empower staff in decisionmaking at the local unit level, such as at the primary care practice level, with the goal of enabling health care professionals to develop multi-professional care. In the United States, much of the shared governance focus has been on nurses as participants in shared governance, often in hospitals. In the United Kingdom, there has been significant focus on primary care, and on the role of administrative managers. There are few empirical quantitative outcome studies on these models; however, there is substantial qualitative evaluation information supporting them.  
• Ensure strong central (executive) leadership engagement, including allocation of resources, such as staff time, in implementing a shared governance model; without this, very autonomous practices without a prior shared governance culture are unlikely to succeed.  
• Assess and improve primary care practice leadership team communication by developing willingness to participate in shared decisionmaking and ability to focus on task conflict and differences in opinion rather than on personality differences and interpersonal tensions.  
• Avoid top-down pressure to deliver rapid measurable changes, lack of attention to professional autonomy, and a focus on blame. These are major impediments to success (balance with standardization).  
• Promote open accountability, willingness to learn across disciplines or professions and from mistakes, and willingness to problem-solve through quality improvement. These characteristics are linked to the concept of psychological safety, which is predictive of success.  
• Legitimize and balance managerial (administrative) and health care professional (physicians, nurses, and others) perspectives; respect for professional autonomy and for the benefits of shared administrative approaches are essential.  
• Develop approaches for sharing learning across primary care practices; this can facilitate effective local practice site leadership. |

References and further reading for the recommendation


**Recommendation**

Level: Can be initiated by midlevel managers, including unit managers, primary care site leaders, or care team leaders

**Suggestions for implementing the recommendation**

- Teach the teachers (practice site leaders) to use and transmit the problem-solving approaches typical of high-functioning teams, including, for example, practice redesign and quality improvement techniques.
- Develop organizational strategies that facilitate success for local quality improvement innovation.

**References and further reading for the recommendation**


Ensure that inter-professional primary care practice leadership is trained in problem-solving approaches and in how to teach these to providers and staff.
<table>
<thead>
<tr>
<th>Priority action</th>
<th>Maximize access managers’ routine use or ability to demonstrate systematic approaches to ensuring adequate availability of contingency staffing (i.e., planned minimal excess staffing to cover routine absences, such as those resulting from hiring gaps, vacations, illness).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recommendation</td>
<td>Analyze demand data and use that information to anticipate upcoming needs for contingency staffing either from internal staffing resources (e.g., local or regional primary care teams) or from external sources (e.g., contracted temporary staffing). Contingency staffing is a work-force method in which staff members are hired as and when needed for limited periods of time.</td>
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</tbody>
</table>
| Level: Must be initiated at the executive level | Suggested approaches to predicting demand include:  
- Use demand data to predict daily, weekly, and seasonal demand and adjust staffing accordingly.  
- Add more appointment times for seasonal events, such as seasonal migration from cold climates to warm climates, flu shot clinics during flu season, or pre-school physicals for clinics serving children.  
- Assess any backlog and consider whether contingency staffing is needed to reduce or eliminate it.  
- Plan to cover leave times by reviewing past-year leave data. Then calculate the contingency staffing needed to cover leave and arrange for it on a routine basis, such as by hiring or arranging for regular but intermittent additional contingency staff to cover leave times.  
Suggested approaches to matching contingency staffing supply to demand include:  
- Use daily huddles to review demand and to proactively match daily supply and demand, identifying any upcoming needs for contingency staffing.  
- Schedule discretionary time for providers to cover absences of other providers or team members.  
- Minimize the need for contingency staffing through planned management of provider leave time (e.g., hold time in a vacationing provider’s schedule for the first week back from vacation; when the provider leaves, start filling morning appointments of the return week; and when provider returns, start filling afternoon appointments of that week).  
- Plan for the sudden absence of a provider or other team member—short-term (e.g., sick day) or long-term—by identifying emergency contingency staffing sources (e.g., through community support agencies and care management companies or through shared internal staff across panels).  
- Minimize the use of external contingency staffing by cross-training team members and internal contingency staff (e.g., float team trained to cover responsibilities throughout the clinic when needed; scheduling staff trained to clean instruments and set up rooms for procedures; nursing staff trained to do scheduling if necessary; scheduling or reception staff trained to gather patient information and assign patients to exam rooms; check-in and check-out staff trained to fill in for each other; physicians, nurse practitioners, and physician assistants trained to substitute for each other). |
| References and further reading for the recommendation | Health Quality Ontario, “Predict the Expected: Contingency Plans to Manage Advanced Access Schedules,” Toronto, undated.  
Institute for Healthcare Improvement, “Changes: Optimize the Care Team,” webpage, undated-a.  
Table 3.8. Recommendations for Priority Action: RN Demand Management and Care Coordination Role

<table>
<thead>
<tr>
<th>Priority action</th>
<th>Maximize the ability of the primary care team’s registered nurses to prospectively manage demand by leading care coordination for their panels.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recommendation</td>
<td>RNs should be specifically trained and supported to become leaders in proactive demand management and care coordination at three distinct levels (RN executives, RN site-level or multisite-level nurse managers, and RN team-level care coordinators).</td>
</tr>
</tbody>
</table>
| Level: Must be initiated at the executive level | Training at each level should include, for example:  
- appropriate leadership skills (e.g., inter-professional communication, understanding access and care coordination, development of RN primary care careers and roles)  
- basic primary care access and care coordination management and outcome measures, as well as RN roles in promoting access improvement  
- primary care team functioning and the RN role within it  
- panel management based on data, such as dashboards or care coordination software  
- available alternatives to individual in-person visits, such as telehealth, telephone care, secure messaging, group visits, and e-consults  
- contingency management (see Table 3.7, on development of contingency staffing)  
- demand management (see Table 3.10, on maximizing the ability to manage demand). |
| Support should include: | ensuring that RNs have the appropriate level of authority and appropriate time allocation for achieving effective hands-on demand and care coordination management. |

References and further reading for the recommendation

### Table 3.9. Recommendations for Priority Action: Provider Experience

<table>
<thead>
<tr>
<th>Priority action</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assess primary care provider and staff morale (e.g., low/high burnout, job satisfaction, or turnover rates) in relation to access mismatch (e.g., panels exceeding recommended size, primary care provider vacancies).</td>
<td>Develop a central organizational focus on tracking primary care provider and staff morale (including retention, recruitment) in relation to access mismatch at the local primary care practice, local health care system (medical center), and regional levels.</td>
</tr>
<tr>
<td><strong>Suggestions for implementing the recommendation</strong></td>
<td></td>
</tr>
<tr>
<td>Assess each primary care practice for supply versus demand mismatch at the site level:</td>
<td></td>
</tr>
<tr>
<td>• Assess overall patient numbers at each primary care practice site, calculated as the patient load (e.g., the number of primary care patients seen at the site + the number on a wait list in the prior year) versus the expected number of patients that currently available providers and staff could see (e.g., the number of full-time employment equivalent providers, teamlets, or patient panels × the number of patients expected to be cared for per provider, teamlet, or panel at the site). If the difference between the expected number of patients that could be seen and the number of patients seen or waiting to be seen last year is substantial, that is a major mismatch that is likely to cause provider and staff burnout.</td>
<td></td>
</tr>
<tr>
<td>• Ensure that data assessing burnout and turnover in relation to local primary care site supply versus demand mismatch are assessed and communicated at regular intervals to regional and local health care system leadership.</td>
<td></td>
</tr>
<tr>
<td><strong>Use standard measures to assess morale, such as:</strong></td>
<td></td>
</tr>
<tr>
<td>• burnout (e.g., the Maslach Burnout Inventory [MBI], including MBI-Human Services Survey, MBI-Human Services Survey for Medical Personnel, or MBI-General Survey)</td>
<td></td>
</tr>
<tr>
<td>• job satisfaction (e.g., Areas of Worklife Survey that assesses aspects of work experience; Institute for Healthcare Improvement job satisfaction measure)</td>
<td></td>
</tr>
<tr>
<td>• provider and staff turnover (e.g., Institute for Healthcare Improvement Measure of Nurse Turnover Rate assessing the number of voluntary uncontrolled separations during the month for unit registered nurses and advanced practice nurses divided by the number of unit employees [full-time + part-time] on the last day of the month for registered nurses and advanced practice nurses, multiplied by 100 to get the percentage).</td>
<td></td>
</tr>
<tr>
<td><strong>Focus on supply-demand mismatch, but assess additional causes of low morale:</strong></td>
<td></td>
</tr>
<tr>
<td>• Assess provider and staff turnover, burnout, and staff satisfaction in relation to changes in access management, such as implementation of advanced access features.</td>
<td></td>
</tr>
<tr>
<td><strong>Focus on both retention and recruitment:</strong></td>
<td></td>
</tr>
<tr>
<td>• Assess current provider and staff retention incentives and whether they are sufficient to retain providers and staff in locations with access mismatch.</td>
<td></td>
</tr>
<tr>
<td>• Interview departing providers and staff to assess reasons for leaving, categorize causes, and report periodically (e.g., yearly) to leadership.</td>
<td></td>
</tr>
<tr>
<td><strong>References and further reading for the recommendation</strong></td>
<td></td>
</tr>
</tbody>
</table>
Health Services Research & Development Service, FORUM: Translating Research into Quality Health Care for Veterans, Boston, Mass.: Veterans Health Administration, Fall 2015.


### Table 3.10. Recommendations for Priority Action: Maximization of the Ability to Manage Demand

<table>
<thead>
<tr>
<th>Priority action</th>
<th>Recommendation Level: Can be initiated by midlevel managers, including unit managers, primary care site leaders, or care team leaders</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Maximize primary care team members’ ability to proactively manage demand (e.g., alerts, reminders, and telephone contacts from patients on their panels) by optimizing provider visit schedules (e.g., through triage, prospective “scrubbing” of appointments to the extent appropriate given their training/licenses).</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Train primary care site leaders and teams in four key principles of proactively managing demand, including:</strong></td>
<td></td>
</tr>
<tr>
<td>• analyzing site-level data on past demand to plan short-term supply (i.e., workforce) adjustments</td>
<td></td>
</tr>
<tr>
<td>• enabling providers to achieve needed same-day continuity visit availability by right-sizing their panels and by using advanced access principles</td>
<td></td>
</tr>
<tr>
<td>• integrating patient preferences into all aspects of access management</td>
<td></td>
</tr>
<tr>
<td>• using data resources to track site-level and team-level access (e.g., through dashboards).</td>
<td></td>
</tr>
</tbody>
</table>

**Suggestions for training of primary care site leaders and teams include developing and implementing:**

• an open, engaged, problem-solving culture, not a punitive culture, around improving access
• flexibility relative to local primary care site limitations and resources and on how to get assistance for problems implementing advanced access principles, especially when overall local primary care site workforce supply is inadequate to meet demand
• use of advanced access principles, including adjusting return visit rates, enabling same-day continuity access, and matching provider expected and actual availability to see patients
• support for use of non-face-to-face encounter methodologies (see Table 3.3, on telephone access)
• procedures for addressing patient preferences in arranging either face-to-face or non-face-to-face visits, especially when trade-offs between appointment promptness and desire to see a continuity team member are required
• scripts to let the patient decide whether to wait for his or her provider to return from a scheduled leave or to be scheduled with his or her team or a different provider
• patient education about the team approach and about alternative care options with team members
• patient education about opportunities to contact the care team (e.g., telephone, email, or a patient portal) to enhance continuity (see Table 3.3, on telephone access).

**Suggestions for anticipating demand and adjusting supply include the following:**

• Measure past demand and use data to predict demand daily, weekly, and seasonally and to schedule supply (i.e., primary care workforce) accordingly.
• Distinguish between activity (number of patients seen) and demand (number of requests for care), and focus on meeting the demand rather than the amount of activity.
• Monitor overflow visits during periods of low access, such as preventable emergency department or urgent care visits, and account for the demand these patients represent.
• Identify opportunities and plan for group visits or consultations with patients requesting or needing frequent visits (e.g., patients with chronic illnesses).
• Develop roles for team members other than providers for subpopulations of patients (e.g., those with congestive heart failure, those with hyperlipidemia, or those using anticoagulation).
• Plan for nurse practitioners and physician assistants to see patients of absent providers and/or to have their own panels.
• Plan to spread high demand times, such as for school physicals and flu shots, over a longer period of time (e.g., schedule school physicals on the patient's birthday).
### References and further reading for the recommendation

- Eliminate the distinction between routine and urgent appointments; distinguish, instead, between short and long (multiples of short) appointments (e.g., annual exams, new patients, chronic illness patients).
- Measure nonappointment delays and efficiency (e.g., telephone message).
- Plan to use tele-pharmacy, tele-primary care, and tele–mental health hubs.
- Encourage providers to accomplish as much as possible during patient visits, anticipate patient near-term visit needs, and select follow-up visit intervals based on patient needs.
- Assess management of telephone care (see Table 3.3, on telephone access).

Achieving optimal access to health care for eligible populations is a complex process that must be sensitive to changes in patient characteristics (e.g., mix, health care use, and preferences) in combination with changes in provider, other staff, and space availability. The process is also shaped by organizational context, and, to some extent, actions and recommendations must be site specific. While access management is critical for all health care services, access to primary care is of particular importance to integrated health care systems because of the critical functions performed by primary care providers (Bhat, 2005).

Achieving optimal access involves addressing process, structural, and cultural challenges (Institute of Medicine, 2015). These include having appropriate organizational and clinical performance measures; flexible technology to accommodate digital medical records, patient portals, and telephone access systems; capacity to balance staffing and facility availability with patient demand; and supportive, trained leadership at multiple levels. Although many health care organizations have made changes in access management policies (Institute of Medicine, 2015), empirical evidence evaluating different access management approaches is sparse.

