HRSA Ryan White HIV/AIDS Program
CENTER FOR QUALITY IMPROVEMENT & INNOVATION

Institute for Healthcare Improvement

Walk-In Availability and Open Access to Care Implementation Guide

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A. What is Walk-In Availability and Open Access to Care?

Walk-in availability of and open access to Ryan White HIV/AIDS Program (RWHAP)-funded clinics allow clients to come for services at a time that is convenient for them, without an appointment, and be seen by a provider within a reasonable period during normal business hours.

B. Target Population

This intervention could potentially help all people with HIV, but is specifically useful for clients who have:

- Active substance use issues
- Housing instability, especially clients experiencing homelessness
- Been lost to care
- Been sporadically connected to care
- Need the flexibility offered through walk-in availability and open access (for whatever reason)

C. Core Elements of the Intervention

An effective walk-in availability and open access strategy would include the following elements.

1. Developing a clear operational definition for what walk-in availability and open access means at the clinic.

- Questions to answer when developing this operational definition include:
    - Does walk-in availability and open access apply to all services at the clinic or just some services (e.g., intake and case management)?
    - To what extent (if at all) will the clinic attempt to schedule appointments with some or all clients?
    - How much of total visit capacity (the total number of visits for each service that a clinic can provide during a typical day) will be reserved for walk-ins (e.g., 10%, 20% 75%)?
    - Will the clinic have walk-in availability and open access during all hours of operation or during specific hours and/or on specific days?
    - What is the definition of being seen by a provider (e.g., a staff member of the clinic speaks to the client, or the client speaks with the most appropriate staff member based on their reason for coming)?

2. Setting an aim for being able to see any/all walk-in clients within 30 minutes of arrival using an operational definition of being seen by a member of the clinic's care team within 30 minutes of a client signing in.

- Over time, the clinic may set a goal of seeing a walk-in client within 20 minutes or even 15 minutes.

3. Developing workflows, systems, and processes to see walk-in clients within 30 minutes of

arrival based upon the operational definition (above).

    - Understanding the characteristics of walk-in clients to better meet their needs and preferences on an ongoing basis.
    - Understanding walk-in numbers at the clinic (this can be done by plotting the daily number of walk-ins to the clinic and then finding the median, high, and low numbers of walk-ins over the previous 2-4 week period).
    - Understanding the "surge" times for walk-in clinics (this can be done by plotting the times of walk-ins to the clinic and then finding peak and low times for walk-ins over the previous 2-4 week period).
    - Designing a system with clients and front-line staff to accommodate the anticipated number of walk-in clients including during "surge" times.
  - Developing and continually refining the theory for how the clinic can accommodate walk-ins in the form of a driver diagram.
  - Developing a workflow (including staff roles/responsibilities) that aligns with the aim, driver diagrams, anticipated number of walk-ins, and surge times.
  - Ensuring that all staff understand the current workflow, systems, and processes for achieving the goal of seeing all walk-ins within 30 minutes of arrival.
  - Putting in place a system that any staff can use to call for additional support if they are having trouble meeting the walk-in aim.
  - Designing a system to efficiently and accurately track the time that a client checks in and the time that they are seen by a provider.
  - Designing a system that provides staff with work alternatives at times when they are not meeting directly with clients (e.g., preparing notes/reports, following up with clients via phone/text, etc.).
  - Designing a system that is financially viable for the clinic and that doesn't result in undue burden and stress for staff during surge times and/or nothing for staff to do during times with few or no clients.

4. Regular communication with clients about walk-in availability and open access options (including explicit mention of these during each visit and in written communications).
  - Written notices, including signage at the clinic in the languages spoken by clients
  - Written notices to primary sources of referrals
  - Reminders for clients during each appointment/visit
  - Outreach/engagement strategies, including website, text messages, etc., all include up-to-date information on walk-in availability and open access options

5. Using continuous quality improvement methods to track progress toward achieving the aim, using data to improve the processes, and continually updating the system based on changes to walk-in data and/or surge times.

D. Adaptable Elements of the Intervention

This is not yet an evidence-based intervention. While the high-level elements in the Core Elements section are likely sound and should not require adaption (e.g., 1: Developing a clear operational definition for what walk-in availability and open access means), the detailed sub-

elements are more likely to be guidance or guiding questions that can (and should) be adapted to meet the needs of clients and the clinic. Because of this, CQII recommends trying to implement the core elements as outlined in this implementation plan, while noting any adaptions you make and then using continuous quality improvement methods to improve upon this Client Self Care Model over time.

Should you see improved results from one or more adaptations, CQII would be interested in hearing about the adaptations made and the results achieved (see section on contact information in this guide).

