Improving Patient Access:

Pushing the Boulder Uphill

White Paper

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Abstract: In all healthcare entities—whether private practice, employed physician networks (EPNs), or academic medical centers—patient needs outpace provider supply at almost every turn. Based on that premise, the question becomes: *With limited resources, how do you meet patient demand for access?*

Most people think that patient access problems can be remedied through examination of a few areas of practice. However, an effective solution only can come from a multilevel and comprehensive review of every area to discover how all the "systems" mesh or where they fracture. Without a full-scale assessment of the practice operations, the discovery process is impeded, and the possibility for remedies are thwarted. From a recount of a recent assignment by an academic medical center, calling for the use of a limited platform for assessment, this paper will communicate the optimal results that can come from extensive review as well as the consequences of restricting the charge to the evaluator. In these parameters, we were tasked with pushing the boulder uphill.

Key Words: Patient access, patient demand, academic medical center, funds flow model, financial performance, clinic hours, scheduling architecture.

INTRODUCTION

The population of the United States is aging with more people seeking healthcare. Meanwhile, the number of physicians, while modestly growing, is finding it increasingly difficult to keep up with the patient demand. Though patient access is mainly an economic supply and demand consideration, patients are also more informed via the Web or other sources, for the good or the bad, and are more demanding when it comes to the delivery of care. Too, there are an increasing number of Americans with health insurance through the expansion of government programs and other avenues. Thus, the geometric growth in demand is exceeding the nominal growth of physicians.

In all healthcare entities—whether private practice, employed physician networks (EPNs), or academic medical centers—patient needs outpace provider supply at almost every turn. Based on that premise, the question becomes: *With limited resources, how do you meet patient demand for access?*

Most people think that patient access problems can be remedied through examination of a few areas of the practice. However, an effective solution can only come from a multilevel and comprehensive review of every area of practice operations to discover how all the "systems" mesh or where they fracture. Without a full-scale assessment of practice operations, the discovery process is impeded, and the possibility for remedies is thwarted. Recounting a request by an academic medical center calling for the use of a limited platform for assessment, this paper will communicate the optimal results that can come from extensive review as well as the

consequences of restricting the charge to the evaluator. In these parameters, Coker was tasked with pushing the boulder uphill.

Patient Access

What is patient access?

"Patient access" is not one dimensional. It is not a simple exercise of opening the doors and "….letting patients in." Instead, it's a complex amalgamation of varying systems and processes that mesh (or don't) to yield the optimal number of patient encounters during a clinic day. Due to the nature of clinic operations, a thorough review of patient access entails a full-scale operational assessment of a practice to obtain insight into the multivariate components that conspire to enhance or detract from patient access.

What is a "patient access review"? A patient access review is more than a mere function of trying to get patients in the door. For instance, the starting point is the number of resources (e.g., providers) and the current patient demand for both established and new patient visits. Other key components of a patient access review include the physical plant and the capacity for the facility to *handle* an increase of new patients, patient flow through the office, staffing at both check-in and checkout, staffing of clinical teams, equipment, the electronic medical record (EMR), provider productivity and compensation models, etc.

However, when a client recently asked us to perform a patient access review, our charge was simply to consider *impediments* to access by new patients without performing a complete operational assessment for each practice. We will use this assignment and the client's limited, and fairly strict, parameters to explain the complexity of resolving the complicated problems that have an impact on patient access.

The Client

A large academic medical center (1800 +/- physicians) engaged Coker to assess fissures between patient demand and provider (physicians and advanced practice professionals) supply. This exceptional health system had subspecialties with subspecialties with subspecialties--you get the picture. They performed cutting-edge, elite work and provided their community and the greater healthcare arena with outstanding research and results.

Unlike many academic medical centers that we have worked with, this medical center's funds flow weighted the value of teaching and research significantly higher than clinical duties. Physicians were attracted to this prestigious and sought-after setting with their professional objectives of research and teaching, with minimal clinical time and commitment included in their offer letters. To be fair, physicians were not hired exclusively for clinical duties; no one

could fault them for their lack of clinical productivity. Although their productivity was measured, it was not "valued" as enthusiastically as their research.

In 2014, after an 18-month engagement and analysis of the then-current funds flow model, the academic funds flow of the medical center was adjusted with different nuances to amend how available monies moved to the Center. These tweaks nudged the medical center into a situation where the clinics would now need to contribute more of their own "funding" via patient visits/billing/collections, etc., rather than through traditional, historical funding models. Given that the system is still in a largely fee-for-service environment, the revenue gaps of the funds flow shift spawned the need for an improvement in patient access to clinics to increase revenue flow to the clinics.

Our Charge

While never unidimensional, the project was made more challenging due to the research and academic commitments of the providers relative to their clinical, patient-facing commitments.

Coker's year-long access review involved hundreds of specialist physicians with multiple locations dispersed throughout a major metropolitan city. The medical center we worked with is prestigious, the area desirable, and the opportunity for physicians to perform, in many cases, substantial grant-loaded research in sub/sub-specialties is unparalleled.

The system set out an overarching access goal for all providers and one that was being pushed by a rival facility nearby. By FY 2017, the medical center's goal was for 95% of their practices to see 85% of new patients *who wanted an appointment* within 14 days of their request. (This was the final delineated goal in an incremental, three-year process, from 2015 to 2017.)