We assembled a broadly representative expert panel with extensive experience to identify key priority actions to guide organizations attempting to achieve optimal access. Expert panels can provide a basis for moving forward when existing research is insufficient. Panel results can, in turn, provide a rigorously examined basis for further investigation. We primed the panel with a systematic review of the research literature and qualitatively analyzed results of interviews with VHA group practice managers. The expert panel process identified eight priority actions that were endorsed by more than half of the panelists as both important and urgent for achieving optimal access. The priority action with the greatest level of agreement (i.e., 100-percent agreement) addressed telephone access for patients:

Routinely evaluate the degree to which patient telephone calls are (a) answered promptly and (b) routed accurately and appropriately, as judged in terms of patients’ clinical needs and preferences.

Other priority actions identified included two related to organizational structure (establishing a clearly identified group practice management structure with a designated group practice manager and identifying clinical and administrative leaders at each site), three related to process improvement (maximizing systematic approaches to contingency staffing, maximizing registered nurses’ opportunities to manage demand through care coordination, and proactively managing demand by optimizing provider visit schedules), and two related to outcomes (assessing the quality of patient experiences of access and assessing provider and other staff morale in relation to access mismatch).
With expert panel review, discussion, and comments based on a review of published literature and access management workbooks, we developed recommendations and suggestions for implementation of the eight priority actions. The format we developed is designed to allow primary care sites to identify implementation steps that are appropriate for their sites. For example, one recommendation for improving patient telephone access addresses patients with mental health or hearing challenges:

- Ensure that patients with hearing loss or difficulty attending face-to-face visits are accommodated through telephone adaptations, print materials, or other virtual technologies.

Suggestions for implementing this recommendation, in the context of ongoing programs or prior investigations, could be selected from the following list by a primary care site team:

- Identify target vulnerable groups for ensuring telephone access; always include patients with mental health issues and patients with hearing loss.
- Assess patient telephone access and care experiences among other vulnerable patient groups seeking care at a given primary care site, such as those who live distant from the site; are homeless; are women veterans; are frail elderly; have language difficulties; or belong to ethnic, cultural, or sexual minorities. Institute training, technology, or protocols for ensuring appropriate and effective communication with clinic staff regarding needed care.
- Assess patient satisfaction with telephone access among each target vulnerable group, and institute training, technology, or protocols for improvement where needed.
- Ensure prompt availability of local help for mental health problems (e.g., “hot numbers” to primary care and to mental health specialty, or to an appropriately skilled triage, for patients with mental health problems, in addition to national suicide hotlines).
- Reach out to patients with mental health diagnoses proactively through a hotline (Buell, Huckman, and Travers, 2016).
- Identify patients with critical hearing loss, and proactively identify technology or alternative communication methods to accommodate telephone access.

Technology advances have substantial implications for access to health care and management of health care access. The introduction of secure messaging, telemedicine options, and the ability to book appointments online has increased the number of modes of primary care contact, as well as the complexity of managing access in primary care. Although increases in the opportunity for primary care access through technology may have the potential to increase in-person provider encounters and decrease capacity for accommodating new patients (Bavafa, Hitt, and Terwiesch, 2018), the panel recognized that optimal access is a balance between (1) patient preferences and needs and (2) provider, other staff, space, and other resource availability that must be continually adjusted to assure that patients receive optimal care. To achieve this goal, the panelists emphasized the importance of supportive and effective leadership to establish a clearly identified group practice manager structure with a designated group practice manager.
Our study had both strengths and limitations. The results we describe are derived from a large and unique panel process representing a diverse range of stakeholders in health care access management. However, more than half of the panelists had VHA backgrounds. The panel represented North American input and was focused on the U.S. health care system—in particular, the type of managed care offered by the VA and other large not-for-profit health care systems.

We did not achieve (and did not aim to achieve) full agreement among panelists; we followed strict procedures to identify rather than coerce consensus. We elicited responses with a comprehensive survey informed by a logic model and available empirical evidence, building on what is already known in this highly complex area. We developed materials, such as the vignettes, to facilitate meaningful discussion, but we acknowledge that we presented only examples and by no means an exhaustive set of critical access management situations.

Access to health care is very complex. It can be addressed from a population-based perspective (i.e., ensuring population health), as well as a more concrete supply and demand perspective. The developed recommendations translating the priority actions often address both perspectives. It can be argued that supply and demand issues must be addressed to effectively improve population health. However, we acknowledge that both perspectives of access are valid, and future work may want to differentiate the perspectives more clearly and develop more-targeted recommendations.

We translated expert panel discussions into key priority actions that can help guide primary care access management improvement initiatives within health care organizations that are accountable for the health of defined populations. For each priority action, we developed recommendations and suggestions for implementation. Implementation of these priorities will require commitment from practitioners, primary care managers and leaders, consumers, and policymakers. There are likely additional variables that different health care systems may want to consider, including cost-sharing as a potential access management strategy.

Implications for Research and Practice

Review of the priority actions, recommendations, and suggestions for implementation may be useful to managers at all levels, from executive to frontline, as a guide for improving access. In some cases, primary care site level managers may be able to undertake an improvement directly. In many cases, managers may benefit from initiating a more comprehensive access improvement planning effort, involving leaders at the executive level and frontline staff. In either case, the first step will be choosing specific priority actions and recommendations to focus on.

Future research and individual quality improvement projects may specifically review utilization. Studies would need to analyze the percentage of the eligible patient population accessing primary care and the average number of contacts in a given time frame, both stratified by mode of primary care contact. Modes with high volumes may suggest where access
management is required the most. This assessment will determine how improvements align within the organization’s or unit’s unique requirements.

Considerations for choosing priority actions may include review of relevant organizational data (e.g., performance data) and consideration of the importance and feasibility of the area or recommendation relative to organizational goals and resources. In general, identifying one or, at most, three recommendations from within a chosen priority action may lead to greater success than taking on too much at once.

Conclusion

Defining optimal access and conceptualizing access management components are instrumental in determining the goals of access management improvement initiatives, in facilitating evaluations to determine the success and impact of strategies within a health care delivery organization, and in shaping the organizational processes and resources needed. The expert panel established a parsimonious set of action-oriented management priorities for guiding initiatives aimed at improving primary care access management that were translated into recommendations and suggestions for implementation.


Health Quality Ontario, “Predict the Expected: Contingency Plans to Manage Advanced Access Schedules,” Toronto, undated. As of June 29, 2018:

———, “Advanced Access and Efficiency Workbook for Primary Care,” Toronto, July 2011. As of June 29, 2018:


Institute for Healthcare Improvement, “Changes: Optimize the Care Team,” webpage, undated-a. As of April 12, 2018:
http://www.ihi.org/resources/Pages/Changes/OptimizetheCareTeam.aspx

———, “Measures: Percent of Voluntary Nurse Turnover,” webpage, undated-b. As of April 12, 2018:
http://www.ihi.org/resources/Pages/Measures/VoluntaryNurseTurnover.aspx

———, “Today’s Office Visit Survey Card,” webpage, undated-c. As of April 12, 2018:
http://www.ihi.org/resources/Pages/Tools/TodaysOfficeVisitSurveyCard.aspx


Appendix A
Flow Chart of Patient Access to Primary Care and Characteristics Affecting Achievement of Optional Access

To understand access management processes better, we developed a flow chart to conceptualize patient access to primary care (Figure A.1). The chart shows different ways for patients to get access to primary care in person or by telephone, ranging from scheduled appointments to walk-ins. It also depicts the system and patient characteristics featured in literature as affecting flow.

Specifically, the chart depicts how patient-level factors may influence demand for care and how system-level factors can facilitate access to care (here defined as types of appointments and types of visits). Call triage and patient-centered medical home features may influence the availability of appointments. These, in turn, are influenced by middle management and facility or health care system characteristics. In addition, poor access to specialty care can result in greater workload for primary care clinics, influencing patient access to appointments and visits.
Figure A.1. Flow Chart of Patient Access to Primary Care and Characteristics Affecting Achievement of Optional Access
Appendix B

Literature Collection Informing the Recommendations and Suggestions for Implementation

This appendix lists literature that informed our recommendations for achieving the described priority actions and suggestions for implementing those recommendations. We compiled the list from the results of the systematic review on access management, as well as from targeted searches of online databases, reports, and other gray literature.


Alessandrini, Evaline, and Arnold Strauss, “Developing and Implementing a Standard Dashboard for All Medical and Surgical Divisions at Cincinnati Children’s Hospital,” presentation at the 2012 ELAM Leaders Forum, Cincinnati, Ohio: Cincinnati Children’s Hospital, 2012.


Cincinnati Children’s Hospital, “Managing Capacity to Improve Care,” webpage, 2016. As of June 29, 2018: https://www.cincinnatichildrens.org/service/j/anderson-center/capacity-management


Health Quality Ontario, “Predict the Expected: Contingency Plans to Manage Advanced Access Schedules,” Toronto, undated. As of June 29, 2018:  

———, “Advanced Access and Efficiency Workbook for Primary Care,” Toronto, July 2011. As of June 29, 2018:  

———, “Advanced Access and Efficiency for Primary Care,” Toronto, 2018. As of January 2, 2018:  
https://machealth.ca/programs/advanced-access-efficiency-primary-care/


https://www.rand.org/pubs/research_reports/RR1165z2.html


———, “Changes: Optimize the Care Team,” webpage, undated. As of April 12, 2018: http://www.ihi.org/resources/Pages/Changes/OptimizetheCareTeam.aspx


machealth, “Advanced Access and Efficiency for Primary Care,” webpage, 2015. As of May 5, 2017:
https://machealth.ca/programs/advanced-access-efficiency-primary-care/


Maslach, Christina, and Susan E. Jackson, “MBI—Human Services Survey,” Mind Garden, 1986. As of June 29, 2018:


Prior to the in-person panel meeting, we sent panelists a survey to identify areas of agreement and disagreement that should be discussed further. The survey content was informed by the logic model (see Figure 1.1) and the existing evidence. The survey addressed five content areas:

1. patient populations, service and practice contexts
2. evaluating and managing supply and demand in primary care
3. promoting successful group practice management
4. managing demand: identifying and managing complex or challenging patients
5. access management outcomes.

In this appendix, we reproduce the survey.
The following survey asks about access management from the point of view of primary care. We have used an online Microsoft WORD format that records data to make it easy for panelists to view the entire survey and to move forward or backward within it. This format, however, requires that you click carefully over the drop down boxes. If you prefer, you can print out the survey and fill it out on paper and mail back by 1/27/2017 to:

Patty Smith  
RAND Corporation  
1776 Main Street  
Santa Monica, CA 90407  
USA

The survey is informed by the draft logic model and data sources made available to you in your pre-panel materials. Feel free to consult these. We are also interested in any comments you may have on the materials; you can email us and/or please bring your comments to the meeting.

INFORMED CONSENT

Please read the information below before proceeding to the survey.

Research description: The goal of this project is to develop key recommendations for access management, with a focus on primary care. We will use a modified Delphi approach consisting of two online surveys that will each take about one to two hours of your time and a two-day in-person meeting. Over the course of the project you will be asked to review the results of recent efforts to identify successful access models and rate different access measures and management methods based on the evidence base, feasibility, and importance for the VA. Consensus finding will involve group discussions and anonymous rating.

Risks and benefits: There will be no risks related to participation in this project. During the completion of the surveys, if a question is not applicable to you or you feel uncomfortable answering it, please complete it to the best of your ability or skip it. The project aims to improve our understanding of how to manage access to primary care and the services it links patients to, with the ultimate goals of improving both patient health and patient experiences in care. While the VA initiated this effort, we expect its results to apply to other large population-based healthcare organizations as well. The
The project expects to accomplish these goals by establishing key recommendations regarding access management that will benefit primary care organizations.

**Participation and withdrawal:** Participation in the project is entirely voluntary. You have the right not to participate at all, to leave the project at any time, and to decline to be acknowledged as a panelist. Deciding not to participate or choosing to leave the study will not result in any negative consequences. If you decide that you cannot participate or cannot attend the in-person meeting, we will ask that you nominate someone else to join the panel (if possible).

**Confidentiality:** Your name will not be linked to your survey responses in any feedback of results to the group. We will circulate final recommendations for your approval and comments prior to dissemination. Project results will be accessible only to the project team. Survey responses and discussion points will be documented in aggregate form across participants. You will be asked for consent to be named as a content expert in future publications describing the results of the project.

**Contact information:** If you have questions about this research, please email Susanne Hempel (susanne_hempel@rand.org) or Lisa Rubenstein (Lisa.Rubenstein@va.gov). If you have questions about your rights as a research participant or need to report a research-related injury or concern, you can contact RAND’s Human Subjects Protection Committee toll-free at 866 697 5620 or by emailing hspcinfo@reand.org. If possible, when you contact the Committee, please reference Study # 2016-0610.

**Consent:** Your consent to participate in this project is implied by submitting your responses after completion.

Your Name (for tracking only):
PURPOSE: The purpose of the Access Management Expert Panel is to identify recommendations for inter-professional leaders at multiple levels in the Veterans’ Health Administration (VHA or VA) regarding access management. The survey aims to identify the most important areas for discussion at the in person meeting.

DEFINING ACCESS MANAGEMENT: Access management encompasses the set of goals, evaluations, actions and resources needed to achieve optimal use of healthcare services by defined eligible populations of patients. Optimal access incorporates considerations of equity, patient preferences, patient needs, and value.

