Improving Care Access for New Patients in an Outpatient Gastroenterology Clinic: A Novel Approach

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New patient access to subspecialty clinics can be improved with simple initiatives, staff education, and improved teamwork.

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Abstract

Background

We performed a quality initiative to improve our gastroenterology clinic access.

Methods

A prospective quality improvement initiative was implemented in 12/2012.

Results

From 10/2011 – 11/2012, 35.1% new patients were seen $\leq$ 10 days. After initiation of the quality improvement initiatives from 12/2012 – 1/2014, 75.2% new patients were seen $\leq$ 10 days ($p < 0.01$).

Conclusion

New patient access to subspecialty clinics can be improved with simple initiatives, staff education, and improved teamwork.

Introduction

Access to subspecialty clinics is an important health care issue for patient care, referring physicians, downstream revenue, and practice efficiency.

With long waiting lists, high no-show rates, and increased patient demand for gastroenterology (GI) services, access to GI specialty clinics is causing clinical and financial concern for all GI practices. Increased clinic wait times can cause increased nursing time to triage patients (decreased clinic efficiency), increased urgent care and emergency room visits, and increased negative health outcomes.¹ These increased wait times do not satisfy the Institute of Medicine's call for timely access and patient-centered care.²

Advanced access scheduling is a system in which patients are able to see who they want, when they want, and is a more patient-centered appointment method.^{1, 3} Advantages of advanced access scheduling are decreased no-show rates and lower health care costs, while improving continuity of care, patient satisfaction, and productivity of health care providers (operational efficiency).^{1, 3-7}

Challenges for practices adopting advanced access are many. Several barriers to advanced access are as

follows: physician and clinic administrator's buy-in and level of participation, physician leaves/vacations, and patient supply and demand issues.² Also, continuity of care with a specific provider was difficult to maintain with the advanced access system.⁸ Advanced access research is limited and studies lack detailed evaluations of data, such as utilizing appointment availability only without checking no-show rates or patient and staff satisfaction scores.²

Over the past two years, our institution, like many others, have struggled with supplying optimal access to new patients while trying to address high no-show rates. Therefore, a quality initiative was undertaken by the Division of Gastroenterology at the University of Missouri (MU-GI) to meet a goal of > 70% of new patients to be scheduled ≤ 10 days.

Methods

Setting

The quality improvement study was performed at the University of Missouri in the Division of Gastroenterology. The project was approved by our Institutional Review Board (IRB). The GI division is an academic, tertiary-care facility which services the entire state of Missouri. The GI division has 10 attending physicians, 12 fellows, and one nurse practitioner with 8,215 patient visits in 2013.

Implementation

A prospective quality improvement study was conducted from December 2012 to January 2014. All new patients referred to our outpatient GI clinics were monitored and recorded. Data before December 2012 was retrospectively evaluated, dating back to October 2011. A quality initiative was implemented by a new Director of Ambulatory Services (beginning December 2012).

In December 2012, a supply-demand analysis was performed. On December 5, an educational session to faculty and fellows regarding prolonged access times and adoption of an open or advanced access clinic model with a front-log emphasis were performed. On December 26,

Figure 1

Timeline and details of quality initiative performed in the GI clinic.

a policy was created and implemented with all Patient Service Representatives (PSRs) to notify Director of Ambulatory Services if any new patient referred to MU GI cannot be scheduled ≤ 10 days. If a new patient cannot be seen ≤ 10 days, one of three options was initiated: referred providers to over-book their clinic, Director of Ambulatory Services to overbook his clinic, or the Director created a special clinic outside of normal clinic time to see the patient. In January 2013, an advanced access model was adopted and initiated at MU GI. In July of 2013, we implemented a 60/40 rule – 60% return and 40% new patients over each clinic schedule. Figure 1 describes the timeline and details of the quality initiatives.

Statistical Analysis

Descriptive statistics were utilized in evaluating the populations. Fisher's exact test was used to compare recent groups with baseline.

Results

From October 2011 to November 2012, a total of 2,478 new patients were referred to MU GI. Of those 2,478 new patients across multiple clinics, 871 were seen ≤ 10 days (35.1%) with the best month being 47.7% in August 2012. A supply versus demand analysis

Figure 2

Supply versus demand analysis performed in December 2012.

