IMPROVING ACCESS

A MODEL FOR MENTAL HEALTH CARE

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Same-day access systems have shown promise in primary care practices, but can they work for mental health care? Here's the experience from one VA clinic.

At one time, evaluating access to health care simply meant determining whether services offered to a given population were sufficient to meet the population's needs. In response to the challenge of reconciling efforts to contain health care costs and utilization with the expectations of patients, payers, and regulators, however, today's investigators have begun to study more closely the supply and demand characteristics of health care delivery systems.

In their examination of patient access to primary care under different practice models, Murray and Tantau noted that changes in health care reimbursement mechanisms over the years have shifted trends in practice management.[1] The incentives inherent in traditional fee-for-service models, for example, drove providers to fill their appointment schedules well into the future, which inevitably produced delays in access to care. Concern with these delays led to the development of complex systems in which patients were triaged according to the urgency of their condition and providers needed to carve out or create capacity specifically to meet urgent clinical needs.[1]

Problems with this type of system, which Murray and Tantau have termed "first generation open access,"[1] include the diversion of clinical expertise from direct patient care to triage duties and clinical and liability risks created by the triage process. In addition, the need to predict and manage multiple appointment types makes it difficult to sustain prompt access for patients at lower levels of clinical urgency, which creates a backlog of routine care appointments and requires the development of protocols for deflecting overflow that ultimately reduce both continuity of care and patient satisfaction.[1]

More recently, a conceptually different approach to improving primary care access has emerged, which Murray and Tantau have termed "second generation open access systems"[1]—and which we will call "same-day access" henceforth. They describe a same-day access practice as "an office where patients are offered an appointment today for any problem and all of today's work is done today. Physicians are accountable for the care of a panel of patients, not appointment slots."[1] In such systems, triage is minimized, patient satisfaction improves, and continuity of care—and, thus, efficiency—is maximized.

When leaders of the VISN 13 mental health patient service line

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decided that the principles of open access could be used to improve access to mental health care for their veteran population, they began training mental health care teams from each medical center to integrate these concepts into their respective mental health practices. Following implementation, all participating mental health care teams demonstrated improvement in access—and three teams achieved sustained same-day access. In this article, we describe the process by which one of these teams—from the mental health clinic at the Hot Springs campus of the VA Black Hills Health Care System, Hot Springs, SD—attained this goal, and we discuss specific outcomes that have been observed as a result of these efforts.

APPLYING THE MODEL TO MENTAL HEALTH CARE

Viewed from the perspective of the same-day access model, mental health practice shares characteristics with both primary and specialty care. Like primary care, mental health care involves treating both acute and chronic illness and therefore requires both routine and urgent appointments. Furthermore, continuity of care is critically important to both types of practice. On the other hand, as with specialty medical care, most patients are referred to mental health services by other medical providers with whom they sustain a long-term treatment relationship. Patients whose mental health conditions achieve remission or stability with uncomplicated treatment regimens may be referred back to these providers for continued management. Thus strategies pertinent to both primary and specialty care are useful for improving access to mental health care.

The clinic we discuss in this article is responsible for providing all urgent and routine psychiatric care to patients treated at the Hot Springs campus of the VA Black Hills Health Care System. It's staffed by two psychiatrists, one psychiatric nurse practitioner, one registered mental health nurse, and one secretary.

The clinicians have minimal teaching and research responsibilities, but most of their time is devoted to direct inpatient and outpatient mental health care and clinical team meetings. Services of psychologists and social workers are available by consultation but aren't included within the administrative umbrella of the mental health clinic. The clinic receives both self- and clinician-generated referrals. In general, the practice more closely resembles primary care than specialty care, and strategies to improve access were chosen accordingly.

BASELINE PRACTICE CHARACTERISTICS

Prior to implementation of the same-day access model, the scheduling structure of the clinic was that of first generation open access. Clinicians reserved some "off-schedule" time for urgent appointments, which usually were entered as "overbooks." Scheduling was complicated by the fact that each clinician needed to manage four basic responsibilities: inpatient consultation, treatment of residential patients, treatment of outpatients, and telephone care. For administrative purposes related to workload capture, these duties were treated as four distinct "clinics," each assigned specific times under the facility's computerized scheduling package. This software allows no overlap in clinic scheduling—for example, scheduling a visit with an outpatient during the hours designated for the residential treatment clinic.