Any comments on the general definition above:

THIS EXPERT PANEL AND SURVEY: This survey’s focus is on access management in relationship to primary care. When questions involve specialties, they focus on the primary care perspective—i.e. access management for patients seen in primary care. The survey aims to identify priorities related to access management for the Veterans Health Administration and may apply to other large population-based healthcare organizations you are familiar with.

VA CONTEXT: In VA, Central Office houses top level executives and a variety of specific offices dedicated to particular strategic or operational functions. Central Office reports to Congress and leads 22 administrative regions, called Veterans Integrated Service Networks (VISNs). Each region manages four to eight local healthcare systems. A local healthcare system usually but not always includes a hospital. The hospital or other medical center facility houses the local health system’s executive team. The executive team leads all services in the local system such as hospital, nursing homes, special units and hospital and community based outpatient clinics (CBOCs). These outpatient clinics may be VA-owned, or contract providers. Some specialists are based in outpatient clinics, although the majority are based centrally in each healthcare system. In VA, management of local healthcare systems vary; some are tightly organized, others are quite diffuse. Typically the CBOCs located at greater distances from their central management (e.g. medical center) operate more autonomously. The number of affiliated clinics can vary from few (2-3) to many (12).

VA panelists in particular should consider the importance of items asked on the survey not just in terms of current needs, but in terms of developments for the future. For example, we know that VA’s information technology will change in coming years. By considering which information technology-based access management features are important for the future, even though these features may not be currently feasible, panelists can prioritize around future needs.

EVIDENCE BASE ON ACCESS: The availability of rigorous evidence on access evaluation and management is relatively sparse. We have therefore relied on assessing published but not necessarily empirically tested tools and perspectives as much as on rigorous empirical literature in identifying survey questions. There is also little rigorous evidence on health effects of access management features. We therefore assume beneficial population effects of optimal access, and ask questions regarding what it takes to achieve optimal access. Your views will be critical in building a stronger access management foundation over time.

THE PERSPECTIVE FOR ANSWERING SURVEY QUESTIONS: Please assume that VA or another organization you have in mind has recently or is about to undertake an initiative to improve access management in primary care, including access to key services typically used through orders from primary care providers.

As you answer the survey questions, please keep in mind that the ultimate goal of access management initiatives is achievement of high value care. This will reflect a balance between meeting patient desires and achieving optimal
population access to needed care, such that patient experience, patient health outcomes, and economy of care are considered. The survey seeks your perspective on the best recommendations for achieving an optimal balance.

Areas of disagreement or of confusion are typically important to discuss during the in-person meeting. Please do not be concerned if a question is not understandable to you; just answer the questions you can as well as you can. The area of access management is not well defined in the literature, and we expect that issues of technical knowledge and term definition will arise. When important, these can be discussed at the meeting.

SURVEY SECTIONS: The survey sections focus on recommendations regarding:

I. Patient Populations, Service and Practice Contexts
II. Evaluating and Managing Supply and Demand in Primary Care
III. Developing an Organizational Culture Favorable to Access Management
IV. Managing Demand: Identifying and Managing Complex or Challenging Patients
V. Access Management Outcomes

RATING GUIDE: The wording for ratings and the columns vary somewhat. In general, the following rating columns are included.

**Column A:** When present, this column asks an orienting question regarding the topic.

**Column B:** Asks you to rate the priority of the indicated item. To rate priority, you may include for example the item’s importance, the urgency of addressing it, the feasibility of addressing it, or any other consideration you may have and integrate these into your final rating. We ask you to rate each item on a continuum from very low priority (1) to very high priority (5). Please keep in mind that category 5 (very high priority) should be used sparingly throughout the survey. We are trying to determine the relative importance and acknowledge that not all important item can be addressed at once.

As a guide:
1 = very low priority; or need not be addressed
2 = low priority; should be addressed over the next decade
3 = medium priority; should be kept in mind by initiative organizers and addressed within the next five years
4 = high priority; should be kept in mind by initiative organizers and addressed within the next three years
5 = very high priority; must be addressed by initiative organizers this year

Please aim to use category 5 sparingly such as no more than once or twice per section or subsection.

**Column C:** When present, this column asks you to rate the priority for discussing the item at the face-to-face meeting. For example, items that you think are important, but that are likely to show disagreement among the group, that are unclear, or for which there is uncertainty may be particularly important as a focus for discussion.

At the end of the survey, we include several vignettes composed from sites we have visited in the course of qualitative evaluation or quality improvement. We welcome your optional comments on these; we hope they bring forward some of the challenges different types of primary care sites face in attempting to achieve optimal access.
**Instructions:** The first and second subsections below ask you about the relative importance of taking account of specific patient (subsection 1) or primary care practice (subsection 2) characteristics in evaluating and managing access. For example, access measures could be designed to subsample on these characteristics and thus identify problems requiring special management. Subsection 3 then asks about the importance of problems accessing specialty care in impeding primary care access through increased demand/workload.

---

### 1. Patient populations requiring special access management attention to assure access to needed services:

Access management literature identifies a variety of types of patients practices should consider as they assess access or develop access improvements. Those rated high priority should be routinely assessed at appropriate intervals. In some cases, these populations may require links to specialized services, or adaptions to typical access management resources.

<table>
<thead>
<tr>
<th>Patient Demographic or Social Characteristics That May Interfere with Use of Key Access Resources</th>
<th>A. Is it likely that a disparity in access exists relative to this characteristic? (Y = Yes N= No/don’t know)</th>
<th>B. What should the priority be for taking account of this characteristic in assessing or managing access? (0 = cannot answer; 1 = very low priority or need not be addressed, 2= low priority, 3= medium priority, 4 = high priority, 5 = very high priority, must be addressed this year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Difficulty getting to clinic (i.e., is home bound, transportation difficulties, lives far away from nearest primary care practice, is homeless)</td>
<td>Y</td>
<td>0</td>
</tr>
<tr>
<td>b. Difficulty using computers (limited computer access, low computer literacy, blind, homeless, non-English speaking)</td>
<td>Y</td>
<td>0</td>
</tr>
<tr>
<td>c. Difficulty using the telephone (limited telephone access, hearing loss, homeless, non-English speaking)</td>
<td>Y</td>
<td>0</td>
</tr>
<tr>
<td>d. Difficulty reading or getting mail (blind, learning disabled, low education, homeless, non-English speaking)</td>
<td>Y</td>
<td>0</td>
</tr>
<tr>
<td>e. Women Veterans</td>
<td>Y</td>
<td>0</td>
</tr>
<tr>
<td>f. Sexual minorities (lesbian, gay, bisexual, transgender)</td>
<td>Y</td>
<td>0</td>
</tr>
<tr>
<td>g. Belonging to an ethnic minority (Native American, African American, Hispanic)</td>
<td>Y</td>
<td>0</td>
</tr>
<tr>
<td>h. Other (specify):</td>
<td>Y</td>
<td>0</td>
</tr>
</tbody>
</table>
### 2. Primary care practice types requiring special access management attention

The characteristics below have been shown to affect a wide variety of site level access-related outcomes. Those rated high priority should be routinely assessed at appropriate intervals and recognized in judging access performance. In some cases, these practices may require adaptations to typical access management approaches.

<table>
<thead>
<tr>
<th>Primary Care Practice Site Context</th>
<th>Is it likely that a disparity in access exists relative to this characteristic?</th>
<th>What should the priority be for taking account of this characteristic in assessing or managing access?</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Site is in an urban or rural medically underserved county or service area</td>
<td>Y</td>
<td>0</td>
</tr>
<tr>
<td>b. Few or no on-site or easily accessible VA specialists or specialty services (e.g., small sites)</td>
<td>Y</td>
<td>0</td>
</tr>
<tr>
<td>c. Complex access management due to academic or part time clinicians, very large size, or trainees</td>
<td>Y</td>
<td>0</td>
</tr>
<tr>
<td>d. High demand for services from Veterans/enrollees living far from the practice site and/or the nearest VA hospital</td>
<td>Y</td>
<td>0</td>
</tr>
<tr>
<td>e. High demand for services from enrollees dependent on walk-in face-to-face consults (e.g., large homeless population)</td>
<td>Y</td>
<td>0</td>
</tr>
<tr>
<td>f. The region (VISN) the site is located in is losing or gaining large numbers of potentially eligible patients</td>
<td>Y</td>
<td>0</td>
</tr>
<tr>
<td>g. The number of patients visiting the practice is substantially and rapidly growing or falling</td>
<td>Y</td>
<td>0</td>
</tr>
<tr>
<td>h. Other context characteristic, please specify:</td>
<td>Y</td>
<td>0</td>
</tr>
</tbody>
</table>
### 3. Specialty Care Needs in Relationship to Primary Care:

While specialty care access overall is a critical issue for access management, for this primary care focused panel we want to understand whether, and which types of specialty access problems, are burdening primary care and potentially reducing primary care access. For example, a single primary care visit for a problem requiring specialty care can generate four or five unproductive primary care visits as a consult is resolved.

<table>
<thead>
<tr>
<th>Type of Specialty</th>
<th>A. Are access issues related to this type of specialty care having major negative impacts on primary care access/workload nationally?</th>
<th>B. What is the priority for further development and implementation of methods for evaluating and managing access to this type of specialty?</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Mental health specialist care for serious mental illnesses (e.g., suicidality, psychosis, bipolar, severe PTSD, alcohol or drug dependence)</td>
<td>Y</td>
<td>0</td>
</tr>
<tr>
<td>b. Mental health care or support for common primary care mental and behavioral health issues (depression, substance abuse, anxiety, etc.)</td>
<td>Y</td>
<td>0</td>
</tr>
<tr>
<td>c. Medical or surgical specialist/subspecialist care for severe, complicated or urgent issues</td>
<td>Y</td>
<td>0</td>
</tr>
<tr>
<td>d. Medical or surgical specialist/subspecialist care or support for very common, non-urgent conditions (e.g., sleep disorders, wound care, dermatologic conditions, eye evaluation etc)</td>
<td>Y</td>
<td>0</td>
</tr>
<tr>
<td>e. Medical or surgical specialist/subspecialist procedure completion</td>
<td>Y</td>
<td>0</td>
</tr>
<tr>
<td>f. Other (specify):</td>
<td>Y</td>
<td>0</td>
</tr>
</tbody>
</table>
OVERVIEW

We begin this section with evaluation of overall primary care practice level supply and demand. Literature documents that a practice that is substantially out of balance on these dimensions will not be able to achieve reasonable access despite heroic efforts, and that the calculation continuously evolves over time. We then look within the practice to the primary care provider, panel and teamlet. We focus on first evaluating, and then managing, to promote better access and on the mechanisms that have been favorably reported to achieve it. Finally, we focus on the alternative types of visits available to providers and teams for maximizing their access.

- **Subsection 1** focuses on **evaluating** primary care **practice level** overall supply and demand.
- **Subsection 2** focuses on what **management approaches** might be taken to address overall supply/demand mismatches.
- **Subsection 3** focuses on **evaluating** supply and demand among **individual providers and their panels** within a primary care practice site.
- **Subsection 4** focuses on **managing** supply and demand among **individual providers and their panels** within a primary care practice site.
- **Subsection 5** focuses on **evaluating** the availability of **alternatives to face to face visits** at a primary care practice site.
- **Subsection 6** focuses on general **management** strategies for **optimizing the quality** of site level patient access.

DEFINITIONS

**Primary Care Teamlet:** Defined in VA as a provider, Registered Nurse, Licensed Practical Nurse (LPN), and clerk assigned to a designated patient panel. The provider can be an MD, Nurse Practitioner (NP) or Physician Assistant (PA).

**MSA:** Clerks or MSAs (medical support assistants) provide admin support on the teams/teamlets. In some sites, MSA’s substitute for LPNs.

**Primary Care Team:** includes multiple teamlets and has access to designated additional resources (e.g. social work, pharmacy, dietician/nutrition, Primary Care-Mental Health Integration).

**Primary Care Practice:** Primary care teamlets and team members delivering care in a geographically distinct site. In VA, mental health providers may or may not be co-located on site.

**Panel:** Patients assigned to a given primary care provider (e.g., 1,200 visiting patients). VA panels are continuously revised to reflect new patients added and eliminate non-visiting patients.

**Group practice manager:** The group practice manager leads the management of the supply of healthcare services in relationship to patient demand, or needs. Access is a major, but not always the only, focus of this job. In the VA, the group practice manager is typically located in a VA hospital (most, but not all VA’s include a base hospital, a nursing
home, and a set of clinics). By directive, the group practice manager reports directly to executive leaders, and is responsible for either all primary care or all ambulatory care services.

**Group Practice Management:** The full management team involved in maximizing the supply of healthcare services in relationship to demand. In addition to the group practice manager, this may include e.g., nursing, administration, and/or physician leads.

**Access Managers:** References the portion of the group practice management team that focuses specifically on primary care access-related issues. E.g., group practice management might have a broader set of responsibilities as primary care leaders that we do not focus on here.

### SUBSECTION - 1

### 1. Evaluating Supply/Demand at primary care practice sites: i.e., the number of patients actively seeking care at the site versus the site’s primary care staff and other resources.

### OVERVIEW

The questions below address recommendations regarding how access managers should evaluate whether there is a mismatch between overall primary care practice level supply and demand. The questions assume the existence of two potential patient population groups seeking visits. One population includes all patients eligible for enrollment in the system (e.g., all Veterans) within reasonable physical proximity (e.g., less than 1-hour transportation time) to the practice. Another population includes all patients who have visited the practice at least once (“enrolled”) during a given period (e.g., two years), but who may or may not have optimal access to needed medical and mental health services.

