Patient Attraction and Retention: Access

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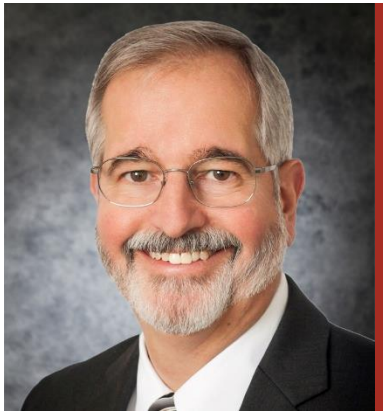

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HSG

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7 Years at HSG
37 Years in the Industry

Strengths

- Shared vision and strategic planning
- Physician alignment and engagement
- Physician leadership structure
- Development of clinical operations, assessments, and transformation

Client Accomplishments

- Worked with client executives and physicians to create shared visions that led to significant advances in network function and outcomes

PROFESSIONAL EXPERIENCE

After retiring from Naval service, Dr. McWilliams spent a decade as the Vice President of Medical Affairs and Chief Medical Officer at Newport Hospital, a non-teaching community hospital within a larger academic health system. As CMO, he supervised the Medical Staff Services Office and was additionally responsible for quality of care/patient safety/risk management, clinical information systems, physician recruitment and clinical service line development. At the system level, he was intimately involved in creating system-wide Medical Staff Bylaws, spearheading various clinical IT projects, and contributing to broad-based performance improvement efforts.

EDUCATION

Terry received his MD from the University of Pittsburgh School of Medicine and completed family medicine residency in the Navy. He completed a Master of Science in Jurisprudence (MSJ) in Hospital and Health Law from Seton Hall University School of Law.

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Patient Access to Care – Evolving Attitudes

- Lynchpin of health system ability to attract and retain patients within their network of facilities and providers
- Can no longer take passive role with patient access
- Without acceptable access,
  - Patients elect to seek care elsewhere
  - Referral Management efforts nullified
  - Reputation tarnished

Patient Access to Care – Definition

Customer Centric Definition

The ability to accommodate requests for patient care consistent with patient and provider expectations or desires.

Patient Access to Care – Expectations and Desires

Access Expectations and Desires

- Patients
  - May be associated with an existing or a desired new relationship
- Treating Providers
  - Primarily related to follow up of a recent or past interaction with the patient
  - Can also be related to new patient referrals once referral reviewed
- Referring Providers
  - Both directions
    - Referring provider to consulting
    - Consulting provider back to the referring provider
- Transitional Care Management
  - From a treating institution (inpatient, subacute care, Emergency Department, Urgent Care Center, and others)
  - From a treating provider

Measurement

Patient Access – Measurement

Access should be measured and monitored

- How do we know if we have "acceptable" access
- Recommended metrics
  - CG-CAHPS Survey results
    - In the last 6 months, when you contacted this provider's office to get an appointment for **care you needed right away**, how often did you get an appointment *as soon as you needed*?
      - Never, Sometimes, Usually, Always
    - In the last 6 months, when you made an appointment for a **check-up or routine care** with this provider, how often did you get an appointment *as soon as you needed*?
      - Never, Sometimes, Usually, Always
    - Most patient centric
    - Only applicable to "established" patients

Patient Access – Measurement

Access should be measured and monitored

- Recommended metrics (continued)
  - Time to third next available appointment by appointment type, by provider, and by practice
    - Time to next available impacted by late cancellation and other special cause variations
    - Recommended metric as objective, readily available, and benchmarkable (MGMA)
    - Some EMRs can directly report but most require periodic manual determinations
  - Number of visits versus external benchmark
    - Difficult to compare when appointment durations vary within and among providers
    - Most applicable to Open Access scheduling or for schedules in which all appointments are of equivalent duration (e.g., only 20 minute appointments on template)

Patient Access – Measurement

Access should be measured and monitored

- Recommended metrics (continued)
  - Panel size
    - Particularly useful for **primary care** in full risk (capitation) scenario as accept risk for empaneled patient population
      - Mutually contracted relationship and "captive" population
    - Difficult to determine in fee-for-service market as no guarantee of patient return or ongoing mutual relationship
      - Mechanisms include
        - Established, active patients (at least one encounter in past 3 years)
          - Overly inclusive
        - Established, active patients with at least one (or 2) encounters per year
          - Likely have a mutual relationship
    - Impacted by patient complexity, practice support (number of staff, skill set of staff, exam rooms, flow, etc.), care delivery model (individual v. team-based care with delegated responsibilities)
    - Risk stratification recommended to allow patient weighting and equivalency determination across providers
    - **Does not directly measure actual access to care**