New work was assigned based on openings in clinicians' schedules: Patients with urgent needs were seen by the clinician who was immediately available and other appointments were assigned to whomever had the earliest or most convenient opening in the appropriate clinic. Current patients with nonemergent problems who called or dropped in to see their clinician often could not be seen that day. Clerical, nursing, and primary care staff had to triage patients to determine who should be worked into hidden urgent care slots and who could be given a future appointment. This system rewarded the production of visits, encouraging clinicians to fill their schedules far into the future to document their value to management (who monitored visits rather than panel size), to ensure availability of follow-up for existing patients, and to reduce their vulnerability to assignment of new patients.

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SETTING OUR GOALS

In September 2000, the clinic staff accepted the goal of improving access to services. We chose the time to the third next available appointment as the primary measure of access. Under the current system, the time to the third next available appointment was typically three weeks, ranging from one to four weeks depending on the clinician and the time of measurement. Our initial goal was to reduce this time to within seven days for each clinician. After achieving this goal, we would work toward a third next available appointment on the day of measurement for each clinician, consistent with the description of same-day access we hoped to emulate.

In order to achieve and sustain this level of improved access, we focused on maximizing clinic capacity and efficiency. Associated goals included reducing the clinic's no-show rate (since no-shows represent loss of useful capacity), managing each clinician's practice using panel size rather than visits, and maximizing continuity of care at the clinician level.

TAKING ACTION

A successful same-day access practice must match supply with demand daily. Strategies to support such daily matching fall into three general categories identified by Murray and Tantau: (1) eliminating delay between demand and resource, (2) reducing demand for unnecessary visits, and (3) increasing supply.[1]

Eliminating delay between demand and resource

Our first task was to reduce backlog gradually, so that each clinician could achieve the goal of the third next available appointment within seven days. This required a short-term boost in clinic capacity to allow clinicians to handle new and walk-in patients promptly without adding to the existing backlog.

In order to accomplish this, we temporarily reduced clinicians' involvement in activities other than patient care. After four months, two clinicians had achieved a third next available appointment within seven days (Table). At this point, all three clinicians resumed some of their non-patient care activities.

In the mental health care setting, making the first visit count is especially important in efforts to increase capacity and improve access. Many mental health care practices put patients through complex triage and assessment procedures that involve multiple providers, result in duplicated work, and frustrate patients—who tend to drop out with increasing frequency each time they're required to see yet another provider.

At the time we began our efforts to implement same-day access, our clinic policy was to assign ongoing care responsibilities for a given patient to the clinician who performed the initial evaluation. While we realized that the use of other staff in support of intake assessment could leverage the time of prescribing clinicians, we concluded that the risk of increasing no-show and dropout rates outweighed the benefits of complex assessment procedures. For that reason, we have continued the practice of initial evaluation by the clinician responsible for continuing care.

At baseline, the clinic's no-show rate was 18%, with a range among clinicians of 11% to 19%. Although this rate already was relatively low (possibly due, in part, to our practice of initial evaluation by the clinician responsible for continued care), we sought to reduce it further because no-shows represent an important limitation on a clinic's ability to work at full capacity.

First, we stopped the practice of automatically rescheduling no-shows.[2] Instead, if a patient missed an appointment, we would either make a clinical decision to reschedule, send a letter requesting that the patient reschedule, or not reschedule at all. When this policy change failed to reduce the no-show rate, we began calling outpatients two to three working days prior to their appointments and notifying treatment teams when residential patients missed their clinic appointments (rather than rescheduling such appointments). At the same time, recognizing that a large portion of no-shows were coming from patients newly referred from primary care, and considering that longer waits from contact to appointment have been associated with increased no-show rates,[3] we notified our primary care colleagues that we could see most of their consultations on the day of referral.

By December 2001, these actions had reduced the clinic's no-show rate to 11%, with less variance among clinicians (between 10% and 13%). The 7% reduction in no-shows meant a boost in usable capacity of nine visits during an average workweek, which noticeably enhanced the clinic's ability to sustain prompt access.