E. Length of Time the Intervention is Delivered to Each Client

As part of developing the operational definition of walk-in availability and open access, the clinic will determine when this intervention will be offered.

As an example, a clinic might decide that:

- Access to case management and intake are always open access during clinic operating hours and open access to a medical provider is available on Monday, Wednesday, and Friday afternoons from 1:00 – 5:00.

The clinic should work with clients and potential clients to determine what would be most convenient and then with clinic staff to design a workflow that makes this practical and sustainable.

F. Staffing Requirements/Roles and Responsibilities

Since each RWHAP-funded clinic may have different staffing models, position titles, and have clients with different needs, it is important for each clinic to ask and then answer the following questions.

- Who will champion open access and work to ensure that it is implemented in a way that is effective, equitable, and sustainable?
- Who can help with developing the workflow(s), systems, and processes needed to ensure that clients are seen by a provider within the stated goal of the clinic?
- Who (once implemented) will be responsible for ensuring that the clinic is effectively implementing its walk-in availability and open access program?
- Who will provide scheduling and logistical supports each day to help ensure the programming works smoothly?
- Who can provide “surge” support if/when there are more walk-ins than anticipated?
- Who can help assess the value of walk-in availability from both the perspectives of client and staff?
- Who can help improve the effectiveness of walk-in availability and open access?

G. Staff Training

Effectively implementing walk-in availability and open access to care requires ongoing training of all staff. This ongoing training (at least annually and as part of orientation for new staff), should at a minimum include:

- Rationale behind walk-in availability and open access to care
- Detailed presentation and discussion on how the clinic provides walk-in availability and open access to care (including policies and procedures, hours of availability, and managing staff absences while retaining walk-in availability)
- Specific process for managing walk-in clients
- How the clinic will assess the usefulness of walk-in availability and open access to care
- Clinic's current plan for improving walk-in availability and open access to care

H. Resources Required for Implementing the Intervention

- Staff training on walk-in availability and open access (see Section G: Staff Training)
    - Implementation guide
- Method for tracking client check-in time and whether the client has an appointment or is a walk-in client (electronic)
- A method for assessing the extent to which Walk-In Availability and Open Access helps improve viral suppression rates (see Section J. Data Collection and Reporting)

I. Implementation

Each clinic's actual implementation plan will be different, but the core pieces of this implementation plan are listed below.

- Understand your current system/workflow by:
    - Determine how many clients your clinic currently sees in a "typical" day
        - How many "no-shows" does your clinic currently average on a typical day?
        - How many clients showing up more than 15 minutes before or after their scheduled appointment does your clinic currently average on a typical day?
    - Determining the current average wait time (measured from the time a client checks-in until they see a member of the care team)
    - Draft your current workflow
        - What is the current workflow from the perspective of a client (from beginning to end)?
            - Is workflow largely standardized or is their lots of variation? If lots of variation, is this good/helpful or would less variation likely result in improvement?
            - How long, on average does each "step" in the workflow take from the client perspective?

        - What is the current workflow from the perspective of care teams (for a "typical" clinic day)?
            - How long, on average, does each member of the care team take on each of their steps (e.g., intake, education, visit with physician, etc.)
    - Determine:
        - If your clinic has "surge times" or surge days (with more clients) and, if so, if there can be predicted (e.g., Friday afternoons)
        - If you have staff that are relatively busy or relatively less busy at different times throughout a typical day. Is there some "slack" time that you could potentially make more productive without overwhelming or burning out staff?
        - Where are their bottlenecks in your system (steps or processes that routinely slow down the entire flow)? How might you alleviate or remove these bottlenecks?
- Develop a draft flow chart to visualize:
    - What the workflow looks like to meet the aim of any/all walk-in clients being seen by a member of the clinic's care team within 30 minutes of a client signing in
    - What does this look like from the client perspective?
    - What does this look like from the perspective of the care team?
    - What does this look like if/when more clients arrive at the same time than anticipated or that the clinic can handle?
    - While it is possible that the same workflow is always used (e.g., client always starts with a medical assistant, then sees the physician and then sees the peer educator), clinics might consider testing a more dynamic workflow where who the client sees first is dependent on which member of the care team is available.
- Develop a draft iterative work plan to have walk-in availability and open access implemented at the clinic in approximately 4-8 weeks. The clinic should consider how it will do the following:
    - Develop a realistic estimate of the number of clients it can see (within 30 minutes of arrival)
    - Select the day or days and times for walk-in clients
    - Test one or more walk-in availability and open access options before making any permanent changes (CQII recommends starting small with an open access day or ½ day)
    - Communicate walk-in availability and open access to clients, potential clients, and the clinic's main referral sources
    - Manage clients with appointments and without appointments in a timely and provide excellent care
    - Train care team staff on walk-in availability and open access
        - Making sure care team staff understand the roles of each member of the care team in the process and making adjustments as needed for planned/unplanned absences, for visits taking longer than anticipated,