Patient Access – Measurement

Access should be measured and monitored

- Recommended metrics (continued)
  - Panel Size (continued)
    - Determination
      - A "standard" does not exist
      - "Average" sizes vary in range of 1400-2000
      - Simplest calculation = # available appointments per year / patient utilization rate (visits/year)
        - Impacted by template management, provider practice patterns
      - References
        - https://www.physicianleaders.org/news/how-many-patients-can-primary-care-physician-treat
        - AHRQ Practice Facilitation Handbook, Module 20. Facilitating Panel Management. https://www.ahrq.gov/ncepcr/tools/pf-handbook/mod20.html
        - Kivlahan, C., Sinsky, C., Identifying the Optimal Panel Sizes for Primary Care Physicians. AMA, 2018. https://edhub.ama-assn.org/steps-forward/module/2702760
        - Weber, R, Murray, M, The Right-Sized Patient Panel: A Practical Way to Make Adjustments for Acuity and Complexity. Family Practice Management, November-December 2019.
        - Kamnetz, S., et al, A Simple Framework for Weighting Panels Across Primary Care Disciplines: Findings from a Large US Multidisciplinary Group Practice. Q Manage Health Care, Vol. 27, No. 4, 2018.

Patient Access – Measurement

Access should be measured and monitored

- Recommended metrics (continued)
  - Productivity (wRVU) per provider
    - Relatively **ineffective measure of actual access** – even as a proxy
    - Accuracy directly impacted by encounter coding accuracy
    - **Better used to determine provider capacity to expand volume or enhance access**

Factors

Patient Access – Factors

The following factors directly affect patient access:

- 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
- EHR Capabilities

Patient Access – Factors

Supply of Direct Care Providers

- Number and mix of Physicians and APPs foundational element defining access
- Cannot access providers that do not exist
- Cannot increase access for providers who are "max'd out"
  - Providers producing at or above the 90th percentile unlikely able to sustain increase

Tools

- Medical Staff Development Plan
  - Determines recommended supply by specialty for population served
- Strategy to achieve Medical Staff Development Plan recommendations
  - Provides internal interpretation of suggested "needs"
  - Defines the priorities of recruitment – including strategic locations – and the reasons for pursuing them

Patient Access – Factors

Utilization of Direct Care Providers

- While supply is foundational, effective utilization and support is critical

Utilization Tools

- Template management
  - Types, duration, and numbers of appointments per day
  - Should vary based on specialty and circumstances, such as
    - Provider experience level
    - Seasonal demand by appointment type
    - Provider absences/coverage
    - Patient complexity (risk stratified)
  - Should not vary arbitrarily within specialty
    - Benchmarkable by appointment type and specialty
      - Primary care benchmark for New = 30 minutes.
        - No longer the traditional 60 minutes.
        - Ability to complete patient history questionnaires online or through support staff
      - Similarly with Preventive Care visits

Patient Access – Factors

Utilization of Direct Care Providers (continued)

Utilization Tools (continued)

- Scheduling process
  - Rules for patient engagement and appointment utilization – and who can adjust
  - Consider centralized scheduling for routine requests and clinical input when requests cannot be met by published schedule
- No Show management
  - Patients failing to keep scheduled appointments affect appointment availability and operational efficiency
  - Risk increases as interval between scheduling and day of appointment lengthens
  - Appointment reminder processes
- Open Access Scheduling

Support Tools

- Provider support mechanisms comprise the remainder of the "Factors" section

Patient Access – Factors

Supply and Capabilities of Support Staff

- The number, types, skill sets, and turnover of support staff are critical factors determining the practice's ability to maximize patient access

- Administrative
  - Office management
  - Front Desk
    - Reception/registration/check in
    - Check out/order management
    - Referral Management
    - Scheduling
- Clinical
  - RNs
  - LPNs
  - MAs
  - Care Managers

Patient Access – Factors

- **Supply and Capabilities of Support Staff** (continued)

Tools

- Staff per physician – both Administrative and Clinical
- Staff per provider – both Administrative and Clinical
- Staff per 10,000 wRVUs – both Administrative and Clinical
- Care managers per 'X' beneficiaries
  (varies based on role, patient complexity)

Caveats

- These metrics address quantity but not mix and quality – significant attributes for efficiency and effectiveness, which impact access – and cost
  - Must be adequately trained to effectively execute roles and responsibilities
- Requisite supply directly by staff utilization, care delivery model

