Authors Reply

Open Access Implementation and Diabetes Outcomes

To the Editor:— We appreciated the critical comments and the questions raised by Drs. Bundy and Randolph in response to our recent article exploring the impact of Open Access (OA) scheduling on diabetes care,¹ and appreciate the opportunity to respond to their questions.

How do the authors conceptualize “Open Access”? “We therefore speculate they use the term “Open Access” to describe only a scheduling strategy that emphasizes same-day appointments and does not allow future appointments to be scheduled” This statement is not true. Care delivery re-design was undertaken at each of the clinics, including uses of the mechanisms mentioned in Dr Bundy’s letter. At all of the sites in our study, pre-booked appointments were allowed. In a system where supply outstretches demand because of our presence in medically underserved areas and that isn’t able to increase overall visits (ie. By adding provider FTE or office hours), then same day appointments cannot be guaranteed if the schedule is completely pre-booked. We agree that the goal of OA is to ensure access for ongoing healthcare needs while enhancing provider availability for same day appointments as “need” arises. This can only be achieved by maintaining some open appointments for booking same day visits. In an excessively comorbid patient panel, it may become challenging to do both without increasing FTE or office hours. Clinics in this study did different things. Although there was an initial plan to pre-book no more than 30% of visits, some clinics immediately went to 50% pre-booking. These decisions were based on the desire to achieve a flexible balance between ensuring continuity of care for ongoing health needs such as diabetes while preserving some appointment slots for same day visits. Thus, we agree with the importance of flexibility and the need to serve both same day and ongoing visits in a way that optimizes access for ALL patients.

Did intervention practices successfully implement Open Access, as described in the literature? Indeed OA implementation varied across clinics precisely for these reasons because the ability to address supply and demand for specific providers and for specific clinics varied. We have no real way of assessing implementation success or fidelity. There simply is no perfect or best strategy for OA implementation across all settings exactly because the strategy must suit the practice design, provider team, and patient case mix. While those who can do an effective implementation should be applauded, many systems cannot achieve that ideal. Evaluating the impact of this real, but perhaps not ideal, implementation on subsets of patients is important in understanding the role of the tool in the system. This all underscores the importance of some restraint in accepting open access as a universal solution for enhancing access for all patients in all settings. We are glad that Dr. Bundy agrees that more research is needed to advance our understanding of how novel strategies to modify scheduling, workflow, and delivery system redesign can be best designed to optimize access, quality, and outcomes of care for all patients.

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REFERENCE

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J Gen Intern Med 25(2):172
DOI: 10.1007/s11606-009-1003-z
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