HSG | PATIENT ACCESS TO CARE

DEVELOPING AN ORGANIZATIONAL APPROACH TO PATIENT ACCESS

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INTRODUCTION

Patient Capture and Retention has always been a priority for health systems looking to maximize revenue, however, with the proliferation of value-based care strategies that necessitate keeping patients "in-network", many health system leaders are evolving their approach to **Patient Access**.

While Patient Retention has historically been focused on provider referral management, **Patient Access** to Care is playing a larger and larger role on the ability of health systems to capture and keep patients within their network of facilities and providers.

EVOLVING ATTITUDES ABOUT PATIENT ACCESS TO CARE

Traditionally, **Patient Access to Care** has been measured by the complaint barometer ("if there are no complaints, we must be doing well") or the wait list barometer ("there are now 10 patients on the waiting list for the next schedule release"). When complaints arose, practices and providers either adopted workarounds ("call me if you can't get in") or diversions (referral to urgent care or Emergency Department if same day requests for care cannot be accommodated). The approach to complaints about access was often passive ("there is only so much we can do"). In fact, the inability to access a provider was frequently considered to represent an indication of excellence ("he/she is so good that it takes 6 months to get a new appointment").

Times have changed. Today, lack of access often means that patients go elsewhere for care. They are either never captured or not retained. While some providers are fine with that ("I am as busy or more busy than I want to be anyway"), the situation tends to tarnish the providers' reputations in the community (public or medical) and sustainability issues can arise – especially under circumstances of decreasing, or flat, revenue and ever-increasing overhead expenses. This scenario is particularly pertinent to the employed provider network environment.

DEVELOPING AN ORGANIZATIONAL APPROACH TO PATIENT ACCESS

HSG recommends adopting a practical, customer-centric definition of patient access, which is the ability to accommodate requests for patient care consistent with patient and provider expectations and desires.

This definition focuses on the following 'customer' perspectives and applies equally to all specialties and circumstances:

- **Patient Expectations and Desires.** May be associated with an existing or a desired new relationship.
- **Treating Provider Expectations and Desires.** Primarily related to follow up of a recent or past interaction with the patient.
- **Referring Provider Expectations.** Consulting provider expectations back to the referring provider.
- **Transitional Care Management Requests.** Whether generated by a treating institution (inpatient, subacute care, Emergency Department, Urgent Care Center, and others) or treating provider as an extension of the circumstance immediate above.

Each of the above pathways to care should be contemplated and assessed when evaluating a practice's or provider's access to care standards and metrics.

Utilizing a physician leadership structure to develop patient access measures and expectations promotes the greatest opportunity for success as creation of ownership and provider champions become part of the process. Incorporating a patient access section in a shared vision document inculcates the concept into the goals for the organization and establishes cultural expectations around it. Alternatively, the concept and parameters can be incorporated into a corporate compact between Administration and providers.

Regardless of mechanism, the factors that affect patient access to care must be addressed and actively managed.

FACTORS AFFECTING PATIENT ACCESS

The following factors impact access to care:

- **Supply of Direct Care Providers**
- **Utilization of Direct Care Providers**
- **Supply and Capabilities of Support Staff**
- **Utilization of Support Staff**
- **Practice Culture**
- **Physical Space**
- **Provider Compensation Plan**
- **EMR Capabilities**

Although these factors overlap, the impact and assessment of each will be discussed in turn.

SUPPLY OF DIRECT CARE PROVIDERS

The number and mix of physicians and APPs lay the foundation upon which patient access is built. As alluded to above, a single provider specialty consistently producing above the 90th percentile is not likely to be able to increase total access to care much further. Although analyzing and altering types of access and the care delivery model are still possible, the solution in this instance is likely pursuing additional provider assets since enhancing one type of access often occurs at the expense of others (e.g., same day or established patient access at the expense of new patient access).

Provider supply requirements are effectively estimated through a Physician Needs Analysis (PNA), which customarily assesses current provider supply by specialty against regional and national benchmarks while incorporating market-specific dynamics, such as anticipated succession planning issues and market demand analysis including population growth, demographics, and disease prevalence data. Adding productivity data for providers in the employed network allows the determination of potential additional capacity for existing providers – or the lack thereof.

