

Applying an Open-Access Model to a Psychiatric Practice

By Richard J Moldawsky, MD

Introduction

It is generally agreed that access to timely medical care is a key to providing quality service. Many practitioners and organizations, including Kaiser Permanente (KP), struggle to achieve this. Psychiatric care is no exception. Employers who provide insurance for their employees have emphasized initial access and much energy is aimed at getting that first appointment for the prospective psychiatric patient; however, there has been comparatively little attention to follow-up visits. Increasing the number of intake appointments per week, using unbooked return appointments for new patients, and appropriating time allocated for activities other than direct patient care (eg, paperwork time, meetings) have improved a member's chances of seeing a psychiatrist for the first time more quickly. The second and subsequent visits are harder to secure.

After 23 years practicing outpatient adult psychiatry at KP, first in Los Angeles County and now in Orange County, I have seen the continuing high demand for, and emphasis on, initial appointments resign doctors and their patients to some very long waits between visits. Most episodes of care that involve psychiatrists as treaters—not simply evaluators—require return visits, care beyond the skills of psychotherapists or referring physicians.

Although many KP psychiatrists have wrestled with this dilemma, longer intervals between visits have become increasingly common. A recent random search for “next available” return appointments in KP Orange County showed that waits of three to four months were common; access reports from other psychiatry departments at KP in Southern California have shown this as well. Increasing the number of psychiatrists, requiring more mental health care from primary care physicians (PCPs), and reliance on com-

munity support services have been some of the remedies that have been proposed to decrease the pressure for better access.

Typical guidelines for monitoring antidepressant therapy call for re-evaluation within four to six weeks.¹ Phone calls are one way to follow-up, but phone calls do not constitute thorough assessments. A patient beginning treatment for a psychotic or manic disorder cannot usually be evaluated from a distance. On the basis of these guidelines, patient care suffers.

In our system, initial appointments are one hour. Most returns are 30 minutes, but each psychiatrist must have six 20-minute return appointments per week. Time itself has had a prominent role in psychodynamically informed psychotherapy,² but our current practice is primarily pharmacotherapy.

Looking for Solutions

I became increasingly frustrated searching for openings in my schedule, “giving away” time set aside for other activities, realizing that the approaches mentioned above weren't going to impact the demands on my practice. However, although I had little control over the “in-flow” to my patient panel, changing how I approached patients once they came to see me allowed me an opportunity for improvement.

Some PCPs and other specialists in KP have also used group visits and found it to enhance both quality and access.^{3,4} Very few psychiatrists in our group have tried this, for reasons that are not clear. The psychiatric literature yielded little help. One valuable concept did emerge, reflecting what might otherwise seem obvious. Population surveys show that much mental illness is undetected, untreated, or undertreated.⁵ What has perhaps been unappreciated is that most people want

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to solve their problems on their own.⁶ Many do not recognize a problem as psychiatric and don't believe that psychiatric treatment is needed. This helps explain why some patients do not accept psychiatric referrals and why others do not remain in treatment after evaluation. Some of our patients, when all is said and done, simply do not want psychiatric care. The significance of this, with regard to return access, is that when a psychiatrist schedules a return visit, that patient may be politely agreeing to do something s/he truly does not want or intend to do.

My review of the literature identified some primary care settings in which a radically different approach to return access was described.^{7,8} Murray and Tantau⁷ at KP in Roseville, California, eliminated the usual distinction between urgent and routine return visits. *All* patients were offered same-day appointments, and no attempt was made to assess whether a patient "needed" to be seen that day or could wait. Wait lists quickly evaporated. This open-access model was

found to be easier and more successful than expected. I decided to adapt elements of this model to my practice of general adult psychiatry with mostly white, English-speaking patients, but including a Spanish-speaking population of about 15%, in north Orange County. Overall, our membership in the county is about 340,000, served by a total of 19 psychiatrists and other mental health providers.

The Open-Access Model

In the spring of 2003, I began to plan implementation of a walk-in system for return patients. I wrote a one-page explanatory letter, (see Figure 1) which I gave to all new and returning patients I saw over the summer, prior to beginning the system in September 2003. Gaining administrative, clinical, and clerical support was quick and easy.

