

## Advanced Access, Open Access, and Continuity of Care: Should We Enforce Continuity?

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Continuity of care and patient-centeredness are longstanding philosophical pillars for the organization of delivery of care in family medicine.<sup>1</sup> At the same time, there is pressure to improve the speed of access to health care for patients by providing “open access” systems.<sup>2</sup> Two articles in this issue of *Family Medicine* sensitize us to the difficulties in creating a health system that will appeal to everyone.<sup>3,4</sup>

Phan and Brown point out that by providing open-access scheduling, the continuity of care between patients and physicians decreased from what it was in a system based on scheduled appointments.<sup>3</sup> Although the decrease was relatively slight, it was statistically significant. Was it really a surprise that a move from advanced scheduling of appointments to seeing whichever physician was available at short notice resulted in decreased continuity, especially when each of the physicians was only available for a limited number of sessions each week? A more important question that may need to be asked is whether, because of the importance

of continuity, it should be mandated and imposed through the health care system.

Continuity of care, and the more current discussion of a medical home, are so ingrained as desirable characteristics defining family medicine that it might seem that the delivery system needs to be built around them. Indeed, data from some cohort and cross-sectional studies have shown distinct advantages to continuity between patients and physicians, particularly in terms of hospitalizations, emergency department utilization, and patient satisfaction.<sup>5-8</sup> Other studies, however, have not found continuity to be as beneficial for quality-of-care measures.<sup>9,10</sup>

Other data suggest that continuity of care is not an endpoint but rather just a strategy to enhance the patient-physician relationship. Indicators of the relationship such as trust between the patient and the physician are the primary key to good outcomes.<sup>11</sup> Thus, greater continuity may not yield the benefits that one would hope unless it is associated with an increase in trust, and this is more likely if patients have chosen to see a particular physician, rather than having them required to see a particular physician.<sup>12</sup> Further, most studies of continuity are observational in nature and may not represent what would happen if continuity were imposed. Relationships between patients and physicians are built on shared experiences and time together.<sup>13</sup> Forcing two individuals together through

scheduling systems that enforce continuity may not yield a positive patient-physician relationship.

Both patients and physicians like continuity but recognize that it is more important in some situations than in others.<sup>14-16</sup> Some evidence suggests that there is a group of patients who particularly value continuity; they tend to be older, have worse health status, and are more likely to have a chronic disease.<sup>17-19</sup> These patients particularly want to see their personal physician. Other patients have a greater desire for rapid access to care for acute problems, even if it is with a physician they don't know. Importantly, not only may different groups of patients place a different priority on continuity or fast access, but these priorities may differ within individuals depending on the nature of the problem.<sup>15,20</sup> Patients are willing to wait longer to see a familiar physician who is well informed about their case when they have a problem causing uncertainty or when they need a routine checkup. The same patients prefer quick access for likely minor “low-impact” problems. Being forced to wait for an appointment with a specific physician when the patient desires rapid care may not be a useful strategy in organizing the health care system.

If mandating a continuity dyad may yield dissatisfaction and may not necessarily translate into a positive patient-physician relationship, how can we maintain patient-physician relationships but also provide fast access to care? One

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(Fam Med 2009;41(1):57-8.)

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strategy might be linking patients with a team of providers rather than with one individual. Relationships do not have to be exclusive—it is possible to get to know and trust a small number of physicians, particularly if they communicate well with each other, share good medical records, and work to the same clinical management protocols. In Bennett and Baxley's study, this approach was used to provide access to a team of individuals' schedules rather than one particular provider of choice.<sup>4</sup> Continuity with a team may be the only way of providing any sort of continuity in settings such as academic medical centers, where each physician is only available intermittently.

This idea assumes that the benefits of continuity can be transferred from an individual doctor-patient relationship to a team, but can this transfer be made successfully? This and other related questions should be priorities for future research. We need to know more about why and in what way a positive relationship with a doctor really matters to patients, whether these findings are transferable to relationships with teams of physicians, the characteristics of a team that can generate the sense of trust and positive regard that patients feel for "their doctor," and the size of team to which patients can easily relate.<sup>6</sup>

Until we know the answer to these questions, there are some practical strategies that seem reasonable in light of current research. Although it is important to allow an element of open access scheduling for people who want or need to see a physician on the same day, this approach to scheduling should not restrict the ability of other people to book in advance with a physician of their choice. Indeed, the advanced access approach does not propose that people are always seen on the same day because they are not

allowed to book ahead.<sup>21</sup> Instead, the claim is that by measuring and planning for predictable demand, it is possible to allow patients to be seen on the day they wish—which includes both same-day appointments and booking in advance to see a preferred physician. We would suggest that doctors work in small "teams within teams," with each small team consisting of about three physicians within a larger medical center. At least one of these physicians would be available on each day of the week. In this way, each patient can relate to and usually consult one of their three usual physicians and can balance fast access and the ability to consult a known and trusted doctor. Since both access and doctor-patient relationships are important to different people at different times, team-based continuity may be the way forward.

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