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Advanced Acces

Promising practices to strengthen primary care in northern, rural and remote communities

If you are looking for promising practices being used in Canada to improve access to safe, high-quality, team-based primary care, that have the potential to improve access to team-based primary care in northern, rural or remote communities, then this promising practice will be of interest to you.

About Healthcare Excellence Canada

Healthcare Excellence Canada (HEC) works with partners to spread innovation, build capability, and catalyze policy change so that everyone in Canada has safe and high-quality healthcare. Through collaborations with patients, essential care partners and people working in healthcare, we turn proven innovations into lasting improvements in all dimensions of healthcare excellence.

HEC focuses on improving care of older adults, bringing care closer to home, and supporting pandemic recovery and resilience – with quality and safety embedded across all our efforts. We are committed to fostering inclusive, culturally safe, and equitable care through engagement with different groups, including patients and essential care partners, First Nations, Métis and Inuit, healthcare workers and more.

Launched in 2021, HEC brings together the Canadian Patient Safety Institute and Canadian Foundation for Healthcare Improvement. We are an independent, not-for-profit organization funded primarily by Health Canada. The views expressed herein do not necessarily represent the views of Health Canada.

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Advanced Access Quality Improvement (QI) Coaching Support Model

What is the promising practice?

An advanced access (AA) model is an effective and efficient organizational model for improving the timely access of primary care, where access to care is defined as patients having access to the right professional at the right time according to their situation. The Advanced Access QI Coaching Support Model is a quality improvement model based on a principle of scheduling that allows patients to access their own primary care providers in a timely manner.[1]

Advanced access

Over the last two decades, AA has become increasingly popular in Canada. The model has been widely promoted by the College of Family Physicians of Canada and several other provincial organizations and professional associations. The AA model has been implemented in Canada to varying degrees, in various settings, with the majority of implementation and demonstrated impact evidenced in urban settings. The Advanced Access QI Coaching Support Model is in early implementation phases in six clinics that serve patients who live in rural areas of Québec and New Brunswick, with the expectation that the impacts demonstrated in urban settings will be replicated in the rural settings. See Table 1 below for a list of clinics based in rural settings and the associated status of implementation.

Table 1: *Clinics based in rural settings where the Advanced Access QI Coaching Support model is underway and implementation status*

Name and location of the rural clinic	Patients [2] (2022)	Population [3] (2022)	Status/timeline for implementation
Centre Médical de Huntingdon - GMF du Haut St-Laurent (ZIM Modéré) (Huntingdon, QC)	5,400	2,500	Launch in fall 2022, CQI coaching
GMF Vallée-de-la-Gatineau (Maniwaki, QC)	14,000*	3,700	Launch in fall 2022, CQI coaching
GMF Vallée-de-la-Gatineau (Grand-Remous, QC)	14,000*	1,200	Launch in fall 2022, CQI coaching
GMF Vallée-de-la-Gatineau (Kitigan Zibi, QC)	14,000*	1,200	Launch in fall 2022, CQI coaching
Clinique de santé St-Joseph de Dalhousie (Dalhousie, NB)	4,000	1,090	Launch in May 2023
Unité de médecine familiale de Lamèque (Lamèque, NB)	4,000	1,300	Launch in May 2023

**Combined patient count for GMF Vallée-de-la-Gatineau clinics in Maniwaki, Grand-Remous and Kitigan-Zibi, QC.*

AA is based on five pillars:

1) comprehensive planning for needs, supply and recurring variations
2) regular adjustment of supply to demand
3) processes of appointment booking and scheduling
4) integration and optimization of collaborative practice
5) communication about AA and its functionalities

The five pillars of AA guide the organization of services, which must be adapted to organizational practice and context, including rural and remote communities.[4]

Implementing AA requires a major organizational change implying more broadly reorganizing the practice of the whole team members (administrative staff and health professionals) to be more patient-focused and efficient. Strategies to improve implementation and teach advanced access in a primary care setting include the use of continuous quality improvement approaches and change management supports to help primary care teams utilize practice tools, specific training and to embed processes to monitor relevant indicators to improve over time. On a more local level, the implementation of AA varies to a great extent among both professionals and primary care clinics, so tailored and longitudinal change management supports can facilitate successful adoption.

Continuous quality improvement

Continuous quality improvement (CQI) approaches promote organizational change. The widely used “model for improvement” approach is designed to promote, structure, and sustain changes in organizations to improve both processes and outcomes.[5] Following an investigation of a given problem, changes are implemented through four steps of iterative implementation cycles (represented by the acronym PDSA), where change is:

- **Plan:** The change is planned based on evidence from data, community feedback, and stakeholder experience.
- **Do:** The change is carried out while documenting its effects.
- **Study:** The change is analysed by measuring the results achieved and comparing them to expected results to appreciate the impact of the change.
- **Act:** The change is refined, either by maintaining or adjusting actions in future cycles or

by expanding its scale.