### DEFINITIONS

**Primary Care Practice Level Supply:** In general, at the local primary care practice level, supply typically centers on the number of providers (MD, NP, PA), although this requires assumptions regarding the team support available to the providers. In VA with the PACT reorganization, the teamlet ideally can function as a support team to the provider. The questions below assume that supply is dependent primarily upon the number and location of providers, and patient centered medical home team resources (e.g., RN, LVN, clerk) available to leverage provider time.

Also in general, the major measure of access is face-to-face visits; this is most often the focus of calculations, although the number of needed face-to-face visits depends on the clinical and mental health needs of the patient population as well as the access enhancement resources available (e.g., non-face to face visit alternatives), and the quality of these resources.

**Primary Care Practice Level Demand:** There are a variety of possible ways to define and measure demand at the primary care practice level, however, there is little or no consensus on the ideal number of visits per patient. Systems
may or may not serve a defined population, and may or may not have functioning mechanisms for controlling the size of the population they serve. For example, government systems (e.g., VA, Medicaid) in general must plan for a variable but not explicitly controlled number patients seeking care. Depending on circumstances, private or non-profit care systems may or may not be able to “close” to additional patients, and may or may not be able to dis-incentivize participation, such as through increased price (e.g., deductibles, co-insurance or co-payments) or time (e.g., long waits for referrals, long wait times in clinic). All systems may be able to discourage participation through reductions in services or quality of services. As a public healthcare system, VHA has limited ability to manage demand, so most of the items below focus primarily on managing supply in the face of excess demand.

<table>
<thead>
<tr>
<th>Primary Care Practice Site Level Supply/Demand Context Evaluation</th>
<th>B. What should the priority be for the indicated evaluation?</th>
<th>C. Importance of Discussing at the Panel Meeting</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(0 = cannot answer; 1 = very low priority, 2 = low priority 3 = medium priority, 4 = high priority, 5 = very high priority, must be addressed this year)</td>
<td>(0 = cannot answer 1= Not important 2 = Somewhat Important 3 = Very Important)</td>
</tr>
</tbody>
</table>

Demand Parameters that should be routinely measured or evaluated at appropriate intervals, such as annually:

- **a.** Total number of patients visiting the primary care site during the past year  
  | 0 | 0 |

- **b.** Geographically-related primary care access difficulties among patients who are regularly cared for by other VA services such as the Emergency Department or hospital but show low primary care access (e.g., patients from geographic service areas with low transportation resources plus poverty).  
  | 0 | 0 |

- **c.** The site’s patients’ perceived needs for healthcare (e.g., through surveys, focus groups)  
  | 0 | 0 |

- **d.** The site’s patients’ perspectives in relationship to identified issues or plans for improving access to services (e.g., through surveys, focus groups)  
  | 0 | 0 |

- **e.** The rate of potentially preventable (e.g., ambulatory care sensitive condition-related) hospitalizations and emergency department visits generated by the primary care practice site  
  | 0 | 0 |

Supply Parameters:

- **f.** Primary care practice site level supply (e.g. total number of primary care providers) versus demand (e.g., number of patients visiting the past year)  
  | 0 | 0 |

- **g.** Primary care practice penetration (e.g., proportion of geographically proximate eligible patients who have visited the practice)  
  | 0 | 0 |

- **h.** The primary care practice’s penetration among eligible patients in relationship to the quality of the care the site delivers (i.e., a site could reduce demand by becoming undesirable to area Veterans; the number of patients visiting the  
<p>| 0 | 0 |</p>
<table>
<thead>
<tr>
<th>Primary Care Practice Site Level Supply/Demand Context Evaluation</th>
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<td>(0 = cannot answer 1= Not important 2 = Somewhat Important 3 = Very Important)</td>
</tr>
<tr>
<td>Practice would then not match true demand)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. Primary care provider and staff commitment to research, education, or leadership activities and inclusion of these commitments in calculating available primary care workforce staffing</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>j. Provider, staff, and/or manager competency relative to access-related activities (e.g. know how to develop alternative visit types, manage demand, initiate access improvement projects, etc.)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>k. Primary care provider and staff morale (e.g., burnout, job satisfaction, turnover rates) considered in relationship to access mismatch</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>l. Availability of equipment needed to supporting enhanced access (e.g., telephone systems, use of new mobile technology, etc.)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>m. Other (specify):</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
2. Management approaches to address overall supply/demand mismatches: The previous section focused on evaluating or measuring the supply/demand balance and key factors that may influence it. This section focuses on identifying the features or best practices for managing supply and demand in primary care. Access managers should be enabled (e.g., trained, equipped and supported by leadership) to apply those approaches that are high priority when appropriate.

<table>
<thead>
<tr>
<th>Strong Practices for Managing Overall Site Level Supply/Demand Mismatch</th>
<th>B</th>
<th>C. Importance of Discussing at the Panel Meeting</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What should the priority be for enabling access managers to apply the indicated modality when appropriate?</strong></td>
<td>(0 = cannot answer; 1 = very low priority, 2 = low priority 3 = medium priority, 4 = high priority, 5 = very high priority, must be addressed this year)</td>
<td>(0 = cannot answer 1 = Not important 2 = Somewhat Important 3 = Very Important)</td>
</tr>
<tr>
<td><strong>Access managers routinely use or can demonstrate systematic approaches to:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Building capacity ahead of demand (e.g. actively monitoring for staffing completeness and for upcoming vacancies and initiating recruiting early)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>b. Hiring (or reducing) staffing in relationship to assessed overall site level supply/demand mismatches</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>c. Improving provider and staff morale (e.g., improving the work environment, providing recognition, etc.) during times of access mismatch</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>d. Educating patients about appropriate access behaviors (e.g., making appointments, rescheduling appointments, avoiding no-shows)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>e. Briefing and engaging patient advisory committees about strategies under consideration for improving access</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>f. Communicating with executives, other managers and front-line staff about access management measures, issues, and improvement strategies</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>g. Developing local policies or procedures that are consistent with national and regional policy but address local primary care practice access problems</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>h. Developing agreements, memoranda of understanding, or polices that address expectations for how allied access-related services (e.g., pharmacy, call centers, information technology, etc.) support primary care</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Strong Practices for Managing Overall Site Level Supply/Demand Mismatch</td>
<td>B</td>
<td>C. Importance of Discussing at the Panel Meeting</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>What should the priority be for enabling access managers to apply the indicated modality when appropriate? (0 = cannot answer; 1 = very low priority, 2 = low priority, 3 = medium priority, 4 = high priority, 5 = very high priority, must be addressed this year)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. Implementing explicit approaches to limiting demand at the practice level when supply is insufficient and cannot be increased (e.g. contracting primary care out to community primary care providers) [note: with this solution, pharmacy, radiology, lab, referrals to specialists, acute symptoms are typically brought back to VA primary care to order and arrange, otherwise the patient must pay]</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>j. Ensuring adequate availability of contingency staffing—i.e, planned minimal excess staffing to cover e.g. routine absences due to hiring gaps, vacations, illnesses</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>k. Developing plans for minimizing potentially preventable hospitalizations and emergency department visits</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>l. Serial locum tenens appointments</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>m. Prioritizing and staffing walk-in same day care for patients without an assigned provider</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>n. Enabling some or all panels to expand substantially above expected sizes</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>o. Other supply/demand mismatch management approach, please specify:</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
3. Evaluating supply and demand among individual providers and their panels within a primary care practice site: This subsection focuses on individual primary care providers, teamlets and panels within a site. Measurement of some aspects of supply and demand may facilitate efforts to improve patient care experiences, while in other cases, measurement may identify issues with primary care team functioning. Measurement may be through national measures or through local quality improvement measurement efforts.

DEFINITIONS

Panel: A set of patients assigned to a provider and teamlet; in VA, typically 1200 patients with ongoing removal of patients who have not visited in the past 12 months

Scheduling Grid: VA’s scheduling grid has 30 minute appointment slots; although there are likely local variations, in general providers are not allowed to alter visit length to make visits shorter or longer. Also in general, telephone calls cannot be scheduled. Visits to RN’s can be scheduled in some locations and not in others. Overbooking is often accomplished, though not endorsed by VA managers, by booking past the last visit or through the lunch hour, for example when a visit is needed and no slots are available. Continuity walk-in visits are variably managed by teamlets if no provider slots are available. In locations with severe supply mismatch, usually with many patients not currently assigned to a panel, non-continuity walk-in visits are often seen in a walk-in clinic and evaluated as quickly as possible with a focus only on the primary problem.

<table>
<thead>
<tr>
<th>Panel (i.e., Primary Care Provider and Team/Teamlet) Supply/Demand Evaluation</th>
<th>B. What should the overall priority be for ensuring local sites have the capability for evaluating this feature? (0 = cannot answer; 1 = very low priority or need not be addressed, 2= low priority, 3= medium priority, 4 = high priority, 5 = very high priority, must be addressed this year)</th>
<th>C. Importance of Discussing at the Panel Meeting (0 = Cannot answer 1= Not important 2 = Somewhat Important 3 = Very Important)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<tr>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

Below you will find a list of options regarding what access managers should routinely and frequently evaluate/measure. While all items may be important, please limit to up to 5 features which you think are very high priority (i.e., rated “5”):

a. “Cleaning” of panels (e.g. monthly) to reflect the number of patients who have visited the practice in the past year 0 0

b. The proportion of patients visiting the site in the past six or 12 months who are not empaneled 0 0
<table>
<thead>
<tr>
<th>Panel (i.e., Primary Care Provider and Team/Teamlet) Supply/Demand Evaluation</th>
<th>B. What should the overall priority be for ensuring local sites have the capability for evaluating this feature? (0 = cannot answer; 1 = very low priority or need not be addressed, 2= low priority, 3= medium priority, 4 = high priority, 5 = very high priority, must be addressed this year)</th>
<th>C. Importance of Discussing at the Panel Meeting (0 = Cannot answer 1= Not important 2 = Somewhat Important 3 = Very Important)</th>
</tr>
</thead>
<tbody>
<tr>
<td>c. The continuity of care per provider/teamlet (i.e., the proportion of visits the patient has during a time span such as a year that are with his/her assigned primary care provider or teamlet member)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>d. Average revisit rates per patient in the panel to the assigned provider/teamlet</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>e. Panel access related measures adjusted by the proportion of complex patients in the panel (e.g. proportion with a high physical or mental health condition load or who are at high predicted risk of hospitalization)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>f. Validation between providers and access managers that the number of clinic half days scheduled is appropriate (e.g. takes into account all approved research, teaching, or leadership activities), and that the providers have scheduling grids in place for each scheduled half day in clinic (“grid validation”)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>g. Proportion of all slots for a given clinic day that remain un-booked at the beginning of that clinic day (“open water”)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>h. Match of provider hours committed to clinical primary care to the clinic sessions actually booked over the past month (grid validation)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>i. Differences between providers in the type and/or quantity of demand they face (e.g., number of new or new-to-provider patients per panel per month; number of non-continuity patient walk-in visits completed per panel per month number of non-continuity scheduled patients seen per panel per month)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>j. The number of “scrubbed” appointments (i.e., inappropriate appointments made by clerks or call centers)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>k. The proportion or number of “walk-ins” that could have been managed by non face-to-face care (e.g., pharmacy refills, scheduling requests)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>l. The proportion or number of “walk-ins” that are associated with non-health related issues (e.g., homelessness, hunger, under- or unemployment)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>m. Detection of bottlenecks outside primary care that increase primary care workload (e.g. long waits for referrals, labs or diagnostic tests, pharmacy refills)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Panel (i.e., Primary Care Provider and Team/Teamlet) Supply/Demand Evaluation</td>
<td>B. What should the overall priority be for ensuring local sites have the capability for evaluating this feature? (0 = cannot answer; 1 = very low priority or need not be addressed, 2 = low priority, 3 = medium priority, 4 = high priority, 5 = very high priority, must be addressed this year)</td>
<td>C. Importance of Discussing at the Panel Meeting (0 = Cannot answer 1= Not important 2 = Somewhat Important 3 = Very Important)</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>n. Assessment of non-health related issues that drive walk-ins or requests for appointments (e.g., homelessness, hunger, under- or unemployment)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>o. Other (specify):</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
4. **Managing supply and demand among individual providers and their panels within a primary care practice site:** This subsection aims to develop recommendations for management approaches that will promote patient experience of access and teamlet functioning. Some management approaches may be appropriate in locations with better supply/demand match while others may only be appropriate in situations of extreme mismatch. We therefore ask about the importance of enabling access managers to implement the approach when needed. Enabling may involve information technology changes, training, or policy changes.

