



**ACHIEVING A NEW STANDARD IN PRIMARY CARE FOR
LOW-INCOME POPULATIONS: CASE STUDIES OF REDESIGN
AND CHANGE THROUGH A LEARNING COLLABORATIVE**

**CASE STUDY 2: ADVANCED ACCESS LEARNING
COLLABORATIVE AT UNION HEALTH CENTER**

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CENTER PROFILE

The Union Health Center, located on 7th Avenue between West 25th and 26th Streets in Manhattan, has a long history of providing much-needed health care to garment industry workers. Union was originally founded by the ILGWU (International Ladies Garment Workers Union) in 1914, in response to high rates of tuberculosis among garment workers and their families during local epidemics. It now serves workers and families affiliated with UNITE, the union formed by the merger of the ILGWU and the Amalgamated Union, as well as a small number of non-UNITE members who live or work in the neighboring area.

For decades, Union dispensed care that followed a very traditional model. Workers and their families came to the center annually for head-to-toe physicals. If problems were identified, patients received referrals to outside specialists. Over the last decade, however, approaches to health care changed nationally, and Union sought to broaden its mission. It evolved into a primary care facility that treats patients' needs in one location.

“We strive to be really comprehensive,” says Dr. Molly Collins, Union’s associate medical director, “and to take care of everything for patients, not just parts of things. We think patients get better care that way, as opposed to seeing many doctors on the outside and receiving fractured care.”

For almost half a century, Union occupied the same floors of its 7th Avenue building, operating in space that had not been updated since the 1940s. In 1999, the

center moved to two and one-half floors in the same building. These newly renovated facilities were designed for the practice of contemporary primary care, with 54 exam rooms and new computers in every room.

Union's busy urban office handles an active population of about 25,000 patients, or approximately 115,000 visits annually. Roughly 90,000 visits are for medical treatment and 25,000 are for ancillary services. The center employs 12 full-time primary care physicians and nurse practitioners, and 45 part-time medical specialists and surgical sub-specialists. The multidisciplinary clinic offers everything from flu shots to surgery. It houses a pharmacy and offers such specialty services as dermatology, cardiology, radiology, mammography, breast surgery, bone density testing, x-rays, lab facilities, and physical therapy.

CENTER CONDITIONS PRIOR TO ADVANCED ACCESS

In 1999, the same year Union moved to its renovated quarters, a new CEO and medical director, Dr. Karen Nelson, took the helm of the facility in September. "When I arrived," she recalls, "everyone from senior management to union members was complaining about waiting times."

When patients wait too long to see providers, their own jobs are compromised. As hardworking union members, getting time off from work for medical appointments was awkward for them—and not returning to work because they were held up at the doctor's office was difficult to explain to their supervisors.

Lengthy Patient Visit Times Addressed Through PCDC's Redesign Program

Nelson realized that the center had to make changes, and turned to PCDC. Union's management was familiar with the ways PCDC helps community-based health facilities because it helped Union secure bond financing for its extensive renovation. Union signed on for PCDC's Redesigning the Patient Visit. The program tackles long wait times by creating teams from participating health centers and then coaches the teams on how to make their visit process and procedures more efficient.

Union embraced Redesign wholeheartedly. Once it determined that the average patient visit lasted 120 minutes, the team and the rest of the center worked hard to implement highly efficient office and clinical procedures to reduce that time. To save time and provide additional support, staff and providers were cross-trained:

- Staff members became patient care associates (PCAs), readying rooms for providers and taking a patient’s vital signs
- Providers began to use electronic medical records (EMRs) and input patient information on the computer in the exam room at the end of a visit

By the end of Redesign, the average visit lasted around 45 minutes, down from 120.

Nelson calls the program “a fabulous success. Patients loved it. Everyone loved it. It flips primary care on its head a little because it makes everything patient-focused. The point becomes to get patients what they need.”

Ultimately, Union’s shift to a patient-focused approach went far beyond decreasing visit wait time. Focusing on the patient changed employees’ images of themselves and their colleagues; each person now felt he or she had a significant role to play as a team member working toward higher-quality patient care.