At the time I implemented the new process, I was working three days (Tuesday, Thursday, and Friday) at the Euclid Medical Office in Anaheim; I worked the other 1 1/2 days at the Aliso Viejo clinic. The system was only applied at Euclid.

These are the essential features of the system:

- *Designated walk-in times*—Tuesday afternoon (1-7 pm) and Thursday morning (8:30-noon)—*for any return patient who wishes to see me*
- On the basis of our agreement regarding return visits, *patients are strongly encouraged to come in on Tuesdays or Thursdays – this plan is put in writing* (Figure 2)
- *When the patient comes in, the appointment is booked*
- *Patients are seen on a first-come, first-served basis, unless an emergency arises or someone only needs a signature or a prescription.*

Results

I tracked the numbers of patients seen between September 2003 and December 2005. It covers 90 weeks; data were inadvertently not collected for two periods and they are not retrievable.

Table 1 shows the average numbers of patients seen, the lowest and highest numbers of patients seen during these clinics, and the utilization during these time periods. Utilization is computed by dividing the average number of patients seen by the number of slots that would be ordinarily available under the traditional scheduling model; for example, on Tuesdays, 12 slots would be available in six hours, so $10/12 = 83\%$.

Dear Patients,

This letter explains how you can set up follow-up visits.

On *Tuesday afternoons and Thursday mornings*, I am available for unscheduled return appointments. If you come to the office during those times, we will have time to address your needs.

Here's how this works:

The days and times for these return visits are

Tuesdays between 1:00 and 6:15 pm
and
Thursdays between 8:30 and 11:30 am

If you need a return appointment, please call the office to verify that I will be in the office on the day you want to come in. If I'm not going to be in that day, we'll tell you when the soonest time is after that. You won't be given a specific appointment on the phone, but you may come in any time during the days and hours listed when I am here. It's important that you call, so you don't come in on a day when I'm not here.

Patients will be seen in the order they are checked in, unless there is an emergency. You must be checked in no later than 6:15 on Tuesdays or 11:30 on Thursdays. I will do my best to limit your wait time.

If it's not possible for you to come in during these times, please let me know. There will be a few scheduled times available when we may be able to meet.

I hope this system will work for you. Please feel free to let me know.

Richard Moldawsky, MD
xxx-xxx-xxxx

Figure 1. Getting an appointment when you need to see someone.

Discussion

This system has now been in place for over two years. The main advantages have been:

- *Patients who want treatment are always seen at a time consistent with clinical need and/or a patient's subjective need*; this includes patients recently discharged from hospital
- *It is easier for collaborating therapists to get rapid help* with psychopharmacological issues, disability, or related matters
- *The workload is decreased for clerical staff*, who no longer have to pull charts for patients who do not keep appointments (DKA) and do not have to deal with patients' complaints about the unavailability of appointments.

Most patients have been pleased with this new idea, reflecting their own frustration with return access. A frequently voiced sentiment was that "anything is better than what we have now." My commitment that no patient need wait more than four days (from Friday to the following Tuesday) for a return visit generally compensates for not offering a specific appointment time. Framing this explicitly as a trade-off is a key. Patients understand and accept that the responsibility to initiate a return visit was now the patient's. A minority of patients still prefer the traditional system. They are accommodated with the understanding that fewer of these appointments are available, meaning potentially a longer wait for one of those. The walk-in system remains available to all.

Although this process has been well-received by patients and colleagues at Euclid, it has created some difficulties and challenges.

There has been no way either to predict the number of patients who will walk in or the level of care each one needs. Patients themselves have tried a variety of tactics to minimize their wait times; this has been the most perplexing problem. Some have checked in as much as 90 minutes prior to the beginning of a walk-in session; others have called the clinic during the session to ask clerical staff to help them estimate the probable wait, if any. Patients frequently ask me when is the best time to arrive to ensure the shortest wait. We have no data on wait times, which varies from none to (rarely) as long as two hours. I have been impressed with how patients have adapted and how they usually accept some wait time as an acceptable trade-off; many now bring reading materials or other pastimes. About once a month, a patient has left because s/he could not wait; typically, those patients were called and offered a specific appointment.