and other circumstances that will affect the ability for each client to be seen within 30 minutes
        - Managing unexpected "surge" periods where too many clients arrive at the same time to be seen within the aim of 30 minutes
    - Track each client's "check-in" time and whether they have an appointment or are a walk-in client
    - Assess the effectiveness of walk-in availability and open access
        - How the clinic will continuously get feedback from clients on what is (and isn't) working
        - How the clinic will continuously get feedback from staff on what is (and isn't) working
    - How the clinic will use data to improve the effectiveness of walk-in availability and open access
- The next step of the implementation plan is based on what is learned from the previous step (regardless of what your draft iterative work plan says)

CQII recommends that clinics test walk-in availability and open access through multiple small tests (e.g., from 1:00 – 3:00 on one Friday) before scaling up to the entire clinic. This evidence-based approach to implementation makes it more likely this intervention will become well integrated into the overall workflow of the clinic, make the change process easier for clinic staff, and result in better outcomes for clients.
CQII anticipates that most clinics will continue iterating and improving upon their processes, workflow, and forms, especially in the first few months of implementation and as the clinic begins to see the results of its efforts (see J. Data Collection and Reporting). On at least an annual basis, the entire process should be reviewed and adjusted as needed to improve outcomes for clients.

J. Data Collection and Reporting

CQII recommends clinics develop systems to collect and analyze the following data.

Process Measures

- % of walk-in clients seen within 20 minutes (initial goal may be 30 minutes) using the clinic's operational definition

Outcome Measures

- % of walk-in clients that achieve viral suppression within 4 months (percentage of clients with a HIV viral load less than 200 copies/ml at last viral load test during the measurement year)

Balancing Measures

1. Comparison of wait times for scheduled patient visits and walk-ins
2. Staff self-report on the extent to which walk-in availability and Open Access to Care is sustainable

K. Implementation in Action: Ryan White Wellness Center, Roper St. Frances Healthcare

Having implemented many of the interventions that were suggested by the create+equity Collaborative, the Ryan White Wellness Center, part of Roper St. Frances Healthcare in South Carolina, selected the "walk in" appointment intervention. They had been considering this intervention and it seemed like a good time to try it. The CQI team made the decision to select the intervention, with input from the medical director, who would be the physician for the walk in (called "open access" by the Wellness Center) appointments. While the focus was on HIV care, for the patients targeted by the intervention, they received so much more.

Roper St. Francis Healthcare is a large system providing services to Charleston, South Carolina and seven other counties. While the majority the Wellness Center's r approximately 1,000 patients (either people with HIV or on PrEP) are from the Charleston area, there are clients that come in from rural areas.

The planning team was led by Aaron O'Brien, the former quality and development manager for the Wellness Center. They consulted the medical director to identify a specific time to offer walk-in services. The medical director would be the only physician for walk-in appointments. A 4-hour time slot on Thursday afternoons was selected for multiple reasons. That was the day that the clinic was open until 7 pm. This gave patients additional hours and options to access care. Another key factor is that all of the clinics three physicians were scheduled as well as many case managers and other key staff. This provided surge capacity.

To ensure that open access was documented, a custom field was added to CAREWare. The field flagged clients that had open access appointments so that they could be tracked over time. Alerting receptionists about the changes was also necessary. While the administrative process was not different in terms of logging in a client, they would have to do it in real time and the client would have to wait.

To promote open access the clinic relied on case managers—they know their clients best. They looked at their data to identify clients who had been out of care, with substance use disorder, or those that had missed appointments. Case managers could then contact these clients and encourage them to drop in on Thursdays for a health care appointment.

"They loved it," states Aaron O'Brien. "They could show up and get everything done in one appointment. Lab work, see a doctor and more. One of the patients on that first day got important care. He had an untreated STI (which was treated), received missed vaccines, and got a referral to mental health services."

There were some challenges related to maintaining walk in appointments. Having designated only one physician for the appointments, when he was unavailable due to travel or getting sick (COVID), the walk in appointments were not available on Thursdays. There was turnover in

other staff key to the intervention (medical assistants). This impacted their ability to provide the weekly open access day. But given the success, open access may return soon.

Contact for More Information:
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Implementation Staff
The following staff members participated in implementing this intervention.
Dr Toby Fugate
Dr Eunice Guzman
Aaron O'Brien
Chakeyda Mack
Kristin Farris
Laurie Tomlin
The CQI implementation team also included direct input from patients.