Figure 3

New patients seen ≤ 10 day in the GI clinic from October 2011 to January 2014.

was performed in December 2012 showing 233 new patients scheduled with 180 being seen (77%). (See Figure 2.) This analysis demonstrated that the clinics were able to perform at >70% of new patients seen at any time based upon current infrastructure (number of providers, number of clinics, etc). Since December 2012, after initiation of the multiple quality improvement initiatives from December 2012 to January 2014, 1,903 of 2,530 (75.2%) new patients were seen ≤ 10 days, which was statistically significant increase as compared to October 2011 to November 2012 ($p < 0.01$). (See Figure 3.) The best month under the new system was

90.6% in March 2013. A statistically significant increase was noted in new patients seen ≤ 10 days per month from October 2011 to November 2012 as compared to December 2012 to January 2014 (62.2 ± 25.1 versus 135.9 ± 27.8 new patients, $p < 0.01$). From June 2013 to August 2013, clinic access for new patients ≤ 10 days dropped below 70%, likely due to physicians vacations, sick-leave, and increased number of return patients being seen (due to increased new patients over the past 6 months). In response, the system was altered in every clinic in mid-July 2013 to be 60% return patients and 40% new patients. Overbooking of returns was allowed only in return patient slots. After this new quality improvement initiative was implemented from September 2013 to January 2014, 733 of 920 (79.7%) new patients were seen ≤ 10 days with no month falling below 78.4%.

Discussion

New patient access is an important issue for all clinical settings. Open access, also known as advanced access, scheduling has been shown to decrease wait times, urgent care/walk-in clinic utilization, cancellations/no-shows while creating and improving patient satisfaction, physician morale and market growth.⁵ However, according to Solberg et al., the major issue with

organizational change is the tension among physicians related to their autonomy.⁹ Secondly, balancing the need for flexibility and need for clarity creates pressure for the entire office. Primary care and various specialties have attempted to rectify patient access issues by utilizing different scheduling procedures with varying success.

Previous attempts to improve patient access have been mixed and efforts not easily sustained. In 2004, Schall et al. implemented changes consisting of reducing the number of appointment types, extending the return appointment times, and transferring patients back to their primary-care provider allowed for increased access

to their clinic.¹⁰ Parente et al. in 2005 found improved operational efficiency and PCP access, while decreasing wait times with their VA clinics.³ Patient satisfaction did not increase. In 2009, Snow et al. blocked 10% of the appointments for five weeks to have 50% of the schedule reserved for new patients.¹¹ These appointments were then opened the week prior to the clinic date to have the necessary space for new patient demand. In 2010, Cameron et al. found within their academic primary-care center, open access scheduling improved patient access and no-show rates without affecting patient volumes.¹²

In our quality initiative, our access for new patients seen ≤ 10 days was significantly increased by a few minor system changes. With the adoption of the open or advanced access model with a front-log emphasis and enhanced team-work among physicians, nurses, and PSRs, we were able to improve from a dismal 35.1% to 79.7% over the span of one year. The quantity of new patients seen in ≤ 10 days per month doubled. A unique aspect to the open or advanced access model is the concept of a front-log emphasis. When initiating this system, a back-log of patients will be present. Instead of seeing all the back-log of new patients over the span of six to twelve months, we chose the front-log approach in which all new patients requiring appointments were fit into schedules by schedule openings due to cancellation or overbooking. We believe this approach led to a more rapid compliance with our goal than the back-log emphasis. Based upon all these changes, this quality improvement model may be replicated in other clinics, especially those struggling to see new patients in a timely manner.

A major strength of our study is we accomplished the organizational changes through teamwork. From the PSRs to physicians (fellows and attendings), all members contributed and adopted the new scheduling process. Secondly, access was improved with simple initiatives and staff education. Third, the key to our organizational change success was having a physician champion to facilitate the initiatives and maintain accountability. Through teamwork, we were able to increase new patient access consistently above 70%.

A few weaknesses in our QI study are noted. Our GI program is an academic tertiary-care center with only one private for-profit hospital with GI services in the same city. Therefore, this may not be applicable to all

subspecialty clinics in every system. Secondly, patient or physician satisfaction data was not obtained. Thirdly, new patient appointments were further limited by provider/physician vacations and increased number of returns, which are noted by the increase in wait times during July and August. This is the reason the 60/40 rule was initiated. Finally, some GI subspecialty providers simply have more patient demand than they can manage. Our pancreatobiliary specialist and hepatologists initially had longer wait times than general gastroenterologists; however, over time, these sub-specialties met the 10-day goal.

Conclusion

New patient access to subspecialty clinics can be improved with simple initiatives, staff education, and improved teamwork. This successful model may be used to meet the current and future new patient demand in GI and other subspecialty clinics.

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Disclosure

None reported.

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