**DEFINITIONS**

**Provider:** MD, Nurse Practitioner, or Physician Assistant (sometimes called a prescribing provider)

**Scrubbing:** The process of teamlet members (usually the licensed professional nurses or medical support assistants) looking at upcoming appointments and finding mistakes such as duplicates and calling some patients to find out whether their needs can be met by telephone

<table>
<thead>
<tr>
<th>Access Management Approaches to Provider/Teamlet Level Supply/Demand</th>
<th>B. What should the overall priority be for ensuring implementation of this approach?</th>
<th>C. Importance of Discussing at the Panel Meeting</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>a.</strong> Leadership at all levels “respects patient panels” by prioritizing continuity care for patients within a panel and by maintaining the approved panel size (e.g., through methods of booking appointments; methods of assigning patients to panels)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>b.</strong> The scheduling process (i.e., from patient phone calls going to and from call centers, teamlets or other intermediaries to a booked appointment in the computer) maximizes care continuity with teamlets/providers</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>c.</strong> The scheduling process enables scheduled appointments with teamlet nurses (i.e., not only with providers) when appropriate</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>d.</strong> The scheduling process enables scheduling of telephone calls with primary care providers or other teamlet members</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>e.</strong> The scheduling process enables flexibility in visit duration (e.g., visits of different lengths based on patient need, provider/team experience level</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Access Management Approaches to Provider/Teamlet Level Supply/Demand</td>
<td>B. What should the overall priority be for ensuring implementation of this approach?</td>
<td>C. Importance of Discussing at the Panel Meeting</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>f. 1/4 to 1/3 of all visit slots with providers are maintained open up to the day of a given provider’s clinic day for use for urgent visits, telephone or other panel management tasks (“open water”)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>g. Teamlet members proactively manage demand (e.g., alerts, reminders, and telephone contacts from patients on their panels) and optimize provider visit schedules (e.g., through triage, prospective “scrubbing” of appointments) to the extent appropriate given their training/licenses</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>h. Teamlet RN’s prospectively manage demand by acting on chronic disease and outcome markers (e.g., dashboards)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>i. Teamlet RNs prospectively manage demand by leading care coordination for their panels</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>j. Patients are able to book visits (e.g., face to face, group or telephone visits on line)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>k. Other (specify):</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
5. Evaluating the availability of alternatives to face to face visits at a primary care practice site:
This section asks about which types of alternatives access managers should routinely evaluate the needs and preferences of their primary care patients and be able to maximize use of high priority alternatives as appropriate and feasible.

<table>
<thead>
<tr>
<th>Types of visit modalities to evaluate and consider maximizing:</th>
<th>B.</th>
<th>C.</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Weekend, early morning or after hours face to face visits</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>b. Weekend, early morning or after hours symptom or clinical need related telephone care</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>c. Group visits for common chronic conditions (e.g., diabetes, hypertension)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>d. Telephone care visits with assigned panel providers or nurses</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>e. Secure interactive email messages with assigned panel providers or nurses</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>f. Primary care video visits (similar to Skype)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>g. Communication via mobile telephones</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>h. Communication of physiological data remotely (e.g., through monitoring devices on the person or in the home, such as pacemaker data, blood pressure, or exercise level)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>i. Pre-visit completion of needed prevention by assigned panel team members, (e.g., enabling teamlet members to complete reminders; pre-provider visit booked time for teamlet members to complete reminders; birthday letters to initiate implementation of needed prevention)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>j. Classes available through video or remote locations</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Managing Supply through Use of Alternatives to Face to Face, Weekday Visits</td>
<td>B. What should the overall priority be for enabling access managers to implement the alternative visit type? (0 = cannot answer; 1 = very low priority or need not be addressed, 2 = low priority, 3 = medium priority, 4 = high priority, 5 = very high priority, must be addressed this year)</td>
<td>C. Importance of Discussing at the Panel Meeting (0 = Cannot answer 1 = Not important 2 = Somewhat Important 3 = Very Important)</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td></td>
<td></td>
<td>k. Other (specify): 0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>0</td>
</tr>
</tbody>
</table>
6. General management strategies for optimizing the quality of site level patient access: Managing supply and demand requires in depth knowledge of the capabilities of an individual site. For example, alternative visit types may require special training to initiate, designated administrative support, and ongoing upkeep regarding quality and use. Differences in availability of community resources, patient population, size and location may all influence what and how improvement can be accomplished. The promising practices below may support better supply and demand management. Access managers should be able to implement high priority promising practices to foster site improvement when appropriate, and should be supported by executive leadership in doing so.

<table>
<thead>
<tr>
<th>Promising practices for managing site level supply and demand include:</th>
<th>B. What should the overall priority be for enabling access managers to implement the indicated promising practice when appropriate?</th>
<th>C. Importance of Discussing at the Panel Meeting</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Local site strategic planning: Review evaluation data on site level supply and demand as well as used and unused alternative visit types. Meet with inter-professional leaders to develop an improvement plan with consideration of available resources and potential impacts on high quality access.</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>b. Engage Veteran representatives in strategic planning and improvement projects</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>c. Ensure specific training of the access managers and teams for addressing each prioritized element of successful access management (e.g., as consensus on priority elements emerges from the panel)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Implementing improvements with the goal of ensuring:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Inter-professional leader communication and input into decisions</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>e. Patient representative and patient data collection input into decision-making</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>f. Local primary care practice site leader sense of autonomy for assessing and promoting access (within general policy guidelines)</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
Promising practices for managing site level supply and demand include:

### B. What should the overall priority be for enabling access managers to implement the indicated promising practice when appropriate? (0 = cannot answer; 1 = very low priority or need not be addressed, 2 = low priority, 3 = medium priority, 4 = high priority, 5 = very high priority, must be addressed this year)

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>g. Regular communication with executive leadership</td>
<td>0</td>
</tr>
<tr>
<td>h. Regular communication with local primary care practices by group practice management</td>
<td>0</td>
</tr>
</tbody>
</table>

### C. Importance of Discussing at the Panel Meeting (0 = Cannot answer 1= Not important 2 = Somewhat Important 3 = Very Important)

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>g. Regular communication with executive leadership</td>
<td>0</td>
</tr>
<tr>
<td>h. Regular communication with local primary care practices by group practice management</td>
<td>0</td>
</tr>
</tbody>
</table>

Implementing improvements in access quality improvement management with the goal of ensuring:

### i. Sufficient support for access improvement project initiation by local primary care practices (e.g. leadership priority setting, facilitation of local innovation, appropriate release time from other duties for those involved in approved projects) | 0 |
### j. Reliance of improvement projects on relevant data/measurement | 0 |
### k. Leadership support to engage care providers outside primary care (e.g., specialty care, pharmacy, rehab/physical medicine) | 0 |
### l. Other (specify): | 0 |
This section focuses on the structure and culture of group practice management as it impacts achievement of access related goals.

<table>
<thead>
<tr>
<th>Promising Organizational Features for Promoting Access Management Success</th>
<th>B. What should the overall priority for achieving this organizational feature?</th>
<th>C. Importance of Discussing at the Panel Meeting</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>a.</strong> A clearly identified group practice management structure exists, including a designated group practice manager who reports to executive leadership, communicates with individual primary care sites and can collaborate across roles and service lines (e.g., medicine, nursing, administration).</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>b.</strong> Group practice managers and team members are given the protected time, training and leadership support / involvement to carry out their functions</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>c.</strong> Access managers have sufficient authority and training to develop and implement policies and procedures related to access</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>d.</strong> Ongoing multi-level training (executive, middle-management, front-line) is implemented to enable performance of high quality access management</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>e.</strong> MD, RN, and Administrative leaders are identified for each primary care practice site with authority to support access management priorities within local site contexts.</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>f.</strong> Access management engages key primary care team services such as MD, nursing, administration, pharmacy, social work, mental health and integrates their concerns into strategic and day to day planning.</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>g.</strong> Group practice managers are evaluated by and evaluate site leaders with reference to achievement of access management goals (e.g., through the performance review process).</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>h.</strong> Primary care access managers are perceived by front line primary care leaders and staff as supportive and interested in a positive work environment</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
### Promising Organizational Features for Promoting Access Management Success

| i. Each site has or is linked to an inter-professional body or council responsible for prioritizing and overseeing local quality improvement innovation for improving access | 0 | 0 |
| j. Quality improvement projects, initiatives or innovations for improving access management are regularly undertaken. | 0 | 0 |
| k. Other (specify): | 0 | 0 |
Complex patients, such as those at high risk of hospitalization, multiple chronic diseases, mental health conditions or impairments, and those who are disruptive or combative have major impacts on access. First, they are often high utilizers of primary care services. Second, they are likely to generate unscheduled visits (walk-ins), either related to emergent or urgent problems, or because they have difficulty with appointment adherence. Third, they are often challenging and time consuming to evaluate within a primary care visit. They may or may not have non-health related issues (e.g., homelessness or unstable housing, hunger, unstable or unemployment) that may impact their health status.

Additionally, an unanticipated negative consequence of focusing on face-to-face visits with primary care providers can be that providers seek to avoid these challenging or patients. It may be seen as a better alternative to either passively or actively encourage these patients to switch providers, yet these patients may need continuity more than many others. Providers and teams also may become burned out trying to care for them. These patients may also require more frequent visits than others, raising the revisit rate and resulting in excess acute care use (such as Emergency Department visits) if visits are not available when the patients perceive they are needed.

While primary care sites are generally fairly similar, within a given care system such as VA, in the proportion of complex patients attending the site, studies have demonstrated that within the same site, providers often care for substantially different proportions of patients who are complex or have mental or behavioral conditions.

Over 80% of the sickest 5% of Veterans are cared for in general primary care (i.e., general PACT). Currently, lower panel sizes are expected for primary care within geriatric, homeless, women’s health, HIV and other specialized primary care clinics. We do not know of existing approaches for managing the known variations across individual patient panels within general primary care sites in the proportion of complex patients they follow.

DEFINITIONS

**CAN score**: the Care Assessment Needs score; this score predicts each patient’s risk of subsequent hospitalization based on extensive VA data. The score is available across all enrolled patients and can be pulled for patients at individual primary care sites.
<table>
<thead>
<tr>
<th>Improvements related to access management for complex patients</th>
<th>B. What should the overall priority be for the indicated improvement?</th>
<th>C. Importance of Discussing at the Panel Meeting</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>( 0 = cannot answer; 1 = very low priority, need not be addressed, 2 = low priority, 3 = medium priority, 4 = high priority, 5 = very high priority, must be addressed this year)</td>
<td>(0 = Cannot answer 1= Not important 2 = Somewhat Important 3 = Very Important)</td>
</tr>
<tr>
<td>Panel metrics/evaluation used by access management for matching primary care supply and demand include:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. The proportions of complex patients in each panel within a site (e.g., to detect variations in the average CAN score between providers/teamlets at the site)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>b. Basic metrics (e.g., panel size and revisit rates) adjusted by panel sickness or mental health condition load</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Access management approaches that reflect consideration of the needs of complex patients include:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Adjustment of expectations for maximum panel size and/or expected revisit rate based on patient complexity (e.g., similar to geriatric, homeless, infections disease and other special population primary care practices)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>d. Mechanisms for engagement of inter-professional input (e.g. from mental health, pharmacy, social work, primary care and the patient) to support primary care provider management of challenging patients (e.g. disruptive, combative, or severely non-adherent)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>e. Mechanisms for providing additional care coordination support for patients with high needs for care from multiple sources</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>f. Availability of a primary care based interdisciplinary team to provide consultation and management support to primary care for complex or high risk patients</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>g. Other (specify):</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
If rated as high priority, the outcomes below may be monitored for improvement at the primary care practice site level (formative or quality improvement evaluation) and/or monitored centrally for assessing local health system/medical center or local primary care practice site performance.

**Same day Care:** VA leadership has emphasized same day care, meaning that the patient is seen the same day they call for an appointment. There are two types of same day care. One type consists of care with the assigned continuity provider/team. The other consists of care with anyone available to see the patient.

**Walk-in Care:** Walk in care is care that occurs when the patient did not schedule an appointment prior to coming in. PACT teams generally aim to reduce walk-in care by enabling prospective scheduling and triage of scheduling calls for their panels, including “scrubbing”, or reviewing schedules ahead of time such that errors can be corrected and patients can be called if appropriate.

<table>
<thead>
<tr>
<th>A. Should evaluation of this outcome be used primarily for local improvement (formative) or should it be used as a performance measure to evaluate the site or its executive management (summative)? (0 = cannot answer/don’t know, QI = used as formative, for local improvement, PM &amp; QI = used as a performance measure, as well as for local improvement)</th>
<th>B. What should the overall priority for evaluating this outcome be? (0 = cannot answer/don’t know; 1 = very low priority, need not be available, 2 = low priority, 3 = medium priority, 4 = high priority, 5 = very high priority, must be addressed this year)</th>
<th>C. Importance of Discussing at the Panel Meeting (0 = Cannot answer, 1= Not important; 2= Somewhat Important; 3 = Very Important)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Short term, medium term, and long term access management outcomes</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Overall time patients must wait for a requested face to face visit (e.g., 3rd next available or same day) with their assigned continuity primary care provider</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>b. Same day access in primary care for unassigned patients or for assigned patients visiting a non-continuity provider or team.</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

**Section V: Access Management Outcomes**

93
<table>
<thead>
<tr>
<th>Short term, medium term, and long term access management outcomes</th>
<th>A. Should evaluation of this outcome be used primarily for local improvement (formative) or should it be used as a performance measure to evaluate the site or its executive management (summative)? (0 = cannot answer/don’t know QI = used as formative, for local improvement PM &amp; QI = used as a performance measure, as well as for local improvement)</th>
<th>B. What should the overall priority for evaluating this outcome be? (0 = cannot answer/don’t know; 1 = very low priority, need not be available, 2= low priority, 3= medium priority, 4 = high priority, 5 = very high priority, must be addressed this year)</th>
<th>C. Importance of Discussing at the Panel Meeting (0 = Cannot answer 1= Not important; 2= Somewhat Important; 3 = Very Important)</th>
</tr>
</thead>
<tbody>
<tr>
<td>c. Ratio of continuity to non-continuity same day access</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>d. Continuity for patients assigned to a panel/primary care provider and teamlet by balancing access and continuity goals</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>e. Telephone access management (e.g., management of patients attempting to call primary care) quality and/or productivity</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>f. Telephone management of patients calling in with symptoms or clinical needs</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>g. Secure messaging quality and/or productivity</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>h. Provider and staff burnout or dissatisfaction with their jobs</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>i. Quality of patient experience of access (patient-rated access)</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>j. Improved patient health outcomes</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>k. Improved practice environment and culture</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Short term, medium term, and long term access management outcomes</td>
<td>A. Should evaluation of this outcome be used primarily for local improvement (formative) or should it be used as a performance measure to evaluate the site or its executive management (summative)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(0 = cannot answer/don't know QI = used as formative, for local improvement PM &amp; QI = used as a performance measure, as well as for local improvement)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. What should the overall priority for evaluating this outcome be?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(0 = cannot answer/don’t know; 1 = very low priority, need not be available, 2 = low priority, 3 = medium priority, 4 = high priority, 5 = very high priority, must be addressed this year)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C. Importance of Discussing at the Panel Meeting</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(0 = Cannot answer 1= Not important; 2 = Somewhat Important; 3 = Very Important)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>I. Balance (equilibrium) between supply and demand for primary care services</th>
<th>0</th>
<th>0</th>
<th>0</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>m. High value care (e.g. minimized per capita patient costs and maximized quality and economy/cost benefit of care)</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
One of the reasons access can be classified as a “wicked” problem is that there is no one size fits all recommendation regarding most of its aspects. In addition, the challenges to balancing supply and demand are dynamic, with changes in primary care provider or staffing, spikes in enrollment or healthcare use disrupting achievement of balances. Here we provide vignettes of difficult access-related situations based on our site visits to practices in our own region and across the US. Some details may be changed, however. You may want to just read through the vignettes, or you may want to make comments about them.