L. Assessing Fidelity to the Intervention

As mentioned previously, the core elements of this intervention have not yet been sufficiently tested to ensure that fidelity to them will result in better viral suppression rates for the target population. The core elements, have, however, been developed in consultation with a range of experts including people with HIV and are believed to be best practices.

M. Suggestions for Improving Effectiveness

As you begin implementing walk-in availability at your clinic, it is likely beneficial to conduct brief surveys of clients seen during walk-in availability/open access hours, and participating staff to assess their satisfaction, identify areas for improvement, and solicit ideas for improvement. For clients this can be as simple as a one question survey rating their experience of care during open access hours. For staff, monthly surveys (taking five minutes or less to complete) for the first six months of implementation and then quarterly or semiannual surveys thereafter (questions could be embedded into a larger survey) can help ensure that staff and clients are seeing value in walk-in availability and open access.
As you identify an area for an improvement or a change idea you think might result in improvement, unless you have a high degree of belief that the change idea will result in improvement, CQII recommends that you test the change idea at the smallest increment possible. This could be testing the change idea for 1-2 clients, testing the change idea for one day, or with one participating staff member. As you develop evidence that these small tests of change appear to be working (with or without modifications) you can scale them up over time to be a formal part of your practice.

N. Tips and Tricks

- Implementing an effective and efficient walk-in availability system takes time, testing, and refining before going to scale, and using continuous quality improvement methods.
- Keeping a work board up at the clinic that monitors the "wait time" for the previous day and running charts for the current period can be useful and, if done correctly, motivating to clinic staff.
- The **Max Clinic** in Seattle, Washington[1] offered walk-in access to primary care five afternoons per week and walk-in access to case management services 5 full days a week.

O. Contact Information

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P. References

Dombrowski, J. C., Ramchandani, M., Dhanireddy, S., Harrington, R. D., Moore, A., & Golden, M. R. (2018). The Max Clinic: Medical Care Designed to Engage the Hardest-to-Reach Persons Living with HIV in Seattle and King County, Washington. *AIDS patient care and STDs*, *32*(4), 149–156. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5905858/

Q. Appendices

I. Open Access Interview

Appendix I.

Open Access: Roper St. Francis Ryan White Wellness Center

What motivated your organization to pick this intervention? Who was involved in the decision (i.e., were patients involved) ?

We were already doing several of the other create+equity Collaborative interventions. Open access had been discussed in the past so it seemed like perfect time. The CQI team made the decision

[1] Dombrowski, J. C., Ramchandani, M., Dhanireddy, S., Harrington, R. D., Moore, A., & Golden, M. R. (2018). The Max Clinic: Medical Care Designed to Engage the Hardest-to-Reach Persons Living with HIV in Seattle and King County, Washington. *AIDS patient care and STDs*, *32*(4), 149–156. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5905858/

What were your steps to implement it? Did you follow the steps in the guide or were there modifications from the beginning, or at some point?

Didn't really use the CQII implementation guide.

We charted out own case.
We brought in the medical director to determine the best time to schedule open access.
We picked a 4-hour time on Thursday. All three MDs were and there was good case management support. There would be people in the clinic to meet demand. We were able to leave appts open. The medical director would see the open access clients—appointments were left open. If people did not show for appointments, the medical director could use the time to do administrative work.

Also have late clinic on Thursdays. See people until 7 pm. People can roll in whenever they want to.

Publicized that it was available through case managers.
Looked at our data to see people with active sub use, people who had missed appts.
Gave list to case managers. Use it as a starting point – they know their clients better than anyone.
Case managers would say to clients, just come on Thursday after noon.

The first week we did it, we didn't know what to expect.
3-4 clients came. They loved it. They could get everything at once.
Just show up and we will do everything at once – like lab work.

One of the first patients we saw had untreated STIs, got some vaccines he missed, referral for mental health treatment

We had three really good weeks, then medical directors was out for a couple weeks, then he was out sick

Staff changes, medical assistants left,

Driven by individuals – one physician who was seeing clients wasn't there
Consistency and momentum were lost.

What recommendations do you have for other organizations wanting to implement this intervention?

Helpful to define the priority population. Unless you are opening open access to everyone (i.e., anyone can come in and get care), you need to be selective about who to target.

Case managers are key: they know the clients the best and have the most contact with them.

We added a custom field into CAREWare that identified clients that had accessed open access so they are flagged in the system. We will be able to track them over time.

We selected one MD to do this. In hindsight I wish we had other clinicians onboard to make it more sustainable.

It wasn't that big of a shift in the workflow and practices.

It did put some burden on the front desk folks so they did have to process it in real time.
Need to include front desk staff in your planning.
They know that it is Thursday afternoon and people might be coming in without appointments.

With scheduled appointments, patients see the same doctor each time, with open access, they will see the designated open access MD

Created special appt type on schedule.