This type of fundamental organizational and interpersonal change illustrates how PCDC’s programs overhaul health center operations. Its methods change the foundation of an organization’s work structure and alter employee attitudes toward patients and each other. Such changes prompt a transformation of the health center and the type of care it provides.

After Redesign, Looking at Long Waiting Times for Appointments

After Union successfully decreased patient visit time by introducing patient-focused service, it addressed a second issue that affected patient satisfaction and care. The daily schedule at Union was so tight that patients had to wait long periods to get an appointment to see their primary care physician. Both employees and patients were extremely frustrated by this, which led Union to participate in a PCDC program that redesigns the appointment scheduling process at health centers.

THE ADVANCED ACCESS LEARNING COLLABORATIVE

Advanced Access is an Operations Success Program sponsored by PCDC and led by health care innovators Mark Murray, M.D., and Catherine Tantau, R.N. The program’s goal is to enable patients to see their own primary care doctor when they need to or want to—even if they walk in or call for an appointment that day. Advanced Access breaks down a health center’s daily appointment schedule process and its method for making appointments. It evaluates these components and redesigns the scheduling process for greater efficiency and productivity.

The Synergy Between Advanced Access and Redesign

Access is defined as the daily availability of providers to see their patients when patients want to see them. Appointment schedule access cannot be achieved without efficient office and clinical procedures. Program creators Murray and Tantau provide two sets of strategies to program participants. One set assists centers in clearing space and opening up time slots in the daily schedule. The second set assists centers in redesigning procedures so that patient visits unfold as efficiently as possible, a process that supports access.

Union was different from other facilities participating in Advanced Access Collaboratives because the center already had completed the Redesign program. Redesign focuses on overhauling procedures for greater efficiency. Union had essentially completed much of the hard work it would have addressed in that portion of the Advanced Access collaborative. During Advanced Access, Union focused on the access part of the program, at the same time further refining the efficiency of its office and clinical procedures.

Other centers were just as successful as Union in achieving access for their patients. But these centers had to work twice as diligently as Union because they were simultaneously redesigning two significant aspects of their workday: both the visit and the appointment-making processes.

Union's experience taught PCDC that although Redesign and Advanced Access were not intentionally designed as a unit, there is a powerful synergy between the two programs. Redesign effectively paves the way for the smooth implementation of Advanced Access.

Skepticism About Open Access: Anticipating a Tidal Wave

Union employees completed the Redesign journey with a sense of accomplishment and enthusiasm, but still felt some trepidation about Advanced Access goals. "The initial response to what would happen if we opened the doors and served everyone was that we would be inundated," recalls Collins, the associate medical director. "We envisioned a tidal wave."

That fear is understandable. Traditionally, health centers use scheduling methods that result in high stress and extra work. No-show rates are traditionally high. A center tends to overbook by scheduling 40 visits, for example, but assuming 20 will be no-shows. If the no-show rate for the day is 10 percent instead of 50 percent, staff and providers scramble to meet patient needs. They sacrifice efficiency, force patients to endure long waits, and work overtime.

These problems are solved by Advanced Access methods that open up the daily schedule. In this program, centers capture and analyze data and then implement certain protocols. Participating centers learn how to anticipate patient and staff needs and to plan appointments better. These changes give them control over the daily schedule and minimize stress. As Murray and Tantau describe it, Advanced Access enables centers to “define their own day.”

“I know you think you will be overwhelmed but that’s not what happens,” Collins remembers Tantau telling the teams. “You reach an ebb and flow. You have some bad days but mostly good days, and if you have too many bad days, you refigure your plans and open up the schedule more.”

Union tentatively took its first steps on the Advanced Access journey and found these words to be true. The process of redesigning access frees the provider and the support staff, too. It empowers them, through careful attention and planning, to take control of their workdays.

A Learning Collaborative Model

Less pressure. More time. Better care. Efficiency. Enthusiasm. How does Advanced Access generate qualities that seem to go against the grain of health center culture, which is dominated by overbooked schedules, overworked personnel, and endless waiting times for patients? First, Advanced Access gives health centers access to experts and support throughout a year-long learning collaborative. During this time, participating facilities implement collaborative and program principles.