Another strategy for balancing supply and demand daily at both the clinic and individual clinician level was switching from a visit- to a panel-based method of work output management. Research indi-

Table. Outcomes of same-day access implementation in the mental health clinic at the Hot Springs campus of the VA Black Hills Health Care System

Parameter	First measurement (date)	Second measurement (date)	Third measurement (date)	Fourth measurement (date)
Time to third next available appointment*	7/20/28 days (2000)	0/4/18 days (January 2001)	≤ 7 days (March 2001)	0 days (March 2002)†
No-show rate	Combined: 18%; individual: 11%–19% (September 2000)	Combined: 11%; individual: 10%–13% (December 2001)		
Combined panel size	1,173 (May 2001)	1,186 (February 2002)	1,200 (June 2002)	
Individual panel size per clinic hour	17–22.7 (May 2001)	14.6–24.4 (February 2002)	15.4–20 (June 2002)	
Average annual visits per patient	3.7–4.7 (September 2000)	4.40–4.49 (June 2002)		
Time from referral to new consultation appointment	Range: 0–53 days; median: 13.5 days (September 2000)	Range: 0–16 days; median: 1 day (February 2002)		
% of scheduled visits among all patient visits	77% (May 2001)	68% (March 2002)		
Satisfaction rating among residential patients‡	2.95 (1998)	3.02 (July 2001)	3.39 (February 2002)	

*In this row, when three numbers are separated by slashes, each represents a value that corresponds to one of the clinic's three clinicians; when only one number appears, it represents a value that applies to all three clinicians. †At a follow-up measurement point five months later (in August 2002), the three clinicians had third next available appointment times of 0, 0, and 1 day, demonstrating a sustained improvement in access. ‡Rating scale as follows: 1, below average; 2, average; 3, above average; 4, excellent.

cates that, in clinics that provide longitudinal care, this type of system is the most effective. As long as panel size is chosen correctly, such measurement encourages efficient management of patient care without overwhelming a clinician's capacity to manage each day's demands that day. Panel management also protects efficient clinicians from becoming overwhelmed by inequitable assignment of new patients into slots created by their efficiency.[1]

In our clinic, we assign each patient a primary mental health clinician. Starting in May 2001, we began measuring the size of each

clinician's mental health care panel by first identifying the number of unique patients assigned to and seen by that clinician in the past 12 months and then dividing this number by the number of clinic hours the clinician has available during a full workweek.

We chose to analyze panel size per weekly clinic hour in order to accommodate each clinician's nonpatient care responsibilities fairly. We estimated that, of the 120 hours in our three clinicians' cumulative workweek, 65 (54%) are available for direct patient care. This ratio of time spent in direct patient care to time spent in other activities is similar to that found in private sector practices (58%).[4]

Using our baseline data and unpublished empiric data from other VA practices, we estimated that, in a typical workweek, a prescribing provider in a general outpatient psychiatric practice could manage a panel of 20 patients per available clinic hour. Therefore, with 65 hours per week available for direct patient care, our three clinicians together should be able to manage ongoing care for 1,300 patients. In May 2001, the clinicians had a combined panel size of 1,173 patients; in February 2002, it had increased slightly to 1,186; and in June 2002, it was 1,200—suggesting a fairly stable ratio between new patients and those leaving the practice.

Analysis of individual panel sizes remains a moving target, since available clinic hours must be adjusted constantly to reflect changes in other assignments. At first analysis in May 2001, panel size per clinic hour varied among clinicians from 17 to 22.7 patients. By February 2002, the variability in panel sizes increased, ranging from 14.6 to 24.4. This led us to modify our methods for assigning new patients, so that the clinician with the smallest panel size would receive a higher percentage of new referrals. By June 2002, variance had diminished, with panel sizes ranging from 15.4 to 20.

The surprising instability of panel size suggested to us that there might be differences in various clinicians' ability to develop space in their panels for new referrals. Therefore, we have begun monitoring what we call the "octane" of each clinician's practice: the percentage of total demand that represents new referrals. Between May and November 2002, octane varied from 7% to 12% among clinicians. This measure is correlated inversely with panel size, as expected based on our method of workload assignment. We anticipate the need for continued monitoring of panel size and octane, with periodic workload adjustment based on our findings.