Conducting a PNA is a necessary step to strategically plan recruitment and growth opportunities. However, creating accompanying detailed action plans by specialty, location, and provider mix delineate the specific tactics through which PNA actually achieves success.

A word of caution about the benchmarks used to determine PNA recommendations. First, they may not define need at a granular level. For instance, combinations of internal medicine, family medicine, geriatrics, and pediatrics overlap to fulfill needs; the definition of general surgery can be highly variable and the presence of subspecialists like colorectal surgeons, breast surgeons, and oncological surgeons can significantly alter the landscape. Second, they may not include a critical mass of practices to account for evolving care delivery changes, such as the increasing emphasis on population health or movement toward a capitated care environment. Internal analysis of market forces is necessary to refine the PNA estimates to address local themes.

UTILIZATION OF DIRECT CARE PROVIDERS

While having an idea of how many providers would be needed to provide adequate access to care is important, how the providers are utilized and supported are even more important.

A crucial aspect of provider utilization is the scheduling process, which fundamentally starts with active template management. Template management is the process of building and revising the framework of appointments that make up each day's schedule. Template creation involves determining the number, types, and duration of appointments that the schedule will have. Many networks have difficulty achieving consensus on these essential building blocks within and between practices, including how long appointments will be by type and how many of a certain type of appointment should occur on any given day (such as those for new patients). A lack of consensus can create workload inequities for providers and scheduling complexities for staff. While attaining complete uniformity may be difficult, intimately involving physician leadership in developing conciliation within minor, justifiable individual variations (such as longer appointment lengths for newly trained providers) is advisable.

Once templates are created, many organizations implement them without change or further consideration – unless requested by individual providers. To the contrary, the mix of appointment types within the schedules should be continually re-assessed to anticipate and account for changing circumstances, such as seasonal demand and provider absences. Securing adequate same day access is often the primary consideration driving modifications of appointment type mix – often balancing increasing or decreasing same day access needs by inversely altering preventive care visits to balance the demand for services. In addition, it is important to not lose track of adjusting the longer appointment times for the newly trained providers as they clinically mature. Each of these items affect appointment availability and access.

Effective template management requires complementary scheduling parameters to assure execution and reliable appointment availability. Common considerations include establishing who is authorized to alter existing schedules; protecting same day appointments until the 12-24 hours prior to the appointment; and delineating the process undertaken when the desired patient access cannot be accommodated within the published schedule. Establishing clearly defined guidance is crucial for efficiency and for staff sanity, but allowing a degree of flexibility is also important as inflexibly adhering to an established appointment schedule while trying to accommodate desired access to care can be diametrically opposed forces. Striking a balance is key to avoiding frustration and dysfunction.

One approach to balancing appointment scheduling with meeting requests for care is to relegate routine patient appointing to a centralized scheduling process (including patient self-scheduling through a portal) augmented by specific interventions through the clinical support staff when requests for care cannot be accommodated within the published schedule. The clinical support staff can employ their unique critical thinking abilities to determine what type of care is required, the best mechanism to provide that care, and the best timeframe in which to do it. This allows the centralized schedulers to handle the bulk of the requests for care while relegating "outliers" to the clinical support staff – and maximally utilizing requisite skills accordingly.

Another factor affecting appointment availability is the No Show rate. Individuals who do not arrive as expected for their scheduled appointment effectively use two appointments for one complaint – the appointment that they failed to keep and the one to which they may become rescheduled. Even if the patient does not reschedule, their appointment is lost for others to use. Various reminder tactics utilizing various mediums (e.g., phone, text, email) are usually employed to minimize the number of no-show instances. An additional mechanism to consider is to double book certain appointments (such as same day acute care) to minimize the impact of invariable no shows on overall access to care and practice efficiency. Since this strategy risks "overbooking" on days with few no-show patients, providers and staff must thoroughly embrace this philosophy.

The risk of a patient being a no show increases as the interval between the request for an appointment and the scheduled appointment increases. One approach to balancing appointment scheduling with meeting requests for care and minimizing the no-show rate is to adopt "open access" scheduling. Open access scheduling[1] represents a significant philosophical paradigm shift in which patients receive care when they call to access it rather than having an appointment scheduled for some time in the future. This mindset applies whether the request is for acute care, for routine/chronic care, or for preventive/wellness care. Exceptions include the inability of the patient to accept care that day and timed follow up care, such as follow up care in three months. These circumstances form 'acceptable backlog' and comprise about 25% of a given day's schedule. Appointment durations in this model tend to be uniform and available for any 'complaint' rather than being care type specific.