**Vignette #1 Practice level demand is substantially greater than supply:** A primary care practice has 15,000 patients visiting per year and has lost 60% of its primary care providers. Currently, out of an original set of 10 primary care providers and teamlets 3 years ago, there are now only three primary care teamlets with “permanent” primary care MDs, nurse practitioners or physicians assistants. A large fraction of patients at this site have been assigned to VA-paid community primary care, but these patients frequently return to get medications or laboratory tests ordered outside, or to get urgent care. The combination of unassigned patients and returns from community care result in a large walk-in population, currently cared for by a series of locum tenens providers at considerable expense. A new Chief of Staff and Director have arrived.

- What problem area should the new leaders focus on first?
- What leadership qualities will they need to have to succeed?

Comment:

**Vignette #2 Complex Academic Center Challenges for Achieving Optimal Access:** A practice has a mixture of academic teaching and research faculty, as well as full time primary care providers. Practice teamlet level staffing is nearly complete. Part time academic faculty are assigned to teamlets such that two or three together make up the provider component of the teamlet for a single assigned patient panel, often somewhat larger than the designated 1,200 patients. Trainees have small panels, but there are many of them, creating challenges in terms of coverage and teamlet formation. The number of new patients seeking care at this site is rising. The call center schedules patients into whatever slots are open and available, such that there are typically less than 10% open slots at the start of any given day. Patient ratings of access to care and of satisfaction with their care are slightly lower than the regional averages and seem to be falling.

- What should the practice leaders consider in addressing this situation?
- What style of improvement will likely yield the best outcome?

Comment:
Vignette #3  Disagreement between Different Access Outcome Measures: A practice has six teamlets that are all at capacity. The site has achieved open access, such that at least 25% of slots are open at the start of any clinic day. Non face to face visit methods are maximized. Nurses screen and triage symptomatic patients before assigning them into an available slot; assignment is done with a focus on continuity. Patient ratings of access to care and of satisfaction with their care are moderate (neither very high nor very low).

- What more would you want to know about this practice?

Comment:

Vignette #4 Managing Complex Patient Access: A site manager notices that a provider has a somewhat reduced panel size yet rarely has an open slot. On further investigation, the provider’s revisit rate is near four times per year, higher than the practice average. When told that s/he is out of range on these measures, s/he notes having a substantially more complex patient panel than average, based on the CAN risk score (available on the practice dashboard; it predicts hospitalization, cost, or mortality).

- How would you suggest that the manager handle this situation?

Comment:

Vignette #5 Managing Demand: After a manufacturing or factory plant closes, the number of enrolled Veterans seeking care suddenly increases at a primary care clinic in a small metropolitan city. These Veterans had previously sought care at the clinic, but usually for medications or occasionally mental health; they are now seeking VA as their only source of care. The Veterans are middle-aged, and many have co-morbid chronic conditions (e.g., diabetes, hypertension and hyperlipidemia). Many come in reporting anxiety or depression from being laid off. The VA medical center is more than 100 miles away, so most of the Veterans do not want to seek specialty care at the medical center.

- What should leadership at the primary care focus on first?

Comment:
Appendix D

Results for Critical Items Pre- and Post-Panel Survey

In the post-panel survey, panelists identified eight items as being both important and urgent (see Table 3.2). Table D.1 shows the panel agreement for all post-panel items in addition to the results of the corresponding pre-panel items.
### Table D.1. Critical Items Pre- and Post-Panel Survey Results

<table>
<thead>
<tr>
<th>Pre-Panel Item</th>
<th>Statistical Results(^a)</th>
<th>Post-Panel Rated Recommendation</th>
<th>(N)</th>
<th>Percentage Agreement Among Panelists for the Priority Action’s Importance and Urgency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality of patient experience of access (patient-rated access).</td>
<td>Adj mean = 4.41</td>
<td>Outcome measure:</td>
<td>17</td>
<td>Improvement Toward This Goal Is Important and Urgent(^b)</td>
</tr>
<tr>
<td></td>
<td>SD = 0.79</td>
<td>The quality of the patient’s experience of access (i.e., patient-rated access).</td>
<td></td>
<td>88%</td>
</tr>
<tr>
<td></td>
<td>Mode = 5</td>
<td>We expect patient ratings to reflect both in-person and non-face-to-face (e.g., telephone, secure messaging) care.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Percent 5 = 57.9%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary care provider and staff morale (e.g., burnout, job satisfaction, turnover rates) considered in relationship to access mismatch.</td>
<td>Adj mean = 4.34</td>
<td>Outcome measure:</td>
<td>17</td>
<td>Improvement Toward This Goal Is Important and Urgent(^b)</td>
</tr>
<tr>
<td></td>
<td>SD = 0.79</td>
<td>Primary care provider and staff morale (e.g., low/high burnout, job satisfaction, or turnover rates) in relation to access mismatch (e.g., panels exceeding recommended size, primary care provider vacancies).</td>
<td></td>
<td>53%</td>
</tr>
<tr>
<td></td>
<td>Mode = 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Percent 5 = 52.9%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Access managers routinely use or can demonstrate systematic approaches to ensuring adequate availability of contingency staffing—i.e., planned minimal excess staffing to cover e.g., routine absences due to hiring gaps, vacations, illnesses.</td>
<td>Adj mean = 4.37</td>
<td>Process improvement target:</td>
<td>17</td>
<td>Improvement Toward This Goal Is Important and Urgent(^b)</td>
</tr>
<tr>
<td></td>
<td>SD = 0.81</td>
<td>Access managers’ routine use or ability to demonstrate systematic approaches to ensuring adequate availability of contingency staffing (i.e., planned minimal excess staffing to cover routine absences, e.g., due to hiring gaps, vacations, illness).</td>
<td></td>
<td>65%</td>
</tr>
<tr>
<td></td>
<td>Mode = 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Percent 5 = 55.6%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Teamlet(^c) RNs prospectively manage demand by leading care coordination for their panels.</td>
<td>Adj mean = 4.37</td>
<td>Process improvement target:</td>
<td>17</td>
<td>Improvement Toward This Goal Is Important and Urgent(^b)</td>
</tr>
<tr>
<td></td>
<td>SD = 0.75</td>
<td>Teamlet RNs’ ability to prospectively manage demand by leading care coordination for their panels.</td>
<td></td>
<td>65%</td>
</tr>
<tr>
<td></td>
<td>Mode = 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Percent 5 = 50.0%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

\(^a\) Adj mean, standard deviation, and mode are reported. Percent 5 indicates the percentage of panelists who rated the item as a 5.

\(^b\) Improvement Toward This Goal Is Important and Urgent, Improvement Toward This Goal Is Important but Not Urgent, and Improvement Toward This Goal Is Not Important refer to the percentage agreement among panelists for the priority action’s importance and urgency.
### Pre-Panel Item

**Teamlet members proactively manage demand (e.g., alerts, reminders, and telephone contacts from patients on their panels) and optimize provider visit schedules (e.g., through triage, prospective “scrubbing” of appointments) to the extent appropriate given their training/license.**

<table>
<thead>
<tr>
<th>Pre-Panel Item</th>
<th>Statistical Results</th>
<th>Post-Panel Rated Recommendation</th>
<th>N</th>
<th>Percentage Agreement Among Panelists for the Priority Action’s Importance and Urgency</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Teamlet improvement target:</strong> Teamlet members’ ability to proactively manage demand (e.g., alerts, reminders, and telephone contacts from patients on their panels) by optimizing provider visit schedules (e.g., through triage, prospective “scrubbing” of appointments) to the extent appropriate given their training/licenses.</td>
<td>Adj mean = 4.21</td>
<td><strong>Process improvement target:</strong> Teamlet members’ ability to proactively manage demand (e.g., alerts, reminders, and telephone contacts from patients on their panels) by optimizing provider visit schedules (e.g., through triage, prospective “scrubbing” of appointments) to the extent appropriate given their training/licenses.</td>
<td>17</td>
<td>53% 41% 6%</td>
</tr>
<tr>
<td><strong>Overall time patients must wait for a requested face to face visit (e.g., 3rd next available or same day) with their assigned continuity primary care provider.</strong></td>
<td>Adj mean = 4.18</td>
<td><strong>Improvement measure:</strong> Routine evaluation of the time patients must wait for a requested face-to-face visit (e.g., 3rd next available or same day) with their assigned continuity primary care provider and for communication of the results to local primary care teams.</td>
<td>17</td>
<td>47% 53% 0</td>
</tr>
<tr>
<td><strong>Match of provider hours committed to clinical primary care to the clinic sessions actually booked over the past month (grid validation).</strong></td>
<td>Adj mean = 4.37</td>
<td><strong>Improvement measure:</strong> Routine matching, for each primary care practice site, of total provider hours committed to clinical primary care with the clinic sessions actually booked for providers over the prior month (primary “grid validation”).</td>
<td>16</td>
<td>50% 50% 0</td>
</tr>
<tr>
<td>Pre-Panel Item</td>
<td>Statistical Results</td>
<td>Post-Panel Rated Recommendation</td>
<td>Improvement Toward This Goal Is Important and Urgent&lt;sup&gt;b&lt;/sup&gt;</td>
<td>Improvement Toward This Goal Is Important but Not Urgent</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------</td>
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<td>-------------------------------------------------------</td>
</tr>
<tr>
<td>Validation between providers and access managers that the number of clinic half days scheduled is appropriate (e.g., takes into account all approved research, teaching, or leadership activities), and that the providers have scheduling grids in place for each scheduled half day in clinic (&quot;grid validation&quot;).</td>
<td>Adj mean = 4.40 SD = 0.56 Mode = 5 Percent 5 = 50.0%</td>
<td>Improvement measure: Routine validation between providers and access managers that the number of clinic half days scheduled is appropriate (e.g., takes into account all approved research, teaching, or leadership activities), and that the providers have scheduling grids in place for each scheduled half day in clinic (secondary &quot;grid validation&quot;).</td>
<td>17</td>
<td>47%</td>
</tr>
<tr>
<td>MD, RN, and administrative leaders are identified for each primary care practice site with authority to support access management priorities within local site contexts.</td>
<td>Adj mean = 4.62 SD = 0.53 Mode = 5 Percent 5 = 64.7%</td>
<td>Organizational structure target: Identification of MD, RN, and Administrative leaders for each primary care practice site with authority to support access management priorities within local site contexts.</td>
<td>17</td>
<td>71%</td>
</tr>
<tr>
<td>A clearly identified group practice management structure exists, including a designated group practice manager who reports to executive leadership, communicates with individual primary care sites and can collaborate across roles and service lines (e.g., medicine, nursing, administration).</td>
<td>Adj mean = 4.55 SD = 0.60 Mode = 5 Percent 5 = 75.0%</td>
<td>Organizational structure target: Development of a clearly identified group practice management structure with a designated group practice manager who reports to executive leadership, communicates with individual primary care sites, and who can collaborate across roles and service lines (e.g., medicine, nursing, administration).</td>
<td>17</td>
<td>76%</td>
</tr>
<tr>
<td>Pre-Panel Item</td>
<td>Statistical Results(^a)</td>
<td>Post-Panel Rated Recommendation</td>
<td>(N)</td>
<td>Percentage Agreement Among Panelists for the Priority Action’s Importance and Urgency</td>
</tr>
<tr>
<td>---------------</td>
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<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td>New Items</td>
<td></td>
<td></td>
<td></td>
<td>Improvement Toward This Goal Is Important and Urgent(^b)</td>
</tr>
<tr>
<td>N/A</td>
<td>N/A</td>
<td>Improvement measure: Routine evaluation of the degree to which patient telephone calls are a) answered promptly and b) routed accurately and appropriately, as judged in terms of patients’ clinical needs and preferences.</td>
<td>16</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Improvement Toward This Goal Is Important but Not Urgent</td>
</tr>
<tr>
<td>N/A</td>
<td>N/A</td>
<td>Improvement measure: Routine evaluation of the role of services provided outside of the healthcare system that the patient is enrolled in (e.g., community care).</td>
<td>16</td>
<td>31% 69% 0</td>
</tr>
<tr>
<td>N/A</td>
<td>N/A</td>
<td>Improvement measure: Routine evaluation of the frequency, reasons for, and/or appropriate handling of patient walk-in visits.</td>
<td>16</td>
<td>50% 50% 0</td>
</tr>
<tr>
<td>N/A</td>
<td>N/A</td>
<td>Process improvement target: Routine support by access managers for frontline access-related quality improvement.</td>
<td>16</td>
<td>33% 60% 7%</td>
</tr>
</tbody>
</table>

NOTE: MD = physician; \(N\) = number of respondents; N/A = not applicable; RN = registered nurse; SD = standard deviation.