Once I shifted from thinking of an appointment as a block of time to seeing it as a task (or tasks) to be completed, I became comfortable with some visits lasting five minutes and others lasting an hour. The work of the visit is completed, whatever the time requirement. This work, though primarily psychopharmacology, often entails psychological, social, and other medical issues, including disability.

One concern had been whether patients would "take advantage" of this system and come in more frequently than clinically necessary. There have been perhaps five people who, for a period of a few weeks or 2-3 months, came in as often as 3-4 times a month. Each of these visit clusters was associated with clinical instability. Physician visits do fulfill a social function for some patients.⁹ At times, addressing the frequent visits as both clinical and social events became necessary.

There are probably physician variables which affect

Table 1. Number of patients seen and utilization during walk-in hours: September 2003 – December 2005		
	Tuesday (6 hours)	Thursday (3 1/2 hours)
Average number seen	10	5.2
Range	5-19	0-11
Utilization (percentage kept + percentage available)	83%	75%

Today's Date _____

We are agreeing that you should have a return visit in _____. Please look at your schedule to see when it would be convenient and come in, without a scheduled appointment, on either a:

Tuesday between 1:00 and 6:15 pm

OR

Thursday between 8:30 and 11:30 am

If you check in later than 6:15 on a Tuesday or 11:30 on a Thursday, I will try but cannot promise to see you that day.

It is always a good idea to call either the day you plan to come in, or a few days before, to be sure I will be here. On rare occasions, I may have to change my available hours. Please call xxx-xxx-xxxx.

If it is impossible for you to come in during the above times, a few other appointments are available for scheduling. Please call if this necessary for you.

Thank you.

Dr Moldawsky

Figure 2. Return appointments letter

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one's capacity to manage a panel in which the number of new patients is roughly the same within a given department. There are no data on this, but I offer a few observations.

Whether a new patient becomes a returning patient is primarily driven by the decision to medicate. Many milder psychiatric conditions can be treated without medication, yet many of these patients do request and receive medication. This demand is driven by many factors, including recommendations by PCPs, therapists, family members, advertising, and patients' expectations. It may be that I prescribe less frequently than my psychiatrist-colleagues, so my panel is thereby smaller, even though we have seen the same number of new patients.

Some patients are referred who are already taking psychiatric medications prescribed by a PCP. At times, it is vague as to whether the PCP wishes the psychiatrist to take over that task; some patients do not want to be seen in our department and prefer the PCP continue that job. So, another variable may be the psychiatrist's handling of these ambiguous situations.

Another factor may be that my patients drop out of treatment at a different rate than those seen under the usual process. Again, we have no data on this. Under the traditional process, it is possible to track DKAs, but this measure does not capture patients who cancel appointments in advance of the appointment date and thereby drop out before our system can identify them as DKAs. The walk-in system has no DKAs, because an advance appointment is not booked.

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Conclusions

This walk-in process has made it possible for patients to be seen when it is clinically necessary or when they feel the need. It has done away with waiting lists and telling patients to call for cancellations, two of the more inelegant aspects of practice. It engages patients more actively in their decisions to accept and continue treatment by having them initiate the return contact. It also has reduced the workloads of clerical and clinical colleagues.

This article describes one approach to solving the problem of return access for psychiatrists. It is a shift

away from thinking about visits having a starting and ending time; rather, the visit takes whatever time is needed. It has been satisfying to know one's return access is controllable, and it has been a comfort to patients as well.

Evaluation of this approach has so far been unsystematic. It would be helpful to compare patient satisfaction and outcomes with the traditional approach. Measures of productivity and utilization only tell us how many are seen.

This approach seems adaptable by other psychiatrists who are frustrated with their current efforts to address this problem. One needs to be reasonably comfortable with a less-structured approach to the day and with appointments of variable and unpredictable lengths. Although this approach has not, to my knowledge, been replicated by other psychiatrists, it is hoped that it will stimulate other innovative processes. ❖

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