PCDC staff members facilitate the presentation of Advanced Access and serve as coaches; Murray and Tantau lead the collaborative. Participants must be committed to two critical elements of the learning collaborative: *collaborative principles* and the stages of the collaborative process.

Collaborative Principles: Identifying Roadblocks on the Path to Change

Principle: Build a high-functioning team.

The Advanced Access team at Union included the director of information services, the director of patient relations, a nurse, and Collins, the team leader. Collins, who calls the group “very successful,” describes the team’s relationship to the center: “Union is a big place and the team members each represented a huge part of what goes on here every day. All of those parts need to hum together. The team was able to hear people’s concerns, brainstorm, track data, and monitor progress.”

Principle: Cultivate leadership support and involvement.

“Leadership support cannot be overemphasized,” asserts Collins. “You need to have support from your leaders. Our CEO knew about [the programs] and wanted to have them here.”

Nelson affirms this. “I love these programs,” she admits. “And I wasn’t a distant manager during them. I took an interested role throughout.”

Management participation is particularly necessary during Advanced Access, Nelson points out, because the program succeeds only if providers agree to reevaluate their old habits with respect to seeing patients. A provider’s medical training, for example, often influences such practices as frequent follow-up visits; scheduling different procedures over the course of several visits; or scheduling patients for different appointment lengths according to the nature of the visit. Advanced Access proposes alternatives to these long-established conventions. Once providers experience the results of open access, most are thrilled with the approach. But the initial period of change may generate resistance. Management must be willing to step in and work with providers to help them overcome their resistance.

Principle: Track data in order to redesign the appointment grid.

The primary data tracked by the Union team included:

- Next-available appointment times were three weeks at the start of the program
- No-show rates were around the industry standard of 20 percent at the program start
- Average number of walk-ins were two or three per day per provider
- Patient visit cycle time remained at a post-Redesign average of 45 minutes throughout the program
- Patient satisfaction was tracked by PCAs through surveys, as opposed to numerically

Tracking at Union revealed critical information. The process also illustrated how well the Union team effectively assigned responsibilities to team members, and how well the team worked with the center at large:

- Union was lucky to have complete use of EMRs throughout the center, thanks to the expertise of the management of information system (MIS) director, who was

also a team member. Thorough computer records made it easier to track next-available appointment times, no-show rates, and walk-in numbers.

- The PCAs who had tracked cycle time during Redesign kept tabs on it throughout Advanced Access. The team predicted that cycle time would rise. The PCAs, however, were happy to report that the center was able to maintain the new 45-minute appointment average even as the schedule opened to accommodate same-day visits.
- Personnel under the patient relations director conducted patient surveys. The results were tabulated and shared with the team and the entire center.

Tracking highlighted the following conditions:

A more urgent need for providers to work during morning hours than in the evening. Many Union patients are employed, and the clinic stayed open until 7 p.m. Mondays through Thursdays under the assumption that many people could only come to the clinic straight from work. When the schedule was opened to allow patients to see providers on the same day they called, the team noticed that patients wanted to come in the mornings. Providers, however, were not available because they were scheduled to work late.

“We miscalculated at the beginning what mornings would be like,” explains Collins. “What we needed was the hour in the morning. So we switched doctors who worked from 11:00 a.m. to 7:00 p.m. to 10:00 a.m. to 6:00 p.m.. We worried about repercussions, but people didn’t need that hour.”

The walk-in rate was less overwhelming than anticipated. “When we actually took the time to track walk-in data,” confesses Collins, “it showed that walk-ins came in at a fairly steady number, an average of two to three a day per provider. We told providers to use that statistic to design their schedules. For example, if you tend to get walk-ins Tuesday mornings, book fewer patients during that time and keep those slots open.” When providers were shown that walk-in rates did not fluctuate, it alleviated their anxieties about being overburdened.

Tracking data continues throughout the collaborative. Ideally, it is integrated into the health center’s daily routines so that it can be used as a tool to sustain gains long after the completion of the collaborative. Consistently reported data also let staff see the progress it is making, feel proud of success, and be inspired to keep working.