\(^a\) To adjust for reviewer effects, we computed individual mean scores for each respondent (i.e., their average rating across all measures) and the grand mean for all panelists (i.e., the overall mean across all measures and panelists). The de-biased score is determined by the formula (panelist’s score – panelist’s mean) + grand mean. Percent 5 means the percentage of panelists rating the item as high priority.

\(^b\) Urgent was defined as “should be undertaken this year.”

\(^c\) A teamlet is a primary care team that includes a health care provider, registered nurse, licensed practical nurse, and clerk.

\(^d\) A group practice management team is involved in maximizing the supply of health care services in relation to demand.

\(^e\) Originally, we listed this priority in a fourth category called improvement measures. Upon revising the categories, this became part of the category for process improvement priorities.
This document is intended as a resource for strategic planning for organizations intending to initiate access management improvement. For example, some organizations may have already achieved a specific priority action or recommendation. Specific suggestions for implementing the recommendation are purposely diverse and intended to reflect options recommended by the panel or in the literature. Planners should consider these in light of their organization’s priorities, resources, and other relevant contextual factors.
# Telephone Access

Routinely evaluate the degree to which patient telephone calls are (a) answered promptly and (b) routed accurately and appropriately, as judged in terms of patients’ clinical needs and preferences

<table>
<thead>
<tr>
<th>Level: Must be initiated at the executive level</th>
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## Recommendation

1.1 Ensure that the set of telephone management metrics incorporates four key principles:

1. following calls to resolution
2. accounting for both call center and primary care team roles in telephone management, promoting substitution of telephone management for in-person management whenever appropriate
3. promoting metric availability at local site levels to support targeted telephone management improvement initiatives
4. incorporating patient preferences and experiences into metric development and interpretation.

## Suggestions for Implementing the Recommendation

### Suggested call center measures include:

- the average speed of answer by the call center for all inbound calls (e.g., the percentage of calls answered within 60 seconds)
- whether calls are answered more quickly at certain times of day versus others
- 24-hour availability of call answering
- measures beyond electronic data (e.g., record call center calls for quality assessment)
- call-back workload (e.g., the number of call-back attempts to patients per 100 initiating calls from the patient or call center)
- provider satisfaction (e.g., with types of appointments booked through the telephone, and reasons for dissatisfaction; timeliness of patient appointments in the community-based programs).

### Suggested primary care team measures include:

- average speed of answer to the patient from the final call destination for calls routed from a call center to a medical office or clinic
- number or proportion of potentially avoidable calls (e.g., percentage of patients who call and leave more than one message for the clinic before being able to schedule an appointment; clinician assessments of when and what types of calls could be handled another way)
- average speed of primary care team answers to (a) all inbound calls and recorded messages from the call center, and (b) all inbound patient calls
**Suggested first call to resolution measures include:**

- measures beyond electronic data (e.g., use provider quality review of a set of medical records to determine whether calls are being routed accurately and appropriately based on the patients’ clinical needs and preferences; survey patients’ satisfaction with their ability to contact their physician or care delivery team with a medical question [see the section on Patient Access Experience])
- measures of local primary care site call resolution to provide individual sites with data for improvement
- rates of multiple patient call-backs (e.g., the percentage of patients resolving their problem on a first call, the percentage of patients making a second call, the percentage of patients lost to follow-up after leaving a message, the percentage of patients leaving more than one message before achieving resolution).

**Suggested patient access experience measures (see the section on Patient Access Experience)**

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**Recommendation**

**1.2** Ensure that appropriate telephone management strategies are focused on four key principles:

1. enabling links to each patient’s usual primary care team (i.e., to the patient’s continuity physician, nurse practitioner, or physician assistant and team) whenever possible and appropriate
2. enabling telephone calls to access available non–primary care resources appropriately, comprehensively and accurately
3. facilitating local health care system and site improvement based on data
4. using best available technology for incorporating patient preferences into telephone answering protocols.

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**Suggestions for Implementing the Recommendation**

**Suggestions to facilitate telephone management contacts include:**

- Identify and document all acceptable methods for linking patient calls to their primary care teams and providers.
- Identify all resources that are accessible by telephone and make available as appropriate to staff and patients.
- Develop a plan for regularly updating relevant health resource contact information.
Suggestions to support ongoing, broad-based telephone management improvements include:

• Set improvement goals for telephone answering services by engaging key stakeholders, including patients
• Engage local stakeholders by sharing metrics results widely (e.g., report them in executive leadership and other staff meetings; post on websites or in newsletters) and celebrating improvements
• Identify approaches and mechanisms for initiating improvement initiatives.

Suggestions for use of technology to incorporate patient preferences in call center protocols include:

• Inform patients waiting for call to be answered about estimated wait times and giving the patient the option of waiting longer or leaving a message.
• Use different approaches for patients requesting a medical advice contact versus appointment scheduling contact.
• Remove such messages as “Voicemail is full; call back another time” from call center or designated primary care site phones.
• Identify key areas in which patient preferences should guide the call center’s response (e.g., when the call is not emergent and the patient prefers a call or appointment with his or her assigned provider or team rather than a quicker appointment or answer from an alternative) and train call center staff accordingly.
• Remove performance or technological barriers to responding appropriately to patient preferences.
• Set improvement goals to increase the frequency of real-time medical advice provided to patients with a medical question by a known and trusted caregiver.
• Explore technology to connect the call center to the electronic medical records so that incoming calls can be automatically assessed for medical questions and automatically routed directly to the patients’ physician or care team.
### Recommendation

**1.3** Ensure that telephone management initiatives target call center and primary care team staff satisfaction and stability by prioritizing:

1. appropriate staffing
2. incentives for high-quality performance.

### Suggestions for Implementing the Recommendation

**Suggestions for call center staffing strategies include:**

- Assess overall call center staffing and turnover relative to call volumes and “right size” staffing, even if it means limiting the number of practices or clinics served by the call center at a given time.

- Ensure increased call center staff availability during typical high-volume call times.

- Incentivize call center personnel (e.g., ensure appropriate General Services levels for level of responsibility; reward high-quality performance; ensure pathways for advancement).

- Reduce friction and increase positive interactions between call center staff and clinical care teams (e.g., schedule meetings between the call center director and the care teams as needed to get buy-in for call center procedures).

**Suggestions for primary care team staffing strategies include:**

- Assess primary care team staffing, satisfaction, and stability in relation to telephone management demand (see the section on Provider Experience).

- Ensure increased primary care team staff availability for responding to patient calls and call center messages during typical high-volume call times.

- Identify standard methods aimed at minimizing demand for telephone access while also minimizing demand for unnecessary in-person visits (e.g., robocall high-volume information, such as flu-shot reminders).

### References and Further Reading for Recommendation 1.3 and Associated Suggestions for Implementation


**Recommendation**

1.4 Ensure that patients with hearing loss or difficulty attending face-to-face visits are accommodated through telephone adaptations, print materials, or other virtual technologies.

**Suggestions for Implementing the Recommendation**

- Identify target vulnerable groups for ensuring telephone access; always include patients with mental health issues and patients with hearing loss.
- Assess patient telephone access and care experiences among other vulnerable patient groups seeking care at a given primary care site, such as those who live distant from the site; are homeless; are women veterans; are frail elderly; have language difficulties; or belong to ethnic, cultural, or sexual minorities. Institute training, technology, or protocols for ensuring appropriate and effective communication with clinic staff regarding needed care.
- Assess patient satisfaction with telephone access among each target vulnerable group, and institute training, technology, or protocols for improvement where needed.
- Ensure prompt availability of local help for mental health problems (e.g., “hot numbers” to primary care and to mental health specialty, or to an appropriately skilled triage, for patients with mental health problems, in addition to national suicide hotlines.
- Reach out to patients with mental health diagnoses proactively through a hotline.
- Identify patients with critical hearing loss and proactively identify technology or alternative communication methods to accommodate telephone access.

**References and Further Reading for Recommendation 1.4 and Associated Suggestions for Implementation**

# Patient Access Experience

Assess the quality of the patient’s experiences of access (i.e., patient-rated access). We expect patient ratings to reflect both in-person and non-face-to-face (e.g., telehealth, telephone, secure messaging) care.

## Recommendation

2.1 Regularly assess patient access experiences at the primary care site patient population level, using a reliable and valid survey.

## Suggestions for Implementing the Recommendation

### Suggested surveys include:

- the Supplemental Access Items for the CAHPS® Health Plan Survey 5.0
- Survey of Healthcare Experiences of Patients Consumer Assessment of Health Plans – Patient-Centered Medical Home (SHEP CAHPS PCMH) questions on access.

### Measures of timeliness alone are not sufficient:

- Assess both urgent/same-day access and routine access for new and established patients.
- Measure timeliness of bonded and matched access (e.g., access to the patient’s assigned site, continuity provider, and team) separately from simple timeliness of access, particularly for nonurgent problems.
- Incorporate the hassle factor in surveys of patient access experience.
- Consider patient focus group input on existing patient survey designs and what the surveys do and do not reflect.
- Consider the access experiences and perceptions of patient family members, who may be carrying much of the access burden for some patients.
- Establish a patient and family advisory council for each primary care clinic to provide feedback to improve the patient access experience.

### Recognize the following in interpreting results:

- The degree to which a visit met patient choice (e.g., whether, for a specific visit, bonding and matching were more important or urgency and timeliness were more important) will ultimately shape overall satisfaction.
Different types of patients (e.g., younger versus older, chronically ill versus healthy) have different priorities, as do patients who are anxious, in pain, missing work, or being affected in terms of other daily living activities.

Non-face-to-face modalities (e.g., telehealth, telephone, or secure messaging visits, particularly with continuity providers or teams) can substitute substantially for in-person visits and affect patient experience measures.

References and Further Reading for Recommendation 2.1 and Associated Suggestions for Implementation

- Parchman, M. L., P. H. Noel, and S. Lee, “Primary Care Attributes, Health Care System Hassles, and Chronic Illness,” Medical Care, Vol. 43, No. 11, November 2005, pp. 1123–1129. PMID: 16224306

Recommendation

2.2 Regularly collect real-time data in primary care sites at the time of visits

Suggestions for Implementing the Recommendation

Suggested surveys include:

- American Association of Family Physicians questionnaire at each patient primary care in-person contact
- Health Quality Ontario questionnaire at each patient primary care in-person contact
- Institute for Healthcare Improvement and Dartmouth College’s “Today’s Office Visit Survey Card” at each patient primary care in-person contact.

Suggested additional evaluations:

- Follow up real-time assessments directly with patients that indicate “poor” or “dissatisfied” ratings, to discover what happened.
- Conduct patient focus groups.
- Ask real-time questions via patient kiosks.
- Use of a “patient tracer” (i.e., a real or simulated patient) to evaluate the experience of making, scheduling, and undergoing an appointment.
- Carry out spot surveys focused on key site access issues over several weeks.
- Consider the access experiences and perceptions of patient family members.
- Develop a local patient experience template to reflect the key patient experience goals, barriers, and facilitators at the site.

**References and Further Reading for Recommendation 2.2 and Associated Suggestions for Implementation**


Group Practice Management Structure

*Develop a clearly identified group practice management structure with a designated group practice manager who reports to executive leadership, communicates with individual primary care sites, and can collaborate across roles and service lines (e.g., medicine, nursing, administration).*

**Recommendation**

3.1 Identify a group practice manager position at a high enough level to report effectively to executive leadership, while connecting executive leadership and relevant middle managers with frontline primary care practice–level access-related activities and concerns.

**Suggestions for Implementing the Recommendation**

Characteristics of successful group practice managers (GPMs) include that the GPM:

- serves as the point person for helping local primary care site leaders respond effectively to both central and frontline demands
- reports to the executive team, participates in organizational strategic planning, and has sufficient authority to implement needed improvements
- has both good people skills and data skills, and uses them to enable and monitor access improvement while also managing expectations
- has oversight for the access management program, including identifying gaps and establishing processes to close them.
References and Further Reading for Recommendation 3.1 and Associated Suggestions for Implementation


### Recommendation

3.2 Identify and document the specifics of a group practice management program and team, including key stakeholders in the team’s success, and ensure that the team is trained in (a) how to promote stakeholder engagement, including frontline staff, and (b) how to access and use data for improvement.