Also, practice facilitation is thought to be useful as stand-alone intervention (compared to more limited strategies such as audit and feedback).[6]

Implementation

The CQI intervention was developed and tested with eight primary care teams (2019-2022) with diverse profiles in terms of organizational size (five physicians versus 25 physicians) and settings (rural versus urban). The CQI coaching intervention consists of three activities carried out iteratively until the improvement objectives are achieved or up to a maximum of 18 months of intervention:

1) team reflection and prioritization of change needs
2) PDSA cycles
3) group mentoring

All activities can be conducted virtually but it is recommended to do the first activity in-person to facilitate the engagement and buy-in of participants.

Activity 1 summary: Team reflective sessions and need prioritization

Ahead of initial workshop launch:

- At least three months ahead of the initial workshop (activity 1), a 360-degree portrait is generated, which involves completion of the ORAA tool (Reflective tool on advanced access) by physicians, professionals, and administrative staff and the Patients' Experience on Access Survey as well as gathering of access indicators (based on EMR data).
- Develop a synthesis of personalized results using data from the clinic.

Face-to-face workshop with all types of clinic members to identify the priority need(s):

- Present the AA model and the AA team's previous achievements with the clinic.
- Present a synthesis of the clinic's personalized results.
- Animation – lead facilitation activities.
- Come to a consensus on one or two needs prioritized by the clinic team.

Activity 2 summary: PDSA cycles

- Coordinate virtually the creation of a Continuous Improvement Committee (clinic CQI team) and their regular meetings (every three to four weeks for approximately 30 minutes): Plan the meetings of the clinic CQI team.
- Facilitate the meetings.
- Monitor targeted indicators as part of the PDSC cycles.
- Contextualize results for the practice
- Complete PDSA cycle tracking tools.
- Prepare the necessary materials and logistics in collaboration with local managers.

Activity 3 summary: Group mentoring

- Participate in the follow-up meetings with the other CQI coaches (weekly or bi-weekly).
- Identify existing change strategies based on the experience of other participating clinics (every three to six months).
- Contribute to the coordination and facilitation of cohort meetings.

Tools

Reflective Tool on Advanced Access

Each team member completes the "Outil Réflexif Accès Adapté" (ORAA) questionnaire, which provides a comprehensive portrait of the participant's adherence to AA practices for each AA pillar. Two versions of the questionnaire are available online in both French and English, one for healthcare professionals (39 items) and one for administrative staff involved in appointment setting and agenda management (25 items), which takes approximately 12 minutes and six minutes to complete, respectively. Each respondent is given a unique identifier to ensure confidentiality through a double validation process. Upon completion of the questionnaire, respondents receive a personalized report and suggestions to improve their AA practice.

Patient Survey

To assess the accessibility of services from the perspective of patients, patient-reported experiences are assessed in each clinic using a 50-item online survey. The questionnaire has been developed based on comparable tools assessing patients' access experiences in primary care and includes recommendations from our patient partner committee. The 50-item instrument

covers various dimensions of access from a patient perspective, such as the appointment process, communication and team collaboration. The survey is available in French and English and takes approximately 11 minutes to complete. The survey is distributed by email to all registered patients with a known email address (between 40 to 80 percent depending on the clinic) and the tool is accessed electronically. This data collection strategy is inexpensive and includes friendly reminders.

Indicators

Indicators are calculated on a weekly or monthly basis via the electronic medical record (EMR). Each clinic CQI team will select indicators from among these outcome measures to evaluate the effectiveness of the change strategy tested and inform the PDSA cycles. Extraction of data from EMRs and indicator calculation have been successfully automated for all six indicators from five distinct EMRs in Quebec and New-Brunswick.