Principle: Open lines of communication.

In a hectic and high-pressured work environment such as Union, it is easy to pay attention to immediate work demands and forget that staff and providers affect one another's actions.

Union used new methods to open communications:

- Frequent team meetings, often including the PCDC coach
- Daily department “huddles” during which the day was defined
- All-center staff meetings
- Open communication and sharing information among members of the team
- Ongoing communication with patients through patient satisfaction surveys

In turn, more open communications led to the following results:

- ✓ Colleagues reported in
- ✓ Room, supply, equipment, and work flow needs were anticipated
- ✓ Contingency plans for emergencies or changes were identified
- ✓ Backup and support roles were assigned

Principle: Utilize the expertise of PCDC coaches and program leaders.

Murray and Tantau have led many Advanced Access programs. They are available for consultations at each of the learning sessions and by e-mail throughout the collaborative. In addition, PCDC staff members serve as coaches for health centers participating in Advanced Access.

Coaches meet with teams, often on a weekly basis, throughout the collaborative journey. They also communicate with teams by e-mail and conference calls, and provide skilled guidance along the path. They keep teams focused on immediate tasks and on larger goals, and instill the team and health center with enthusiasm and motivation.

“We were always coming from the perspective that we weren't doing so well with the program,” Collins says. “Our coach understood how hard it was to keep what we were doing in perspective. She kept supporting us and telling us we were the leaders of the pack.”

CORE PROGRAM PRINCIPLES

PCDC operations programs share core principles, but also have distinct sets of organizing principles. These principles are not rigid operating instructions, but can be shaped by teams according to their center's individual needs.

Principle: Doing today's work today.

The key principle of Advanced Access is “Doing today’s work today.” This common-sense method for working efficiently can be challenging; work is often interrupted by the demands of patients and paperwork. Through trial and error, centers learn to avoid putting off until tomorrow—or the next day and the next—what can be done today. When a health center makes the most of its time and personnel, it reduces backlogs, heightens morale, and dispenses high-quality care.

Centers are encouraged to rely on several planning strategies:

- Holding regular meetings to map out the month, week, and day.
- Anticipating patients’ needs so that all information and equipment are available for the appointment
- Completing all paperwork in a patient’s chart before handing the chart off to someone else
- Ensuring that providers do not perform clerical work, such as finding supplies or making appointments

This principle is challenging at first. Typically, when people begin doing today’s work today, they also must complete yesterday’s unfinished business and simultaneously avoid the ingrained habit of putting new work off until tomorrow. During the first leg of the Advanced Access journey, clinical care teams and staff kick into overdrive in order to eliminate “old” work. The program calls this intense level of activity a “work hard” strategy. It is necessary during the jump-start stages of the program to make the goal of doing today’s work today possible from the outset.

Murray and Tantau understand that hard work for its own sake can be discouraging. They do not expect teams to embark on a journey of hard work without the proper traveling tools. These tools are “work smart” strategies that enable teams to predict patient needs, plan for patient flow, open up the daily schedule and begin doing today’s work today. Known as “high leverage changes for patient access,” they include:

- Do today's work today
- Work down the backlog
- Reduce appointment types and times
- Develop contingency plans
- Reduce demand for visits
- Balance supply (provider time) and demand (patient visits) daily

Principle: Balance supply (provider time) and demand (patients visits) daily.

This strategy requires centers to match providers' work schedules with the number of patients scheduled each day. Using a combination of tracking, measurement, and analysis, the team assesses patient volume, no-show rates, visit types and visit lengths to gauge the actual number of patients seen on a daily basis. It then computes how many providers are needed to treat that volume, arranges provider schedules, and creates an appointment grid to accommodate the daily number of projected appointments.

By tracking, Union recognized it had a sufficient number of providers to match the demand for patient visits. Provider time, however, was not meeting patient demand as efficiently as possible. "If we made adjustments in how patients were booked and in the number of patients doctors saw in any particular day, everyone would be fine," explains Collins. Union addressed the issue by adjusting clinic hours to reflect patient flow, from 10:00 a.m. to 6:00 p.m. instead of 11:00 a.m. to 7:00 p.m.

