in provider availability, and communication difficulties when residents are on hospital-based rotations which limit their ambulatory clinical time. The same factors contribute to significant challenges in maintaining patient-provider continuity. Outcomes reported within the few published studies on advanced access scheduling in academic settings have shown varying results.[1-4]

Despite widespread agreement regarding the importance of advanced access, there is a broad diversity of understanding of just what the terms "advanced" or "open" access mean. A 2007 survey of Chairs of Departments of family medicine reveals progress toward the goal of improving access, yet reveals some of the challenges. Over one-half of respondents indicated that they had implemented advanced access scheduling, with two-thirds indicating that they measure and report access data internally or to their health system partners. Yet, fewer than one-half regularly measure the impact of access on continuity or no-show rates. While 49% felt that their no-show rate improved modestly or significantly, 16% reported only marginal improvement and more than one-third no improvement or worsening of no-show rates. Only 29% felt that individual continuity rates had improved, while the remainder felt that rates were either unchanged or had declined.

One explanation of these varied findings relate to definitional confusion among practices reporting access outcomes. In this same survey, respondents were asked to describe the model of access that they utilize. Descriptions of access models varied considerably. Nearly one-third described their access model as: "triage physician of the day," "work-ins," "walk-in care," and "filling no-show slots." The remaining two-thirds described a carve-out model of access, with significant variation in the degree of carve-out involved, ranging anywhere from 10% to 80% of appointments. The appointment "thaw" time also varied considerably, from 14 days to 24 hours prior to appointment time.

The goal of a patient-centered model of appointment access is to give each patient an appointment with their preferred clinician when the patient wants and/or needs to be seen. Yet, access management in academic settings is challenged by interrupted continuity clinic schedules and day-to-day variation in provider availability. Despite this, nearly two-thirds of responding academic departments of family medicine have made the effort toward building this portion of the medical home. Current efforts have been subject to common pitfalls, include managing appointment demand with little attention to continuity of individual or team care; attempting to improve access without truly balancing supply and demand; allowing too much appointment backlog to remain, and limiting patients' ability to book future appointments into the future.

The tools for creating access into the medical home (matching appointment supply and demand to eliminate delays; reducing appointment types to maximize appointment supply; reducing appointment demand; working down the backlog to eliminate delays; and planning for contingencies to prevent future delays from reforming) are clearly defined and doable, even in complex academic settings. In order to achieve a model of integrated, comprehensive care from the patient's perspective, academic practices must move beyond defining access as having a triage doctor of the day, or working patients in to an already packed schedule. Rather, we must persist in working toward true models of access management. It is only then that we will be able to provide patient-centered care, educate medical students and residents in redesigned practices of the future, and compare our outcomes based on congruent methods of definition and implementation.

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FAMILY MEDICINE RESIDENT AWARD FOR SCHOLARSHIP

The need for capacity building in family medicine research is well recognized. One strategy for accomplishing this goal is to mentor and recognize residents for their accomplishments in scholarly activities. The Association of Family Medicine Residency Directors (AFMRD), the North American Primary Care Research Group (NAPCRG), and the College of Family Physicians of Canada (CFPC) have developed the

AFMRD/NAPCRG/CFPC Family Medicine Resident Award for Scholarship to both recognize resident scholarly activity and, by doing so, promote increased capacity building in family medicine research and scholarly activity.

One award will be made by each family medicine residency program annually. The AFMRD/NAPCRG/CFPC Boards have suggested that each program create a committee to review resident scholarly activity applications and make the award recommendation to the program director. AFMRD/NAPCRG/CFPC does not select the honorees; departments or programs will inform the organizations who should be honored from their program. AFMRD/NAPCRG/CFPC supply the certificate that will be presented to the resident receiving the award to the program.

As developed by the participating organizations, the following restrictions apply: No resident may win the award more than once, only one award per program will be awarded annually, the scholarly activity for consideration must have been completed while the resident was in residency training, the nature of the scholarly activity and whether it "qualifies" is at the discretion of the program's award committee, jointly-done scholarly activity between 2 or more residents may be eligible for a joint award (each resident will receive a certificate), and scholarly activity must be in large measure performed by the resident—this activity includes most, but not necessarily all, of the following: the inception of the idea, development of the project, gathering data, presenting the results, or writing a report or publication.

The AFMRD/NAPCRG/CFPC Family Medicine Resident Award for Scholarship was first available last year to residency programs. Further information regarding deadlines for submission of nominees will be provided to program directors later this year.

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