Reducing demand for unnecessary visits

No-show rates, frequency of follow-up visits, and total number of visits have been shown to be reduced in primary care settings that maximize continuity of care.[1] Since our existing practices—such as one clinician performing both initial assessment and continued care—already were focused on continuity of care, changes in this area were modest. Clinicians agreed that, except while on vacation, they would be available for phone calls and drop-in visits with patients in their panel.

We had no baseline measures of continuity of care, and we doubt that the relatively small changes in practice patterns have had much effect on clinic performance. We did obtain a one-time measurement of continuity by clinician in a sample of chronically ill patients. This measurement used a modified version of the modified continuity index[5] and analyzed only visits to prescribing mental health clinicians (psychiatrists, psychiatric nurse practitioners, and psychiatric physician assistants) in the clinic described here and in a similar clinic at the Fort Meade campus of the VA Black Hills Health Care System, Sturgis, SD—which together employed a total of seven clinicians. Continuity scores ranged from 0.81 to 0.624. Perhaps most striking is that, among these seven clinicians with very similar practice and patient characteristics, Spearman rank order correlation between continuity and panel size was 0.89, suggesting a significant positive relationship between these two measures.

Another component of eliminating unnecessary visits is reducing return visit rates. We track these rates as the average number of visits per patient per year and report these data back to clinicians on a monthly basis. At baseline, we found less variability than we expected among clinicians, with average annual visits ranging from 3.7 to 4.7 per patient.

By June 2002, two clinicians had increased this rate—but variance among the three clinicians had vanished, with average visits per patient per year ranging from 4.4 to 4.49. This indicates that patients now are receiving a similar intensity of care from all clinicians. Furthermore, the two clinicians whose annual per-patient visit rate increased also had the greatest reductions in no-shows. This finding demonstrates the complex interdependence of many variables when analyzing capacity and demand.

There is evidence that, in primary care practices, intervals be-

tween return visits vary markedly between different providers treating similar patients.[6,7] This suggests that some clinicians might be able to increase the interval between scheduled appointments without worsening clinical outcomes or reducing patient satisfaction. Given this possibility, we added a monthly sampled measure of reappointment intervals to our ongoing progress report.

The first sample in March 2002 revealed some variability: The median follow-up appointment interval was two weeks for one clinician, two and a half weeks for the second clinician, and four weeks for the third clinician. Upon closer analysis of clinicians' decision making regarding these intervals, we found that two of the clinicians tended to place follow-up appointments at even week intervals, with clear peaks at two and four weeks.

After five months of tracking and feedback, the median intervals for the three clinicians were two, three, and four weeks—with less evidence of two- and four-week peaks. While these data suggest that only one clinician has increased reappointment intervals modestly, it's clear that all three are more thoughtful in individualizing reappointment intervals.

Furthermore, the suggestion of little change in reappointment intervals is biased in that the patients appropriate for the longest reappointment intervals often are not being rescheduled but instead are either being referred back to primary care providers for continued care or being asked to call at their convenience at a recommended time interval. Therefore, there is a reduction in both the number of long interval reappointments and the overall number of reappointments made. These modifications affect the median reappointment interval calculation in ways that minimize the true changes in reappointment patterns, which again highlights the interdependency of all variables in this process.

The possibility of patients "graduating" from care is one area in which mental health care resembles specialty, rather than primary, care. After discussion with primary care colleagues, we agreed that it would be appropriate to consider discontinuing specialized psychiatric treatment for patients who were taking only one or two psychotropic medications, whose clinical status and medication dosages hadn't changed for at least six months, and in whose cases it was felt that the therapeutic relationship with the mental health clinician was not required to maintain stability.

We now refer just under 2% of patients from our panels back for continued management in primary care each month. Primary care accepts these referrals because they know mental health staff are readily available if problems arise. Although small, this graduation rate helps by returning an average of two open slots to our available clinic capacity each week.

A variety of other methods could help reduce demand in a practice such as ours—particularly the use of referral agreements between mental health and primary care to promote treatment of selected uncomplicated patients in primary care rather than mental health. Thus far, we haven't had to develop such agreements, but this method remains available if we encounter future mismatches between demand and supply that fail to respond to other interventions.