Principle: Work down the backlog.

Backlog is defined as all the appointments in the daily schedule made in advance of that day. In some cases, these appointments were made weeks or even months earlier, by patients who could not be accommodated any earlier. Working down the backlog means that health centers must work through these appointments. The goal is to be able to accommodate patients that call for appointments that day (in other words, to be able to do today's work today).

The object of this strategy is to see all of the backlog patients, take care of as many of their needs as possible at the time of their appointments, and then open up space in the future schedule by not rescheduling the patients. This method ultimately eliminates all backlog, except for what is known in the industry as "good" backlog, such as well care visits for infants and toddlers. The method gives patients access to their providers as soon as possible.

The reason a health center avoids rescheduling patients for follow-up visits is that patients are encouraged to call for an appointment the day they want to see their provider. With successful open access, their provider will be available. “For people who don’t show up, which you can see by their history, we call,” explains Collins. “We have a reminder system that flags us to make sure we get in touch with them.”

This new approach means breaking scheduling habits that are ingrained in providers, staff, and patients. Still, people prefer this method of appointment-making once they experience how successful it is.

Principle: Reduce appointment types and times.

Health centers traditionally offer at least two different appointment types and lengths, but can offer as many as eight. These might include new visits, revisits, urgent visits, sick visits, or physicals. The appointments last between 10 and 45 minutes. At first glance, this method seems to offer patients options. But teams realize that arranging this system is like piecing together a complicated jigsaw puzzle. The desk staff finds it difficult to juggle the many pieces, and the limitations of this system create long waiting periods between appointments.

A center’s daily schedule is typically designed to accommodate some or all of these appointment types and lengths. Given the variation in appointment lengths, only a few of each type can fit into the schedule daily. New visits take time, for example, so no more than three new visit slots make it onto the grid each day. These slots fill up quickly. Therefore, when a new patient calls for an appointment, the only open slot may be weeks or months in the future.

Advanced Access encourages teams to reduce multiple appointment types to single-function, standard-length slots. This action immediately helps reduce the backlog because single slots of equal time add more capacity to the schedule. If a doctor thinks a patient needs more than the new standard-length slot, he or she can be scheduled for two consecutive slots.

Union liked the simplicity and efficiency of standard appointments. For primary care, Union had used two different appointment types: 30-minute new visits and 15-minute revisits. “We moved to one appointment type, only for primary care providers, of 20 minutes,” says Collins. This made life easier for clerks, who no longer had to hunt for 30-minute slots. Patients had more of a chance of seeing a provider. And through team

support and streamlined processes, providers now completed more work in a shorter time, and had the option of seeing a patient for a longer time if necessary.

Principle: Develop contingency plans.

Contingency plans are designed after daily supply and demand are in balance, the backlog is reduced, and appointment types are standardized. To develop a contingency plan, the team assesses each day, often during morning staff huddles; examines the schedule; and anticipates who will step in to help in case of an emergency. The teams also develop formal contingency plans, including creating time-off policies for staff and providers, based on the ebb and flow of demand; developing a plan for post-vacation scheduling; developing a plan for unscheduled provider absences, tardy providers, and tardy staff; and developing a plan for predictable periods of high demand such as flu season, physicals for school, and hospital admissions.

Principle: Reduce demand for visits.

Providers implement this strategy in two ways. They address as many patient concerns as possible in a single visit and extend the interval between a patient's visits.

In Advanced Access parlance, addressing multiple patient concerns in a single visit is known as "max packing." Through this approach, providers maximize the use of their time with each patient. Mrs. Jones, for example, has an appointment for her yearly physical during the second week in September but calls a week beforehand with a rash. The front desk staff looks through the schedule, a practice called "combing," and brings this information to the provider's attention. The provider then may conduct Mrs. Jones's physical at the same time he or she treats her rash and administers her flu shot, so she does not have to schedule a shot in October. Three appointments are taken care of during one treatment.