Adopting this approach to scheduling should not be undertaken lightly and requires significant proper planning to ensure that provider supply is adequate to accommodate historic demand (with the required schedule adjustments); that all staff members are knowledgeable about how the model functions; that the 'unacceptable backlog' of appointments is worked off prior to the target start date; and that contingency plans are in place for inevitable times of excessive demand (such as flu epidemics or provider absences).

Contrary to popular perception, demand for care is not insatiable and actually tends to decrease under the open access scheduling paradigm. The practice tends to become more efficient with the same staffing levels as continuity of care with primary providers increases, the patient no show rate decreases, and support staff can focus on the care at hand rather than the backlog of patients and mounting requests for care.[1] For many practices, the benefits far outweigh the challenges.

SUPPLY AND CAPABILITIES OF SUPPORT STAFF

The number, types, and skill sets of support staff are critical factors determining the practice's ability to maximize patient access. Support staff are generally divided into two categories based on roles and skill requirements. Administrative support staff include those individuals involved in office management, "front desk" functions (reception, registration, patient check in/check out, order management, scheduling), and revenue cycle management and billing functions. Clinical support staff include those individuals involved in direct patient care functions, such as RNs, LPNs, CMAs, CNAs.

External benchmark data is available to guide initial determinations of support staff numbers by general type (administrative v. clinical) and can be calculated on the basis of number per physician, number per provider, and/or number per 10,000 wRVUs produced. The number of care managers required can be calculated based on beneficiary ratios adjusted for complexity. Which of the benchmarks to utilize often depends on the circumstances of the practice. Low volume practices (such as those just ramping up) are often staffed on a per provider basis to assure minimum requirements for staffing are met. High volume practices are often best staffed on a per 10,000 wRVU basis, which accounts for higher workload.

Several caveats apply when utilizing the benchmarks to guide staffing ratios:

- The benchmarks account for the recommended number of support staff by general type but do not drill down well into specific type, such as ratio of RNs to CMAs or front desk to revenue cycle staff.
- The benchmarks account for staff quantity based on assumed competency and function. This assumption must be considered during translation to specific circumstances, especially when incorporating relatively inexperienced staff members into a busy practice. The ramp up may require direct teaching and coaching from more experienced staff members which dampens the effectiveness of the number of staff present.
- The benchmarks are currently based on support for traditional office care delivery models and have not yet accounted very well for team-based care delivery models,

UTILIZATION OF SUPPORT STAFF

Effectively utilizing staff is as important as the mix and number. Designing a **Care Delivery Model** that utilizes staff at the top of their license and capabilities permits maximum efficiency, effectiveness, and access. The model must be enthusiastically embraced by the providers, who must also be willing to relinquish some traditional roles to allow the clinical staff to fully support the providers at the top of their license as well. Doing so has proven to achieve maximum patient access while enhancing professional fulfillment and lessening the risk of provider burnout.

These team-based care delivery models include:

- Pre-visit reviews to ensure pertinent clinical information is available for the scheduled visit's stated purpose, including interim test and referral results, and to address preventive and wellness status;
- Expanded rooming processes that utilize standing orders to streamline care and administer/schedule preventive and wellness services;
- Huddles before the schedule begins and before each face-to-face encounter to enhance communication and avoid surprises (especially the "oh by the way" on the way out of the room situations); and
- Incorporation of the CMA within the face-to-face encounter to serve as a patient advocate, contribute to the encounter documentation, and serve as a provider advocate at the conclusion of the visit, ensuring patient understanding and assisting with further are functions.

Another enhanced support activity option employs RNs to conduct Medicare Annual Wellness Visits (AWVs) and freeing physicians and APPs to provide higher levels of care. Patient access increases while comprehensive patient care and practice revenue is maintained or improved. The same RNs can be utilized to provide transitional care management services that streamline follow up care to the point that providers are more willing to work in these patients in a timely fashion.

These care delivery models require higher clinical support staff ratios and more costly clinical support staff than traditional office-based care delivery models in exchange for the beneficial impact on practice operations and patient access, satisfaction, and retention. The financial business case for these interventions are favorable even though they do not account for the less tangible benefits.