### Suggestions for Implementing the Recommendation

- Create an orchestrated access management team in each facility.
- Incentivize clinicians and staff members to work in teams to address the issue of hierarchy, which limits sharing of information and experience; clarify roles. Engage team members by providing feedback on improvement measures and how changes are improving the situation for patients.
- Incorporate flexibility into the access management program to be able to customize the program to unique site and patient needs.
- Create a group practice management culture that is goal-directed rather than punitive and that focuses on improvement.
- Identify or develop tools to track and manage patient care, and use the tools to inform executive management.
- Expect and overcome resistance when decisionmaking crosses professional silos; build psychological safety into improvement efforts to address risk aversion; promote a culture of problem-solving.
- Display GPM-gathered data in one place (e.g., a dashboard) where the data can be easily reviewed by the GPM and shared with others (e.g., clinic leaders) to identify and solve problems.
- Ensure that GPM-gathered data are clean and accurate and reflect what is being done to facilitate access to care and enable decisionmaking.
- Training for group practice managers is critical, particularly regarding acquiring, utilizing and communicating data.
- Engage team members by providing feedback on improvement measures and how changes are improving the situation for patients.
- Engage all team members regardless of hierarchy in understanding the value of data generation and use in improvement and change programs.
- Ensure that the GPM team is trained in advanced access techniques.
- Train GPMs in inter-professional shared decisionmaking, such as shared governance (see the section on Identification of Primary Care Practice Site Leaders).
References and Further Reading for Recommendation 3.2 and Associated Suggestions for Implementation


Identification of Primary Care Practice Site Leaders

Identify physician, registered nurse, and administrative leaders for each primary care practice site with authority to support access management priorities within local site contexts.

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<thead>
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<th>Level: Must be initiated at the executive level</th>
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<th>Recommendation</th>
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4.1 Ensure that the inter-professional structure of team-based care models, such as the patient-centered medical home, is reflected in strong integrated inter-professional governance at the primary care practice site level, including explicitly identified site-level physician, RN, and administrative leaders.

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<thead>
<tr>
<th>Suggestions for Implementing the Recommendation</th>
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</table>

- Consider models of shared governance at the local level. Shared governance is a system of management that aims to empower staff in decisionmaking at the local unit level, such as at the primary care practice level, with the goal of enabling health care professionals to develop multi-professional care. In the United States, much of the shared governance focus has been on nurses as participants in shared governance, often in hospitals. In the United Kingdom, there has been significant focus on primary care and on the role of administrative managers. There are few empirical quantitative outcome studies on these models; however, there is substantial qualitative evaluation information supporting them.

- Ensure strong central (executive) leadership engagement, including allocation of resources, such as staff time, in implementing a shared governance model; without this, very autonomous practices without a prior shared governance culture are unlikely to succeed.

- Assess and improve primary care practice leadership team communication by developing willingness to participate in shared decisionmaking and ability to focus on task conflict and differences in opinion rather than on personality differences and interpersonal tensions.

- Avoid top-down pressure to deliver rapid measurable changes, lack of attention to professional autonomy, and a focus on blame. These are major impediments to success (balance with standardization).
• Promote open accountability, willingness to learn across disciplines or professions and from mistakes, and willingness to problem-solve through quality improvement. These characteristics are linked to the concept of psychological safety, which is predictive of success.

• Legitimize and balance managerial (administrative) and health care professional (physicians, nurses, and others) perspectives; respect for professional autonomy and for the benefits of shared administrative approaches are essential.

• Develop approaches for sharing learning across primary care practices; this can facilitate effective local practice site leadership.
References and Further Reading for Recommendation 4.1 and Associated Suggestions for Implementation


<table>
<thead>
<tr>
<th>Level: Can be initiated by midlevel managers, including unit managers, primary care site leaders, or care team leaders</th>
</tr>
</thead>
</table>

**Recommendation**

4.2 Ensure that inter-professional primary care practice leadership is trained in problem-solving approaches and in how to teach these to providers and staff.

**Suggestions for Implementing the Recommendation**

- Teach the teachers (practice site leaders) to use and transmit the problem-solving approaches typical of high functioning teams, including for example practice redesign and quality improvement techniques.
- Develop organizational strategies that facilitate success for local quality improvement innovation.

**References and Further Reading for Recommendation 4.2 and Associated Suggestions for Implementation**

Development of Contingency Staffing Approaches

Maximize access managers’ routine use or ability to demonstrate systematic approaches to ensuring adequate availability of contingency staffing (i.e., planned minimal excess staffing to cover routine absences, such as those resulting from hiring gaps, vacations, illness).

Recommendation

5.1 Analyze demand data and use that information to anticipate upcoming needs for contingency staffing either from internal staffing resources (e.g., local or regional primary care teams) or from external sources (e.g., contracted temporary staffing). Contingency staffing is a work-force method in which staff members are hired as and when needed for limited periods of time.

Suggestions for Implementing the Recommendation

Suggested approaches to predicting demand include:

- Use demand data to predict daily, weekly, and seasonal demand and adjust staffing accordingly.
- Add more appointment times for seasonal events such as seasonal migration from cold climates to warm climates, flu shot clinics during flu season, or pre-school physicals for clinics serving children.
- Assess any backlog and consider whether contingency staffing is needed to reduce or eliminate it.
- Plan to cover leave times by reviewing past-year leave data. Then calculate the contingency staffing needed to cover leave and arrange for it on a routine basis, such as by hiring or arranging for regular but intermittent additional contingency staff to cover leave times.

Suggested approaches to matching contingency staffing supply to demand include:

- Use daily huddles to review demand and to proactively match daily supply and demand, identifying any upcoming needs for contingency staffing.
- Schedule discretionary time for providers to cover absences of other providers or team members.
- Minimize the need for contingency staffing through planned management of provider leave time (e.g., hold time in a vacationing provider’s schedule for the first
week back from vacation; when the provider leaves, start filling morning appointments of the return week; and when provider returns, start filling afternoon appointments of that week).

- Plan for the sudden absence of a provider or other team member—short-term (e.g., sick day) or long-term—by identifying emergency contingency staffing sources (e.g., through community support agencies and care management companies or through shared internal staff across panels).

- Minimize the use of external contingency staffing by cross-training team members and internal contingency staff (e.g., float team trained to cover responsibilities throughout the clinic when needed; scheduling staff trained to clean instruments and set up rooms for procedures; nursing staff trained to do scheduling if necessary; scheduling or reception staff trained to gather patient information and assign patients to exam rooms; check-in and check-out staff trained to fill in for each other; physicians, nurse practitioners, and physician assistants trained to substitute for each other)

References and Further Reading for Recommendation 5.1 and Associated Suggestions for Implementation


- Institute for Healthcare Improvement, “Changes: Optimize the Care Team,” webpage, undated-a. As of June 29, 2018: http://www.ihi.org/resources/Pages/Changes/OptimizetheCareTeam.aspx

# RN Demand Management and Care Coordination Role

*Maximize the ability of the primary care team’s registered nurses to prospectively manage demand by leading care coordination for their panels.*

## Recommendation

**6.1** RNs should be specifically trained and supported to become leaders in proactive demand management and care coordination at three distinct levels (RN executives, RN site-level or multisite-level nurse managers, and RN team-level care coordinators).

## Suggestions for Implementing the Recommendation

**Training at each level should include, for example:**

- appropriate leadership skills (e.g., inter-professional communication, understanding access and care coordination, development of RN primary care careers and roles)
- basic primary care access and care coordination management and outcome measures, as well as RN roles in promoting access improvement
- primary care team functioning and the RN role within it
- panel management based on data, such as dashboards or care coordination software
- available alternatives to individual in-person visits such as telehealth, telephone care, secure messaging, group visits, and e-consults
- contingency management (see the section on Development of Contingency Staffing Approaches)
- demand management (see the section on Maximization of the Ability to Manage Demand).

**Support should include:**

- ensuring that RNs have the appropriate level of authority and appropriate time allocation for achieving effective hands-on demand and care coordination management.
References and Further Reading for Recommendation 6.1 and Associated Suggestions for Implementation


Provider Experience

Assess primary care provider and staff morale (e.g., low/high burnout, job satisfaction, or turnover rates) in relation to access mismatch (e.g., panels exceeding recommended size, primary care provider vacancies).

Recommendation

7.1 Develop a central organizational focus on tracking primary care provider and staff morale (including retention, recruitment) in relation to access mismatch at the local primary care practice, local health care system (medical center), and regional levels.

Suggestions for Implementing the Recommendation

Assess each primary care practice for supply versus demand mismatch at the site level:

- Assess overall patient numbers at each primary care practice site, calculated as the patient load (e.g., the number of primary care patients seen at the site + the number on a wait list in the prior year) versus the expected number of patients that currently available providers and staff could see (e.g., the number of full-time employment equivalent providers, teamlets, or patient panels × the number of patients expected to be cared for per provider, teamlet, or panel at the site). If the difference between the expected number of patients that could be seen and the number of patients seen or waiting to be seen last year is substantial, that is a major mismatch that is likely to cause provider and staff burnout.

- Ensure that data assessing burnout and turnover in relation to local primary care site supply versus demand mismatch are assessed and communicated at regular intervals to regional and local health care system leadership.

Use standard measures to assess morale, such as:

- burnout (e.g., the Maslach Burnout Inventory [MBI], including MBI-Human Services Survey, MBI- Human Services Survey for Medical Personnel, or MBI-General Survey)

- job satisfaction (e.g., Areas of Worklife Survey that assesses aspects of work experience; Institute for Healthcare Improvement job satisfaction measure)

- provider and staff turnover (e.g., Institute for Healthcare Improvement Measure of Nurse Turnover Rate assessing the number of voluntary uncontrolled separations during the month for unit registered nurses and advanced practice nurses divided by the number of unit employees [full-time + part-time] on the last day of the month for
registered nurses and advanced practice nurses, multiplied by 100 to get the percentage).

Focus on supply-demand mismatch, but assess additional causes of low morale:
- Assess provider and staff turnover, burnout, and staff satisfaction in relation to changes in access management, such as implementation of advanced access features.

Focus on both retention and recruitment
- Assess current provider and staff retention incentives and whether they are sufficient to retain providers and staff in locations with access mismatch.
- Interview departing providers and staff to assess reasons for leaving, categorize causes, and report periodically (e.g., yearly) to leadership.

References and Further Reading for Recommendation 7.1 and Associated Suggestions for Implementation
- Institute for Healthcare Improvement, “Measures: Percent of Voluntary Nurse Turnover,” webpage, undated-b. As of April 12, 2018: [http://www.ihi.org/resources/Pages/Measures/VoluntaryNurseTurnover.aspx](http://www.ihi.org/resources/Pages/Measures/VoluntaryNurseTurnover.aspx)


Maximization of the Ability to Manage Demand

Maximize primary care team members’ ability to proactively manage demand (e.g., alerts, reminders, and telephone contacts from patients on their panels) by optimizing provider visit schedules (e.g., through triage, prospective “scrubbing” of appointments to the extent appropriate given their training/licenses).

Recommendation

8.1 Train primary care site leaders and teams in four key principles of proactively managing demand, including:

- analyzing site-level data on past demand to plan short-term supply (i.e., workforce) adjustments
- enabling providers to achieve needed same-day continuity visit availability by right-sizing their panels and by using advanced access principles
- integrating patient preferences into all aspects of access management
- using data resources to track site-level and team-level access (e.g., through dashboards).

Suggestions for Implementing the Recommendation

Suggestions for training of primary care site leaders and teams include developing and implementing:

- an open, engaged, problem-solving culture, not a punitive culture, around improving access
- flexibility relative to local primary care site limitations and resources and on how to get assistance for problems implementing advanced access principles, especially when overall local primary care site workforce supply is inadequate to meet demand
- use of advanced access principles, including adjusting return visit rates, enabling same-day continuity access, and matching provider expected and actual availability to see patients
- support for use of non-face-to-face encounter methodologies (see the section on Telephone Access)
procedures for addressing patient preferences in arranging either face-to-face or non-face-to-face visits, especially when trade-offs between appointment promptness and desire to see a continuity team member are required

• scripts to let the patient decide whether to wait for his or her provider to return from a scheduled leave or to be scheduled with his or her team or a different provider

• patient education about the team approach and about alternative care options with team members

• patient education about opportunities to contact the care team (e.g., telephone, email, or a patient portal) to enhance continuity (see the section on Telephone Access).

Suggestions for anticipating demand and adjusting supply include the following:

• Measure past demand and use data to predict demand daily, weekly, and seasonally and to schedule supply (i.e., primary care workforce) accordingly.

• Distinguish between activity (number of patients seen) and demand (number of requests for care), and focus on meeting the demand rather than the amount of activity.

• Monitor overflow visits during periods of low access, such as preventable emergency department or urgent care visits, and account for the demand these patients represent.

• Identify opportunities and plan for group visits or consultations with patients requesting or needing frequent visits (e.g., patients with chronic illnesses).

• Develop roles for team members other than providers for subpopulations of patients (e.g., those with congestive heart failure, those with hyperlipidemia, or those using anticoagulation).

• Plan for nurse practitioners and physician assistants to see patients of absent providers and/or to have their own panels.

• Plan to spread high demand times, such as for school physicals and flu shots, over a longer period of time (e.g., schedule school physicals on the patient’s birthday).

• Eliminate the distinction between routine and urgent appointments; distinguish, instead, between short and long (multiples of short) appointments (e.g., annual exams, new patients, chronic illness patients).

• Measure nonappointment delays and efficiency (e.g., telephone message).

• Plan to use tele-pharmacy, tele-primary care, and tele–mental health hubs.

• Encourage providers to accomplish as much as possible during patient visits, anticipate patient near-term visit needs, and select follow-up visit intervals based on patient needs.

• Assess management of telephone care (see the section on Telephone Access).
## References and Further Reading for Recommendation 8.1 and Associated Suggestions for Implementation