Six key AA measures

- **Third next available appointment (weekly)** which is defined as the delay before the third next available appointment. The third next available appointment is used (rather than the first or second) to decrease variation. The measure used is the number of days before the third next available appointment, open for general consultation. Must be calculated at the same time each week.
- **Percentage of 48-hour open slots (weekly)** which is defined as the proportion of appointments available in the next 48 hours. Provides an overview of the provider's ability to respond to urgent care demands. The measure used is a percentage of open appointments out of the total number of appointments offered within the next 48 hours. Must be calculated at the same time each week.
- **Relational continuity (monthly)** which evaluates relational continuity between the provider and their registered patients. This is measured as the percentage of the total number of medical consultations with a patient's attached family physician (or specialized nurse) out of the total number of consultations with any family physician (or specialized nurse) from the clinic.
- **Use of walk-in services (monthly)** which is the proportion of walk-in visits by registered patients to each professional. This is measured as the percentage of consultations of registered patients offered through walk-in visits out of the total number of consultations with their attached professional.
- **Multidisciplinary involvement (monthly)** which evaluates the level of involvement of different types of providers (social workers, nurses, pharmacists, etc.) with registered

patients. This is measured as the percentage of consultations with a physician, resident or specialized nurse out of the total number of consultations with any providers of the clinic.

- **Discontinuity for chronic patients (monthly)** which is the proportion of chronic patients without any consultation within the last 12 months. This is measured as the percentage of registered patients with at least one chronic condition who have not consulted the clinic within the last 12 months.

Evaluation and impact

Outcomes and benefits to date based on data from eight primary healthcare teams that serve urban communities in Quebec include the following:

- Reduction of the third next appointment by seven days.
- Increase of 11 percent in the proportion of available appointment in 48 hours.
- Reduction by 20 percent of walk in consultations.
- From the provider perspective, advanced access has greatly reduced workload; resulted in more flexibility even with less availability; less emails with administrative staff; and greater work satisfaction among administrative and clinical staff.

The results above have been sustained for more than one year in five of the eight primary healthcare clinics.

What do the providers who deliver the innovation think?

- “With COVID, sickness or maternity leave, we could have faced a large imbalance between supply and demand. But with the flexibility that advanced access allows us, we were able to offer timely appointments to our patients.” (Nurse)
- “I started seeing results within six months. It just gets better over time. Patients come in for more targeted health issues so I can see more patients per day... My colleagues are intrigued and peeking at my schedule.” (MD)
- “It’s a much more interesting practice. I used to learn what happened in the last year. I was not involved in their care. Now I see them when they have acute problems…I’m

more useful and the patients are grateful." (MD)

What do the patients and care partners who have received the innovation think?

- "Rapid access is great. But for me, the most important thing is to have an appointment with my family doctor who knows me. I would rather wait a few days to get an appointment… than to get an appointment today with a doctor who does not know me." (Patient)
- As a result of these changes, I have better continuity of care than before, and I feel confident not only with my doctor but also with the care team." (Patient)

Key success factors that support sustainability

- Timely access is a policy priority and provider need.
- Buy-in of all clinic members – inclusive and interprofessional solutions are co-designed and adapted to their context.
- Voluntary participation with external support.
- Team of coaches – sharing learnings, tips, tools and advice.
- Close partnership with a research team – credible external expertise and embedded confidentiality agreements.
- Technology – automated indicator software to fuel a common dashboard and PDSA cycles.

Opportunities for spread

- 360-degree portrait on access is ready to share and bilingual.
- This model is currently being deployed in a cohort of over 24 practices in Quebec and four practices in New Brunswick including rural settings and rural practices.
- National community of CQI coaches sharing learnings and supporting spread.
- Openness and willingness to support the coaching team throughout the process from the research team that developed the CQI intervention on AA (Breton and Gaboury)
- Bilingual coaching training offered by the Academy for Continuous Improvement at the

University of Sherbrooke (one year, 120-hours) and coach mentoring.

- Training credits accredited by the Canadian College of Family Physicians for participation in reflective activities.

Facilitators of spread

- Simple governance structure – Researcher-lead (Breton and Gaboury), teams of four coaches and one project manager.
- Tools ready to share and bilingual.
- Support for data collection – embedded in research projects (some funds obtained; ethical application ready to file).
- Partnerships developed to date:
    - Quebec: Ministère de la Santé et des Services sociaux (funding); Direction accès Montréal (in-kind coaching); Fédération des médecins omnipraticiens du Québec (training credits).
    - New Brunswick: Réseau Vitalité (in-kind coaching).
    - Canada: Canadian Primary Care Research Network (CIHR funding); Health Excellence Canada (promotion).

Costs

- CQI Coach – one full-time covering an average of 15 to 20 practices per year (approximately $85,000/year)
- Project Coordinator – data collection and planning (approximately $85,000/year)
- Meetings in-person (activity 1) including lunch, travel (approximately $500 per clinic)
- EMR – integrated automated of a new software extraction (approximately $5,000)
- Medical training credits at Canadian College of Family Physicians (approximately $250

per clinic)

- Coach training – 120 hours, plus fee registration at Université de Sherbrooke

For more information

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