Increasing supply

One way to increase the capacity (supply) of a health care practice is to reassess and revise policies regarding bookable hours and time off. After reviewing time utilization in our clinic and reprioritizing each clinician's activities, we were able to increase the clinic's maximum capacity (when all clinicians are present) from 110 to 130 half-hour slots per week.

Several of the strategies already described here had the effect of improving the efficiency and effectiveness with which each clinician used his or her time and resources (individual capacity). For example, the attempts to manage revisit intervals more effectively and to graduate appropriate patients—both of which reduced clinicians' self-generated future appointments, or internal demand—cleared away unnecessary work, thereby freeing prescribing clinicians to do appropriate, essential, and timely work.

These changes alone provided a 4% increase in clinic capacity. We believe that, as we become more thoughtful and consistent in managing revisit intervals, we will be able to increase capacity even further. And if we need them, additional strategies for maximizing the effectiveness of clinicians' capacity remain available to us. It may be possible, for instance, to reduce the number of return visits further by having the mental health nurse make interim telephone follow-up calls after medication initiation or adjustment.

The overall capacity of a clinic also is affected by the efficiency and flexibility with which clinic slots can be used to meet that day's demand. Initially clinicians maintained their schedules in the VA scheduling package, which required

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that specific times be set up for scheduling patients from residential, outpatient, and inpatient settings and did not allow us to match time flexibly with need. We decided, therefore, to use a separate computerized scheduling calendar, which allows us to list all available clinic times without identifying them as reserved for any one patient group. This permits maximum flexibility in matching clinical demand and capacity.

This change was an essential first step that supported us in gradually reducing our backlog. We are still able to meet the requirement of tracking patient location for VA cost assignment purposes: The person entering an appointment into the calendar codes the appointment with a letter indicating the patient's location, and the clinic secretary uses this letter code when entering the information into the appropriate clinic in the VA scheduling package later on.

OVERALL CLINIC OUTCOMES

By January 2001, two clinicians had achieved a third next available appointment within seven days—one with a same-day third next available appointment and one with a four-day wait. The remaining clinician was still lagging behind, with a wait of 18 days. Between March 2001 and March 2002, all three clinicians maintained their third next available appointment at seven days or less at all measurement points. And in March 2002, all three clinicians had the third next available appointment on the day of measurement. Five months later, two clinicians still had their third next available appointment the day of measurement and the other clinician's was early the following day, demonstrating sustained improvement.

A net effect of our various policy and practice changes—including the review of bookable hours as well as efforts to decrease no-show rates and increase graduation rates—has been an increase in usable weekly capacity of 31 half-hour slots, or a 30% increase in functioning clinic capacity from baseline.

Actual response time to new consultations, including patients who prefer to be seen at a later date (rather than on the day of referral) and those who cancel and reschedule appointments, has changed markedly. In September 2000, time from referral to a new consultation appointment ranged from the same day (urgent consults) to 53 days, with a median response time of 13.5 days. By February 2002, the upper end of this range had decreased to 16 days, and the median response time had dropped to one day.

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For several years, our facility has measured satisfaction among our residential patients systematically using a four-point Likert scale, in which a score of 1 corresponds to below average; 2, average; 3, above average; and 4, excellent. In 1998, the Hot Springs mental health clinic had a satisfaction rating of 2.95. By July 2001 it had increased to 3.02, and by February 2002 it was 3.39.

Same-day access represents a basic conceptual change from previous implicit and explicit messages that encouraged patients to keep scheduled appointments but not bother staff at other times. Instead, the clinic now emphasizes the availability of same-day appointments to both referral sources and patients in continuing care, which has led these patients to change their appointment scheduling patterns. In May 2001, 77% of all visits were follow-ups scheduled by treating clinicians (in other words, internal demand). By March 2002, this percentage had dropped to 68%—with the remaining 32% representing same-day appointments for current or new patients.

A surprising finding, given the improved access for referrals, is that the percentage of demand consisting of new consultations has diminished (from 20% in May 2001 to 10% in March 2002). This reduction may reflect positive effects of both a decreased no-show rate and a high continuity of care, such that a smaller number of patients drop out of care and then require a second referral. It also may reflect increased confidence in our availability on the part of referring clinicians, paradoxically reducing anxiety-driven, "just-in-case" referrals.