Work also is maximized by extending the amount of time between patient visits. In this example, Mrs. Jones has chronic conditions—diabetes and hypertension—that warrant scheduling return visits. Her provider will assess her ability to manage her conditions on her own through medication and monitoring. Based on best clinical practices for Mrs. Jones' situation, her provider may decide she can be seen at three- or four-month intervals instead of every two months.

Principle: Increase supply.

In Advanced Access terminology, increasing the supply means freeing the provider to do the work that only he or she can do, such as examining the patient and completing the

patient's chart with diagnostic codes. The way to accomplish this is to create "care clusters" or "teams" formed by other clinicians and staff members who take on the work the provider should not be doing.

Union managed this transition beautifully. It trained clerks as patient care associates who handled tasks such as stocking rooms with supplies and equipment. It cross-trained nurses to assume more clerical and clinical duties, such as scheduling appointments and entering information—sugar levels or blood pressure, for example—directly onto the patient's EMR in the exam room.

High-Leverage Changes for Access: In Action

By implementing these high-leverage changes, Union moved closer toward doing today's work today. These changes transformed daily operations at Union.

Before:

Productivity was measured by the number of patients seen daily, without noting whether a patient saw his or her primary care provider or a different physician.

After:

Productivity is now measured by how well a provider manages a "panel" of patients—that is, a group of patients assigned to the provider—for whom the provider is accountable. If a patient comes in on a particular day and the provider is on the schedule, the patient is directed to that provider. By assuming responsibility for a group of patients, providers find themselves getting to know patients better and anticipating what they need. For patients, seeing their own primary care physician instead of randomly being assigned a doctor ensures greater continuity—and quality—of care.

Before:

Union followed a long-standing model for managing unanticipated walk-in patients that protects providers from seeing too many patients a day. It designated each provider as the "walk-in doctor" for one session per week. Through Advanced Access, Union came to appreciate that the "walk-in doctor" designation creates more work for the provider and the center. The walk-in doctor sees all patients without appointments, even if their primary care physician is available. The primary care doctor ultimately will see his or her patient for a follow-up, which means another appointment. He or she might not agree with the walk-in doctor's diagnosis, which means extra work. Even worse, the walk-in doctor may have miscommunicated with the primary care doctor about the patient's

condition, causing future problems. As Collins notes, “you find out later that a problem shouldn’t have waited two months.”

After:

- Union eliminated the walk-in doctor designation so that all patients, walk-ins or scheduled, saw their own provider.
- Administrative sessions were eliminated, based on the idea that the more open schedule allows providers to complete administrative tasks along with direct patient care.
- As a result, most providers gained a full day of appointment slots and benefited from a structure that supported continuity of care.

Before:

Clinicians and staff members performed designated roles, stepping in to assist each other only in emergency situations.

After:

- By creating primary care cluster teams and broadening work roles within each cluster, assistance is available for providers at all times. Nurses in each primary care cluster, for example, are responsible for supervising a provider’s flow. If they see that the provider needs assistance or asks for help, the nurse and the patient care associate step in to work with the provider.
- In an emergency, the nurse may redirect one or more patients with minor concerns to a less-busy provider.

Before:

When patients called in to see a provider who was too busy, on vacation, or out sick, they had limited options for seeing their primary care provider. Front desk staff either squeezed the patient into an overburdened schedule or booked an appointment weeks later.

After:

Contingency plans are in effect for patients who need to see providers who are out of the office. Staff explains that the provider is unavailable and offers the option of seeing a clinician designated by the provider to cover his or her patients. This designated clinician has been briefed on the absent provider’s patient panel. A system is in place for communicating directly with the absent doctor upon his or her return. The patient can

either choose to see the designated clinician or come in when the primary care provider will be in the office.

Before:

A patient made several visits to the center to address multiple issues.

After:

Providers now maximize one single appointment. They anticipate patient needs and take care of multiple items such as lab work, blood work, vaccinations, and physicals.

Before:

Patients with chronic conditions such as hypertension or diabetes were routinely seen every two or three months.

After:

If doctors feel that patients with chronic conditions are able to control and monitor their health independently, they are scheduled to be seen at four- or five-month intervals.

