Adoption of an advanced access model by residents

Pilot project at the Gaspé family practice unit

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Much has been written, particularly in recent years, about the difficulties that patients encounter when trying to access medical services.[1,2] Models for advanced access and collaboration among professionals offer many interesting solutions to this daunting challenge.[3,4]

In spite of the fact that the adoption of these models has been helped by the introduction of family medicine groups and by training in advanced access, family medicine residents have been only marginally involved in this innovation so far.

And yet, family practice units (FPUs) are an ideal setting in which to test and promote innovations in medical practice. This is true for a number of reasons. For example, FPUs have a mandate of excellence. They also have plenty of resident physicians who are there to learn. The mobility of residents during and after their training makes them ideal ambassadors for innovative models.

Evidence-based care and best practices

Murray and Tantau[5] maintain that advanced access is difficult to introduce in settings where general practitioners work fewer than 6 half-days a week—a common feature of FPUs whose staff also have clinical duties at an institution or university. In spite of this, a randomized trial conducted in a teaching setting[6] demonstrated substantial—and surprising—improvements in the functional organization of the teaching setting and its wait times. In addition, a study conducted in 2004 demonstrated that having residents participate in improvement initiatives makes it possible to increase the number of registered patients and to increase the efficiency of a team.[7]

In addition to addressing issues with access, the advanced access model helps residents build skills in CanMEDS–Family Medicine[8] roles, including the following:

- Collaborator—sharing activities with nurses;
- Communicator—simplifying the appointment model and enabling the initial contract to evolve;
- Manager—effective management of patients, time, supply, and demand; and
- Professional—greater autonomy and less wait list pressure.

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Teaching tool

We developed a pilot project to enable 2 residents in their final year of training at our FPU to implement the advanced access model. To increase the likelihood that our project would be a success, we developed criteria for implementation (**Box 1**). First, our teachers had to adopt the model so that they could then guide the residents through the process; this meant that the administrative staff and nursing staff also became familiar with the concept. Second, we standardized our scheduling practices (length of appointments, percentage of time dedicated to open scheduling); this reduced the effect of the change on the team. Third, we clearly defined the practice population of each of the residents, so that their use of the model would resemble their supervisors' use of the model as much as possible.

Box 1. Conditions for implementation of the advanced access model

Conditions for implementation include the following:

- The supervisors involved adopt the advanced model
- One physician is responsible for leading the project
- Administrative staff and other professionals are familiar with advanced access
- The residents' scheduling is standardized
- The residents' practice populations are clearly delineated
- The entire clinical team and administrative staff are made aware of the initiative
- The lead physician schedules follow-up meetings with the residents systematically

When the change was implemented, all of the teachers at the FPU were informed of the initiative and made aware of the potential effect on supervision and the unpredictability of filling appointments. As soon as the model was implemented, the physician leading the project began follow-up meetings with the residents and supervisors to make any necessary adjustments.

Tools and resources from the project

A number of different factors contributed to the success of our experiment (**Box 2**). First, the residents were enthusiastic and open to the changes. This was also true of the teaching team, who offered all of the support and understanding that we hoped they would. Clearly defining the residents' practice populations and having

Box 2. Keys to the success of advanced access

Keys to success include the following:

- Residents and teachers are enthusiastic and interested
- Residents have clearly defined practice populations
- Residents can count on consistent professional support before the project starts
- Patients receive appropriate information about the project when it begins
- Residents develop a system for covering for each other when they are away, in order to provide patients with continuity of care

them conform to the practising physicians' practice populations also proved to be very important.

However, we did encounter a number of obstacles. The greatest obstacle was the availability of nursing staff to support the practice. The problem was not a lack of interest on their part; it was a lack of resources commensurate with the number of physicians who had adopted the model. Some patients found the model difficult to understand; this could have been addressed by providing them with a written explanation beforehand. It was more difficult to provide prompt access to an appointment during the months when the residents were away performing rotations and only performing half-day returns; this could have been addressed by arranging for the residents to cover for each other.

Conclusion

Six months after it was introduced, the project was, on balance, working well. A sense of effectiveness, greater professional responsibility, greater patient satisfaction, and a stronger patient-doctor relationship all generated interest in longitudinal patient follow-up care. The residents reported that they felt better prepared for office practice after completion of their training.

In light of our experience, we believe the benefit to residents could be increased if advanced access were introduced at the beginning of their specialized training. It could be introduced gradually between their first and second years of training. For example, the length of appointments, the percentage of blocks of emergency consultations, and the size of their practice populations could be designed to enable the residents to function within a model that reflected their ability and skill level. Proceeding this way would also give patients time to more fully understand and take advantage of the model. There is no question that introducing this model in family medicine programs has its challenges; the fragmentation of training in different settings and from rotation to rotation goes against the continuity that the model tries to create.

Our experience of using the advanced access model with the residents at our FPU was a positive one. Although a number of adjustments need to be made when the model is implemented in training settings, we believe that any setting that wants to improve access to its primary health care services can and should adopt this model. The advanced access model also has the advantage of stimulating interest in longitudinal care among residents and young family physicians, and of helping all members of the medical community to adapt their access models.

Other resources for the advanced access model are available from the General Practice Services Committee (**www.gpscbc.ca/psp-learning/advanced-access/tools-resources**) and from Alberta Access Improvement Measures (**www.albertaaim.ca**).

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Competing interests
None declared

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TEACHING TIPS

- Advanced access helps residents build skills in the CanMEDS-Family Medicine roles as collaborators, communicators, managers, and professionals. In the process, they achieve greater autonomy and experience less wait list pressure.
- For the model to work, everyone needs to be on board: the residents, their supervisors, the administrative staff, and other professionals.
- The advanced access model has the advantage of stimulating interest in longitudinal care among residents, who take this experience with them as they embark on their own careers.

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