Other care delivery model elements that enhance patient access, staff utilization, and convenience may actually decrease the absolute number of staff members required. These considerations include leveraging technology to directly link home monitoring devices to EMRs; maximize patient portal use for scheduling appointments, completing questionnaires and screening tools, and permitting secure messaging in lieu of or to augment appointments; and adopt virtual visits.

PRACTICE CULTURE

Many elements of practice culture directly impact patient access. Beyond accepting and embracing the care delivery model changes noted above, adopting a true patient-centric philosophy over the traditional provider-centric approach to business operations and clinical care is required. From defining hours of operation to individual practice patterns, office practice decisions often consider patient benefit within constricted provider/staff defined parameters. A patient-centric philosophy flips this lens considerably.

Other elements of practice culture to examine include incorporation of APPs (or additional APPs) into physician-heavy mixes. Some models recommend and predict a future physician to APP ratio of 1:2 to 1:4 to maximize access to care. These same models advocate maximizing continuity of care while allowing for "patient sharing" across providers – a shift from "mine" to "ours" philosophy. Many of the models also include creation of group visits, often facilitated by RNs, dieticians, clinical pharmacists, and other clinical professionals in addition to APPs.

Shifting practice culture is a difficult undertaking involving significant adaptive change that must permeate the entire practice to minimize disruption and maximize effect.

PHYSICAL SPACE

The greatest intentions must be supported by practical reality. The office space must be adequate to accommodate the proposed changes in operations. One notable aspect is having a sufficient number of exam rooms per provider per patient day or half-day to allow expanded rooming and CMA involvement in care. Team-based care delivery often requires three exam rooms (and three CMAs) per provider to be functional. RNs conducting AWVs or care management functions need dedicated office space. If group visits are anticipated, a private space large enough to handle multiple patients (and caregivers) is required.

Benchmarks delineating square footage per provider do not account for these and other 'futuristic' aspects of care.

PROVIDER COMPENSATION PLAN

Compensation plans tend to achieve what they incentivize. Thus, various provider compensation plans can have a direct impact on patient access depending on what is incentivized:

- **Straight salary** lacks any external incentive other than completing contractual requirements. In addition to not providing a palpable incentive to increase patient access, these plans may disincentivize initiatives that require more provider effort or sacrifice. This compensation model is commonly applied to APPs.
- **Revenue minus expense** promotes maximizing access as it will likely directly increase revenue and income. However, the model promotes lean staffing to minimize expense. This factor may make care delivery model transitions more difficult.
- **Straight payment/wRVU produced** promotes maximizing access as increased patient access will increase wRVU production and income. Providers are less concerned with expenses in this model, which can be a double-edged sword.
- **Base plus incentives** comes with the caveat that the ultimate impact of this arrangement depends on the model's construct. These plans are usually productivity based and tend to incentivize alignment with initiatives that increase patient access. However, sole focus on individual incentives risks reinforcing a "mine" mentality as opposed to "our." Incorporating group incentives can promote more of an "our" philosophy.

EMR CAPABILITIES

The practice's EMR can be a boon or a bust when it comes to patient access.

EMR capabilities can be beneficial for promoting efficient pre-visit review processes; tracking preventive, wellness, and chronic disease management items; permitting easier implementation and execution of standing orders; permitting templated encounter documentation; encouraging patient portal maximization; and advancing monitoring device interfaces. Each of these can enhance patient access.

Conversely, EMR inefficiencies, whether through platform design, a lack of direct IT support, or poor staff proficiency, can adversely impact access. These issues impede the desire to add the extra workload associated with caring for additional patients.

Engaging competent scribes, whether onsite or virtual, and permitting team-based documentation of encounters have been shown to improve provider willingness to increase patient access and its associated workload – and overcome EMR-related impediments.

QUANTIFYING PATIENT ACCESS

Patient Access must become an actively managed situation that should be measured and monitored against established internal expectations and external benchmarks – with concrete interventions to address variances. The quantification process must address the various pathways through which patient access occurs.