Patient Access – Factors

Utilization of Support Staff

- Care Delivery Model
  - Top of license utilization
  - Team-based care
    - Pre-visit reviews
    - Expanded rooming process
    - Huddles
    - Standing orders
    - Team documentation
  - RNs performing Medicare Annual Wellness Visits (AWVs)
    - Maintains comprehensive care and patient revenue
    - Frees direct care providers for other types of patient care
  - Multiple points of access
    - Virtual visits
    - Patient portal maximization, asynchronous communications
    - Scheduling process

Patient Access – Factors

Practice Culture

- Physicians/APPs
  - Incorporation and maximum utilization of APPs
  - Practice patterns
    - Significant potential for individual variation in preferences and capabilities
  - Patient sharing
    - Moving from "mine" to "ours"
  - Customer service focus
  - Patient centric focus
    - Hours of operation
    - Multiple points of access (patient portal, virtual care options, etc.)
- Staff
  - Customer service focus

<u>Tools</u>

- CG-CAHPS responses

Patient Access – Factors

Physical Space

- Must be adequate to support care delivery model
- Notable components
  - Exam rooms per provider
    - Per patient day or half-day
    - Team-based care consistently requires 3 exam rooms per provider
      - … and 3 MAs per provider
    - Consider impact of RN doing AWVs and other RN driven care
    - Presence of care managers
  - "Conference room"
    - Group visits
    - Patient education

<u>Tools</u>

- Exam rooms per provider
- Square footage per provider versus benchmarks (though may not be current for new care delivery models)

Patient Access – Factors

Provider Compensation Plan

- Base model impact on access
  - Revenue minus expense
    - Promotes maximizing access but not patient sharing
    - Promotes lean staffing, which may thwart team-based care models
  - Straight productivity
    - Promotes maximizing access but not patient sharing
  - Straight salary
    - Does not promote maximizing access
  - Base plus incentives
    - Impact depends on construct
      - Individual productivity incentive
        - Promotes access but not sharing
      - Group productivity incentive
        - May promote access and sharing

Patient Access – Factors

Electronic Medical Record (EMR)

- Both Clinical and Practice Management components
- Platform capabilities and limitations
  - Patient portal capabilities
- Inefficiencies
- Staff training and proficiency
  - Requires adequate IT support
- Internet/web connectivity, speed

<u>Tools</u>

- Clinical Informatics Committee of Provider Leadership Council (PLC)
  - Multidisciplinary group that can address optimization, standardize procedures, and share best practices
- Users group
  - Serves Clinical Informatics Committee role if PLC structure does not exist
- Consider use of scribes – in person or virtual
  - Additional 1-2 New or 2-3 Established patients per day covers

Approach

Patient Access – Approach with Staff

Approach to increasing access during conversations with providers and staff

- Maximize access for the benefit of ***patients***
  - Current
  - Future
- Minimize complexity of scheduling process and need to develop workarounds
- Equitable expectations of providers across MPN
- Consider potential impact on provider compensation as an incentive
- Take care of patients and revenue will follow
  - Increasing revenue should not be focus of increasing access
    - Though the need for transparency regarding the importance of the financial impact should not be ignored


HSG | Thank You

Company **Overview**

HSG builds high-performing physician networks so health systems can address complex changes with confidence.

Headquarters: Louisville, KY

Formed: 1999

Focus: Health Systems and Physician Network Strategy and Execution

Physician Strategy

Driving a common strategic focus with engaged physicians.

Physician Leadership

Identifying and engaging strong physician leaders is integral to the network's development and success.

Performance Improvement

Improving the performance of employed physician networks.

Network Integrity

Leveraging Physician Network Integrity Analytics™ to create and monitor strategies for patient acquisition and retention.

Physician Compensation

Aligning physician compensation with health system and employed network goals.

HSG **Services**

HSG builds high-performing physician networks so health systems can address complex changes with confidence.

Physician Strategy

Healthcare System Strategic Plans

Employed Physician Network Strategy

Growth Strategy

Shared Vision and Culture Development

Physician Manpower Plans

Service Line Strategy

Co-Management

Physician Leadership

Shared Vision and Culture

Physician Burnout

Physician Governance and Leadership

Performance Improvement

Network Performance Improvement

Performance Improvement Implementation

Network Revenue Cycle

Practice Care Model Transformation

Practice Acquisition

Advanced Practice (APP) Utilization

Virtual Health

Network Integrity

Patient Share of Care

Patient Flow

Provider Location and Service Analysis

Market Insights

Physician Compensation

Compensation Plan Design

Fair Market Value and Commercial Reasonableness Opinions

Advanced Practice Provider (APP) Compensation