Challenge of same-day access in primary care

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In high-quality health care systems, people should be able to see their primary care physicians in a timely manner when they become ill, including on the same day when clinically appropriate. Yet, in a recent survey conducted by the Commonwealth Fund, only 41% of Canadians said they could get an appointment on the same or next day when they were sick or needed medical attention—the lowest reported percentage among the 11 high-income countries included in the study.[1] Perhaps unsurprisingly, Canadians are also more likely to visit the emergency department for care compared with those who live in other countries.[2] Many physicians and policy makers are considering advanced access scheduling to improve access in primary care.[3] But does nationwide implementation of advanced access offer a realistic route to solving our primary care access problems?

Advanced access theory

The concept of advanced access seems intuitively simple at first glance. Patients are offered appointments with their regular providers the same day they call, even if their need is not urgent, and are booked at a time of their choosing, which might be that day or at a later date. The goal is to reduce wait times while maintaining continuity between provider and patient. To do this, practices must continuously strive to match the supply of appointments to patient demand. Although advanced access is frequently viewed as a set of rules to improve scheduling, it is better understood as a philosophy of care that requires a paradigm shift beginning with physicians feeling "accountable for the care of a panel of patients, not appointment slots."[3]

Real-world experience

Practices in the United States (US), Europe, Australia, and Canada have tried to implement advanced access, but results have been mixed. Case studies from the US have demonstrated varied success in a range of settings.[4] The most concerted nationwide effort occurred in the United Kingdom, where practices in England were organized into learning collaboratives with formal coaching support. However, evaluations of the UK experience found that any gains in access were offset by patient dissatisfaction in other areas.[5] In Canada, 6 provinces have supported primary care practices to adopt advanced access voluntarily as part of broader quality improvement training. Although most Canadian implementations have not been formally evaluated, a study conducted in British Columbia found that advanced access training reduced wait times for urgent and nonurgent appointments.[6]

Real-world implementation of advanced access is difficult. Practices must carefully collect and analyze data to balance supply (the number of time slots available for patients) and demand (a combination of roster size, average visit frequency, and average visit length). Even if supply and demand are balanced, practices can only maintain optimal accessibility by accepting that they might have more appointments on busy days and unfilled appointment slots on slower days. However, analysis often reveals that demand outstrips supply. When this is the case, practices that wish to provide high-quality access need to consider structural changes such as reducing roster size, increasing days worked, or enhancing the role of nonphysician team members. These changes can have substantial implications for both physician income and work-life satisfaction.

Most practices that attempt to implement advanced access are unable to do so with high fidelity, and therefore same-day access often remains elusive. In a recent review, only 2 out of 8 studies found advanced access implementation resulted in same- or next-day availability, although all studies reported improvements in appointment wait times.[7] Difficulties in achieving same-day access might explain why others have found that implementation of advanced access has no effect on emergency department use for patients with chronic disease.[8,9]

Unintended consequences

If same-day bookings are prioritized, it is often at the expense of patient preference. Many primary care practices in England misinterpreted advanced access, often "embargoing" 70% of appointment slots for same-day appointments, and then requiring patients to call immediately after the office opened to book into these embargoed slots.[10] These same-day-only booking systems were seen as a way of meeting a government target that patients be offered appointments with their primary care doctors within 48 hours. However, it resulted in frustrated patients who complained that the new system made it impossible to book appointments with their doctors in advance. This approach has poignantly been referred to as "access by denial."[11]

The few studies evaluating the effects of advanced access on patient satisfaction and clinical outcomes have shown heterogeneous results.[7] Efforts to improve access must therefore be balanced with improvement

This article has been peer reviewed.
Can Fam Physician 2015;61:399-400

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efforts and measurement in other areas including patient-centredness and chronic disease care.

Addressing structural challenges

Achieving improvements in same-day availability will require policy makers to move beyond current supports for advanced access to addressing structural issues such as physician supply, average roster size, physician payment models, and meaningful integration of other health professionals into practice. The experience of Group Health Cooperative, a large integrated health system in the US, is illustrative.

Group Health Cooperative tried to implement advanced access scheduling in 2002 as one of many initiatives to improve access to care for patients.[12] They found that advanced access did improve timeliness of care but that physicians reported an increased workload and a compromised focus on population health, resulting in poorer work-life satisfaction. In response to these initial findings, Group Health Cooperative moved to a model where physician assistants and nurse practitioners saw patients for same-day appointments, with physician backup when necessary, while physicians strove for appointment availability within 7 days. But the most transformative change made at Group Health Cooperative was reducing roster size from previous highs of 2500 to 3500 to an average of 1800 patients per physician.

These reforms were possible at Group Health Cooperative in large part because physicians received a salary and were therefore not directly affected by caring for fewer patients. Furthermore, Group Health Cooperative was willing to hire more physicians and support staff because it calculated that the additional expense in primary care would be balanced by reduced spending on emergency department use. The "silo" approach to health care funding in Canada makes such change difficult.

The way forward

Improving same-day access in primary care in Canada will require a multifaceted approach. We should begin with a commitment to measuring and improving patients' experiences of care in all primary care practices. Governments should be responsible for practice-level measurement of patient experience, while practices should be accountable for related improvement work. Patient experience data can highlight the importance of same-day access and can help practices understand whether current systems meet patient needs for urgent care, continuity, and patient-centredness. Practices can use advance access principles to understand if there is a mismatch between demand and supply of appointments but will need support to reorganize service delivery. Reducing appointment demand will involve questioning the frequency of routine appointments that are not based in evidence, such as the "annual" health examination.[13] Increasing appointment supply will mean moving beyond the typical office visit to incorporate e-mail, telephone, or group medical appointments and optimize integration of nonphysician health professionals. Practice facilitation and information technology are key potential enablers.

Governments will need to address structural challenges to improvement. Current physician payment models in Canada reward driving up patient demand—fee-for-service payment incentivizes frequent repeat visits while capitation incentivizes larger roster sizes. Payment reform and greater physician accountability for quality of care are needed to reward practices for being responsive to patient demand instead. Transparent reporting of patient experience and other data on quality of care at the practice level might be a strong nonfinancial incentive for improving same-day access.

Conclusion

Implementation of advanced access in primary care is challenging and often does not lead to improvements in same-day access. However, principles of advanced access can be used to guide practice-level improvement as part of a multifaceted strategy to address same-day access that includes universal reporting of patient experience data, supports to reorganize service delivery, and incentives to respond to patient needs.

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Competing interests
None declared

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