High-Leverage Changes for Office Efficiencies Refined

Successful access cannot be achieved without efficient office and clinical procedures. Well-organized procedures provide the support for open access. Murray and Tantau provide a set of strategies for change that enhance office efficiencies.

Union had completed the Redesign program, so its patient visit and office procedures had already been retooled. During Advanced Access, the team further polished these processes, and tweaked them to improve access. The high-leverage changes for office efficiencies are:

- Balance the demand and supply for non-appointment work (for example, streamline all office and patient visit procedures, which Union accomplished during Redesign)
- Synchronize patient, provider, staff, equipment, and information
- Predict and anticipate needs of the patient at the time of the appointment
- Optimize rooms and equipment
- Identify and manage constraints (for example, develop practices that strip away all extra tasks from the provider so he or she is free to do provider-only work)

Union streamlined office procedures to support open access in two significant ways:

Before:

Two central operators who managed the phone system were so overburdened that patients were often put on hold for up to 10 minutes, if the phones were picked up at all. Many calls were lost, and the walk-in rate was higher than necessary because patients were not able to get through by phone.

After:

In applying the concept of putting a patient's needs first, Union selected the phone system as one of the first systems to be redesigned. It now lets patients choose automated appointment lines in English, Chinese, and Spanish if they do not need to speak with an operator directly. Operators are available to patients who need them.

Before:

Clerical personnel checked patients in and made appointments. Once patients checked in, they sat down, were called to a room to have their vital signs taken, and called back again for their exam. They were then sent back out to the waiting room "to that clerical black hole," as Nelson calls it, to make follow-up appointments.

After:

Patients are welcomed by a receptionist, known as a greeter, who has the patient sign an appointment list that is cross-referenced on the computer. The greeter announces the patient's arrival to the clinical team by walkie-talkie. The nurse or PCA escorts the patient to the exam room, where all the clerical and pre-exam clinical functions are handled before the provider arrives.

Utilizing Principles Strategically: Overcoming Obstacles to Change

Trial-and-error implementation of high-leverage changes helps eliminate appointment and paperwork backlog and creates an open daily grid. These changes also help centers negotiate obstacles that arise because of the organization's redesign.

The most persistent obstacles to change at Union came from providers. These included:

- Skepticism about their ability to handle what could be a massive amount of work if they saw patients on demand

- Resistance to the idea of max packing, reducing demand for appointments, and scheduling longer intervals between appointments. Providers were concerned that these changes would compromise the quality of care
- Resistance to patient paneling (being responsible for seeing a “panel” of one’s own patients) as opposed to seeing patients randomly

Union management and the team were able to address providers’ concerns and win them over to the benefits of the program by using a combination of learning collaborative principles and high-leverage changes for access:

- The team showed providers data on walk-ins. Providers saw that they had two or three walk-ins a day on average and no longer feared being overwhelmed by walk-ins.
- The team pushed for frequent staff meetings to ensure that lines of communication were open and information flowed smoothly. During these meetings, staff members familiarized themselves with the daily schedule and its patterns, anticipated patient needs, and as a team planned each day efficiently.
- Patient care teams relieved providers of work that interfered with treating patients. With a solid support system in place, providers efficiently treated as many patient needs as possible in a 20-minute slot.
- The team stopped scheduling walk-in doctors on the appointment grid, assigned providers a panel of their own patients, and asked providers to set their schedules to accommodate these patients. Soon after these changes were made, providers came to appreciate that being responsible for a panel of their own patients gave them more control over their time and the continuity of care they provided.

THE DATA: DRAMATIC NUMERICAL RESULTS

Union had become accustomed to measuring data as part of the work routine during Redesign. The health center now began to measure information that supported access. Consistent tracking allowed the team to quantify dramatic results that proved the success of the changes made by Advanced Access.

Pre-Redesign	Post-Redesign
Cycle time: 123 minutes	Cycle time: 52 minutes ↓ 58%
Pre-Advanced Access	Post-Advanced Access
Third-next available appt.: 15 days	Third-next available appt.: 0–1 day ↓ 93%
No-show rate: 20%	No-show rate: 15% ↓ 25%

BEYOND THE DATA: THE RIPPLE EFFECT OF MULTIPLE TRANSFORMATIONS

The data above provide evidence of Union's success in completing the Advanced Access journey. Beyond these numbers, Union experienced a permanent shift in its organizational culture because of the PCDC collaborative approach. This shift enabled it to consistently operate as a high-performance organization.