The *best measure* of **Patient Access** for most practices is the **time to the third next available appointment**– by appointment type, by practice, and by provider. Measuring the third next available appointment as opposed to the next available appointment eliminates most special cause variation associated with the determination and relies on common cause occurrences. For instance, a late appointment cancellation can create an available appointment that otherwise would not exist in that time frame. The third next available appointment looks out far enough to be a more reliable indicator of appointment availability over time.

Measuring each appointment type allows for assessment by pathway – new patients, routine follow up, same day access, wellness and preventive services, etc. Assessing each appointment type assesses each patient entryway.

Measuring by provider accounts for individual popularity, longevity, and/or practice style – each of which can be critically evaluated for potential intervention – while measuring for the practice as a whole permits evaluation of the total care delivery model. For example, if one provider does not have a new patient appointment available for 3 months, but the practice has availability the next day, etiologies can be investigated and adjustments can be considered to create better balance.

Another primary care measure is panel size. This metric is particularly pertinent for organizations involved in a heavily capitated environment. Successful capitation performance mandates continuity of comprehensive care for assigned/empaneled patients. In a capitated system, the "at risk" population is well-defined and the provider and patient expectations are better delineated than in the fee-for-service environment. Fee-for-service permits maximum freedom of choice for patients and makes patient panel definition difficult and inaccurate. Health plan requirements and national benchmarks exist for both panel size and expected patient access standards against which provider performance can be measured. This model still requires active management of patient engagement and access to care parameters.

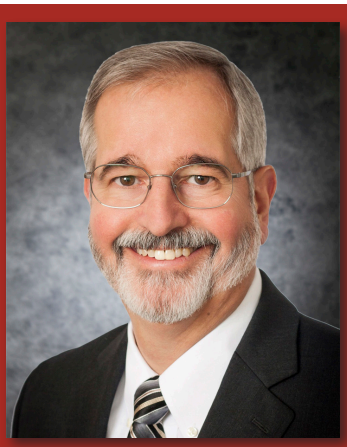
Other measures utilized to assess patient access tend to measure it by proxy by gauging how busy an individual provider (and collectively the practice) is. One metric is the **number of visits against external benchmarks**. This metric can be somewhat flawed as not all appointments are created equal in most practices – including those contributing to the benchmark. This could work well for Open Access scheduling or for situations in which all appointments are equivalent durations (e.g., all appointments are 20 minutes long). Regardless, this proxy measure can provide a sense of comparison with like specialties. A second proxy metric is **productivity measurement**, such as wRVUs generated, compared to external benchmarks. If all providers in a practice achieve above the 90th percentile, supply (and burnout) is a concern and recruitment of additional providers an option to consider – as long as the providers are not churning unnecessary appointments and their coding accuracy is validated.

PHILOSOPHY OF CHANGE

Although a system's natural tendency would be to emphasize points like increasing patient access maximizes patient capture, minimizes "leakage," and increases patient care revenue for the practice and the health system, sage advice would be to resist that tendency – or face resistance from providers and staff.

Instead, emphasizing the benefits to current – and future – patients who otherwise face difficulties getting appointments; the benefits of minimizing the complexity of the scheduling process, avoiding the need to develop workarounds to meet demand, and averting the negative impact of these issues on the staff … and providers; and the benefits to the practice's community reputation, may make proposed changes more palatable for all involved.

After all, when you take care of the patients, everything else (including finances) tends to take care of itself.



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Before joining HSG's consulting team in November, 2013, Dr. Terrence R. McWilliams, a Family Physician, spent a decade as the Vice President of Medical Affairs and Chief Medical Officer at Newport Hospital, an acute care community hospital in Rhode Island. During his tenure as CMO, he supervised the Medical Staff Services Office; was responsible for quality of care/patient safety/ risk management, clinical information systems, medical staff services, physician recruitment and clinical service line development. He was intimately involved in numerous system-wide initiatives, including creating system-wide Medical Staff Bylaws, spearheading various clinical IT projects, and contributing to broad-based performance improvement efforts.

A University of Pittsburgh School of Medicine graduate, he retired from the US Navy after a career spanning more than 20 years working as a family physician and clinical administrator in a variety of practice environments, including leading multi-specialty clinical operations and physician-hospital alignment. Dr. McWilliams completed a Master of Science in Jurisprudence (MSJ) focused on Hospital and Health Law from Seton Hall University School of Law in August 2015.

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