Improving Access to Primary Care

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Waiting for primary care appointments is a major problem in the United States. Some primary care practices have succeeded in offering timely access to their patients, but many still make their patients wait.

A 2015 international household survey found that 48% of people in the United States who were sick could not obtain a same-day or a next-day appointment, the second lowest percentage of 11 developed nations.[1] A 2012–2013 study of simulated patients requesting primary care appointments in 10 US states found that the median wait times for new patients were <1 week in most states, but with a wide range; some wait times were over 30 days.[2] A 2016 follow-up found that 49%–53% of callers reported wait times of ≤ 1 week, whereas 10%–12% reported wait > 30 days. Compared with 2012–2013, fewer callers reported short wait times and more reported long wait times, suggesting that primary care access may be faltering.[3] Another study found significant increases in low-income respondents delaying care because of long wait times after the Affordable Care Act's Medicaid expansions. The worsening of access was observed in Medicaid expansion states compared with nonexpansion states, suggesting that the growing demand for care was not matched by increased capacity to provide care.[4]

The paper[5] in this issue of *Medical Care* extends the findings cited above—by the same group of authors.[2,3] Callers simulating patients requested appointments from thousands of primary care practices in 10 states. The calls were randomized to: (1) a new patient seeking a routine check-up; and (2) a new patient with significantly elevated blood pressure recently uncovered at a pharmacy. Wait times were highly skewed, with a median of 6 days and the 95th percentile at 47 days. On average, callers using the hypertension scenario received appointments 4.7 days earlier than callers requesting a routine check-up. The authors concluded that primary care practices triage patients to see those with greater acuity more promptly.[5]

Proritization of access by patient acuity is a reasonable way to mitigate the access problem in primary care. This editorial examines more broadly some strategies to improve primary care access.

ACCESS METRICS

To improve access, a practice needs to measure it. Several access metrics are available for the entire practice and for each practitioner.

- Percentage of same-day appointments is a spot check of the number of appointments during a particular day that were scheduled today or yesterday divided by the total number of scheduled appointments that day. Over 30% indicates good access because many slots are available for same-day/next-day care.
- Future open capacity is the number of open slots over the next 2 weeks divided by the total number of slots during those 2 weeks. This metric truly shows how much open capacity exists. Ideally, over 40% of slots are open.
- Third next available appointment (TNAA) is a commonly utilized metric that measures the number of days from today until the third next open slot. The first and second open slots are not used because they could be open because of cancellations while all other slots are filled. This is not an ideal metric because the TNAA for a practitioner could be

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7 days even though only 5 slots are open during the next month, meaning that many patients wait longer than the TNAA suggests.
- Another performance measure is to ask patients whether they can get timely appointments.

DEMAND AND CAPACITY

Family physician Mark Murray is the pioneer of access improvement.[6] Murray understood that for patients to gain prompt access, a practitioner's capacity to provide appointments must equal patients' demand for visits to that practitioner.[7] Primary care workforce estimates predict that on a national scale, the primary care practitioner (physicians, nurse practitioners, and physician assistants) to population ratio will fall by 8% from 2010 to 2025, signifying a long-term excess of demand over capacity.[8] Dr Murray proposed ways to reduce demand and increase capacity and introduced the concept of advanced access by which most appointment slots are kept open until the appointed day.[6] Many practices have tried advanced access, but failed to sustain it because of a demand-capacity imbalance.[9]

IMPROVING ACCESS

The first step in improving access is to set a goal; for example, by July 1, 2019, the TNAA will drop from 45 days to 10 days for all clinicians. Strategies to improve access come in 2 buckets: (1) equalizing demand and capacity; or (2) trying to improve access even with an excess of demand over capacity.

IMPROVING ACCESS BY EQUALIZING DEMAND AND CAPACITY

Reducing demand by lowering practitioner panel size is almost impossible, given the primary care practitioner shortage. Encouraging patients to e-mail their practitioners through a patient portal is 1 avenue to reduce visit demand. However, studies are mixed on whether increased patient portal use actually reduces face-to-face visits; among 3 health systems implementing portals, one found a decrease, another found an increase, and a third found no change in face-to-face visits.[10]

Increasing capacity is often promoted by health system leaders by having practitioners see more patients. Given the serious problem of burnout, this is not a sustainable solution because burned-out physicians often reduce their patient care hours.[11]

No-shows are capacity killers: unfilled slots can never be recovered. Thus, reducing no-shows adds capacity. For patients at high risk of no-shows, phone calls from front desk personnel 1 week before the appointment reduced no-show rates significantly compared with patients receiving automated reminder calls.[12] A more drastic strategy is to open appointment books only 2 weeks early to reduce the time between making an appointment and attending the appointment. Wait times of 2 weeks are associated with twice the no-show rate than wait times of 5 days.[13] However, this change creates a problem for patients who wish to plan visits 2 or 3 months in advance.

A powerful way to add capacity without worsening burnout is to empower nonpractitioner team members (usually nurses, pharmacists, physical therapists, and behaviorists) to see patients independent of practitioners. Studies show that nurses and pharmacists can independently care for many patients with diabetes and hypertension with excellent quality.[14,15] Patients directly accessing physical therapists have better quality for uncomplicated musculoskeletal complaints than patients seeing physicians.[16] Physical therapists encountering red flags would refer those patients back to the physician. Behaviorists working with practitioners can manage depression while reducing practitioner visits.[17] Hundreds of patients on a primary care panel can be managed by these team members, thereby adding significant capacity.

Finally, primary care practices can partner with fast-growing urgent care centers and retail clinics to improve access. If care provided in these centers and clinics is coordinated with primary care through a shared electronic medical record, primary care capacity is enhanced.[18]

IMPROVING ACCESS WITH DEMAND EXCEEDING CAPACITY

The acuity-based scheduling article in this journal issue represents one approach to prioritizing access for patients with greater need for prompt appointments.[5]

A number of practices designate one clinician each day to have an open appointment template, available to see patients requesting same-day access. If demand far exceeds capacity, those open slots fill up early in the day, leaving some patients without access. Another drawback to this solution is the disruption in continuity of care.

An alternative that considers continuity of care freezes some appointment slots for each clinician, with those slots thawing (opening) only the day before. Practices experiment with how many slots to freeze to meet same-day/next-day demand. A drawback is that fewer appointments are available in advance. To further prioritize continuity of care, the frozen appointments could be thawed only for the patient's empaneled practitioner.

CONCLUSIONS

For patients with acute health problems or with exacerbations of chronic illness, prompt access to primary and specialty care is an essential building block for any health system to be high-performing. In the case of primary care, with its chronic excess of population demand over practitioner capacity, achieving access is a challenge. The good news is that a number of primary care practices have identified ways to provide prompt access to those patients who need care now.

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