MAINTAINING SAME-DAY ACCESS

Systematic measurement of critical variables is necessary to sustain open access. We provide a quarterly progress report—with individual clinician and clinic summary measures of access, capacity, demand, and mix of workload (walk-in, new, and scheduled follow-up) sampled the first week of each month; panel

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size calculated quarterly; and clinician-specific measures of continuity calculated semiannually. Without such data, we don't believe it would be possible to manage and sustain improved access.

Fortunately, we have found that our efforts to increase capacity and manage demand have resulted in a sustainable balance. Sampling in early July 2002 revealed an actual capacity of 111 half-hour slots that week in response to a demand that required 90 half-hour slots. In June 2002, combined panel size was 1,200 patients, or 92.3% of the expected 1,300-patient capacity. This balance is obviously delicate—extended sick leave, unexpected departure of staff with prolonged recruitment, significant changes in nonclinical assignments, or unexpected demand changes easily could unbalance this equation. Should this happen, we could pursue additional strategies (such as service agreements with referral sources).

Our experience confirms that sustaining open access requires active management of new workload, informed by panel size. Prior to open access, new patients were assigned according to openings in clinicians' schedules, which produced an incentive to fill schedules with follow-up appointments to avoid a disproportionate burden of new referrals. Our first change was to assign consultations on a rotating basis, regardless of time available, to keep new workload equitable and remove incentives for schedule packing or "churning." With this assignment methodology, however, panel sizes appeared to drift slowly, presumably due to subtle differences in retention and graduation rates among panels. We now modify new workload assignment quarterly according to panel size: Currently, the first new consultation each week goes to the clinician with the smallest panel size per clinic hour, with the remainder of the consultations distributed on a rotating basis. This strategy appears to be helping reduce variation in individual panel sizes.

We have found it necessary to make specific plans to protect access when one or more of the clinicians plan to be away for more than a few days. In this circumstance we have reverted to the practice of blocking a few slots in the remaining clinicians' schedules, to ensure our ability to maintain access and avoid new backlog. We fear that even small backlogs could become a slippery slope and, therefore, we must strategize to maintain same-day access and minimize triage.

Finally, we continue to struggle with a lingering belief that clinics booked weeks to months into the future imply effective, busy, and sought-after clinicians. Despite stated acceptance of panel size goals, some clinics continue to report visits to document how busy they are, and administrators at various levels still frequently forget that they have agreed to support panel management goals. Until we achieve institutional consistency in measurement and assignment of workload, any same-day access system is vulnerable to disruption.

BROADER IMPLEMENTATION

Not all of our actions produced significant change, but their aggregate effect allowed us to achieve and sustain same-day access. We believe our experience could be replicated in other mental health clinics throughout the VHA. Opportunities and complications will vary, and other strategies for improving access (which we have either not needed or been unable to implement) could be used. Long-term, systematic analyses will demonstrate the utility of additional strategies.

In the meantime, however, we hope that our experience encourages other mental health providers to accept the challenge of offering this level of access, as well as the conceptual changes that go with it, and that others will experience similarly improved provider and patient satisfaction from their own efforts toward these goals. ●

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REFERENCES

1. Murray M, Tantau C. Redefining open access to primary care. *Manag Care Q*. Summer 1999; 7(3):45–55.
2. Sparr LF, Moffitt MC, Ward MF. Missed psychiatric appointments: Who returns and who stays away. *Am J Psychiatry*. 1993;150:801–805.
3. Nicholson IR. Factors involved in failure to keep initial appointments with mental health professionals. *Hosp Community Psychiatry*. 1994; 45:276–278.
4. Suarez AP, Marcus SC, Tanielian TL, Pincus HA. Datapoints: Trends in psychiatric practice, 1988–1998: III. Activities and work settings. *Psychiatr Serv*. 2001;52:1026.
5. Magill MK, Senf J. A new method for measuring continuity of care in family practice residencies. *J Fam Pract*. 1987;24:165–168.
6. Schwartz LM, Woloshin S, Wasson JH, Renfrew RA, Welch HG. Setting the revisit interval in primary care. *J Gen Intern Med*. 1999;14:230–235.
7. Petitti DB, Grumbach K. Variation in physicians' recommendations about revisit interval for three common conditions. *J Fam Pract*. 1993;37: 235–240.