Realigning Center Priorities: Focus on the Patient's Needs First

Perhaps the most fundamental organizational transformation at Union was how it realigned its priorities to focus on patient needs. This single change inspired other key transformations, much like the ripples that form in water after a pebble is dropped.

Collins notes that before Advanced Access, "clerical staff was always protecting the doctors' time and patients were always battling an overbooked schedule." Once Union adopted the concepts of Advanced Access, however, serving the patient replaced the goal of protecting the doctor. Serving the patient was accomplished through the following methods:

- Providers see a panel of their own patients, which enables them to provide patients with consistent, thorough, and continuous care. Patients receive more fractured care when they see any doctor who is available or a designated walk-in doctor.
- Providers take care of as many patient needs as possible during a single appointment (max packing) as opposed to scheduling multiple appointments, which created more work for providers and staff and forced patients to return more frequently.
- Both workloads and patient traveling times decrease when there are longer intervals between appointments for patients with chronic conditions. This strategy also opens up the schedule and ensures better access.
- Patient requests for same-day or nearly same-day appointments are satisfied. This change lets Union avoid a backlogged schedule and maintain a mostly open daily grid.

The Patient-Provider Relationship at the Core of Patient Care

A ripple effect of these new approaches at Union is that the patient's health care is now a function of the relationship between patient and doctor. Providers trust their patients to call when it is time for them to be seen; patients know their providers are available at a moment's notice. Together, providers and patients determine when and how often they

see each other. Neither need confront an overbooked schedule, a stressed-out front desk clerk, and a randomly assigned walk-in doctor.

SUSTAINING THE OUTCOMES: CONTINUING ON A STRATEGIC JOURNEY

Union management was very satisfied with the transformations engendered by Advanced Access. The health center is determined to maintain its new, patient-centered approach and the positive outcomes it produced. Leadership and staff are aware that sustaining hard-won gains requires an ongoing, vigilant effort. Yet they are confident of success because the Advanced Access journey has taught them to appreciate that paying attention to processes produces exceptional results.

Key changes made in center procedures:

- All appointment types are uniform and last 20 minutes
- Providers see panels of their own patients
- Clerks and clinicians are cross-trained to assume broader work roles
- Patient care teams work together to provide critical support to providers and patients
- A newly designed, efficient phone system is in place
- All staff know how to use patient EMRs
- Information formerly taken at the front desk or in a vital signs room is now gathered in the exam room
- Appointments in the daily and weekly schedule have opened up as a result of:
 - ✓ Eliminating walk-in doctor sessions
 - ✓ Eliminating administrative sessions
 - ✓ Max packing
 - ✓ Scheduling longer intervals between appointments
 - ✓ Combing the schedule
 - ✓ Having patients call for appointments the week or day they want to be seen

Plans to ensure continued success:

- Continuing leadership support of program concepts

- Maintenance of office efficiencies implemented during Redesign and refined during Advanced Access
- Diligent and consistent tracking and analyzing of center data, including cycle time, third-next-available appointment time, and no-show rates. Data are used to measure success and validate protocol changes
- Consistent monitoring of patient satisfaction through direct communication with patients and surveys administered by Union's active Patient Relationship Advocacy department
- Ongoing teamwork at all levels of center business, maintained through meetings, communication methods, and patient care clusters

THE BENEFITS OF WORKING SMART

Advanced Access challenged Union to rethink the way care was delivered. The program demanded that providers give up deeply embedded habits, including scheduling frequent appointments and bringing patients with chronic conditions in for frequent check-ups. The program also demanded that clerical staff abandon the long-held practice of running interference between patients and providers.

Although at first it was challenging to abandon familiar work patterns, people acknowledged the power of the program when the daily appointment grid opened up, and doing today's work today made everyone's life easier. Union experienced the benefits of working smart and can no longer imagine doing business any other way.