Essentially, the underlying aim of the system was to increase new patient volumes via increasing efficiencies throughout the clinics and by better referral coordination. However, at no point could Coker merely recommend that providers "see more patients" by increasing slots.

The client's defined rate-limiting constraints on the project noted that we could not suggest the following:

- Same providers working harder and longer;
- Double-booking to create "sense" of access; and/or
- Inappropriately pushing out (delaying) patient follow-up visits (making room for new patients).

DISCOVERY

The issue that this vast academic medical center asked Coker to assist in remedying is a matter that plagues many academic medical centers across the country and, in fact, many private practices: to wit, an increase in new patient access to clinical care. The struggle, of course, is the ever-present balance between teaching and research bounced against the demands of clinical care. As noted, this amazingly complex system has sub-specialty after sub-specialty in sub-specs so nuanced that few physicians in the world practice the sub-specialty, and, in fact, patients travel from around the globe to visit these highly-regarded practitioners. As noted, the institution's draw for providers is less about clinical care on a daily basis than it is about their outstanding research and results.

At the outset of the project, the immediate focus for Coker, as determined/defined by the medical center leadership, was a focus on "destination" specialties that provided high exposure (e.g., marketing and larger margins) for the Center. We formed two teams, each consisting of Coker staff and medical center staff, with the goal of visiting four (4) clinics per month with the interim period used for aggregating data and coalescing the results of prior visits into actionable items. The combined team would report, and the internal client team would then implement suggested and accepted changes. The medical center determined the clinic site visits (and specialties) and priorities for the groups.

As might be anticipated, there was a fair amount of macro and specialty-specific political wrangling inherent in every step. All Chairs were engaged, but the Chiefs had specialty-specific issues, and in juggling the myriad challenges, there were competing priorities. In some instances, the new revenue model offered compensation for work relative value units (wRVU), but even equitable sharing of those revenues proved challenging.

More acutely, the goals established by the system were to:

- Enhance slot utilization of existing appointment slots
- Reduce patient no-shows and last minute cancellations
- Mitigate patient reschedule rates
- Optimize exam room utilization
- Reduce the referral work queue status and processing capacity
- Enhance the referral evaluation process
- Increase provider availability
- Optimize support staff levels that are tied into workload
- Improve appointment scheduling access: phone, practice management (PM) system, internal referral processing
- Adjust the authorization process

Many academic medical centers function similarly to private medical practices or those of employed physician networks (EPNs). That is, the providers teach and perform research, but they must also carry a somewhat "normal" patient load. The objective is to ensure that the clinic "side" of the ledger produces revenues sufficient to fund research activities fully or, at the very least, supply enough revenue to offset any gaps in funding. While many academic centers might ask a physician to carry 20 to 30 patients on a clinic day, our client seldom set standards for clinic time/patient facing obligations. Thus, Chiefs/Chairs and many physicians carried limited schedules with numerous physicians handling as little as one session (one session = one ½-day) per week. The result was that as few as one to two new patients would be seen per provider per session. In fact, many providers saw one new patient a session filling the remainder of their clinic session with rechecks (normally no more than 4 or 5). Many specialists had no more than one clinic session each week. With this schedule architecture, there was little room to get new patients in the door.

From time immemorial, when the system was "low" on providers (e.g., "capacity"), our client supplemented its complement of physicians with more physicians. That is, when Dr. X was hired, he was provided an offer letter that suggested, say, one session (e.g., a ½-day) of clinic time and 4-½ days of teaching and research. As patient demand grew for Dr. X, and his ½-day of clinic could not accommodate that need, another physician would be recruited (Dr. Y), ostensibly, to fill the void. Invariably, what transpired, was Dr. Y quickly filled his ½-day of clinic time, thereby necessitating the addition of yet another physician. And so this self-defeating process continued unabated until the medical center's funds flow model changed, placing more financial performance burden on the medical practices. The practices were now required to supplement their grant money by rendering clinical care. So adding providers as historically done was no longer sustainable financially for the clinics or the medical center. The glaring reality was that that was a short-term, myopic decision to increasing capacity because any pickup in new patients would be nominal while it baked added costs into the system. Also, that strategy failed to realize or address the structural frailty of the operations infrastructure.

The goals of the system were quite simple: get new patients in the door who wanted to be seen by world-renowned specialists within 14 days of their request. (If patients declined, the clinics were not, in those cases, held to the 14-day standard). The parameter included not creating new "slots" by squeezing rechecks out, not asking current providers to "work harder," and not double-booking patients to cram more patients into the same space.

When we began this project, we were told that we could not suggest that the providers expand their schedules. (That would've been too easy!) So, understanding that we could not expand outside of the 4-hour ½-day block, we approached the task by examining and addressing the impediments.

Avoiding the proverbial third rail, we focused instead on the issues and items keeping the providers from optimizing their schedules based on their current clinical day commitments.

There were additional constraints that needlessly precluded forward motion, such as Union stipulations that had no bearing on the delivery of care but slowed progress toward efficient deployment of staff and delivery of care. For instance, one specialty clinic had two locations directly across the street from one another. (Patient volume had, at some point, dictated the addition of space to accommodate; same specialty, merely yards across the street.) To move a medical assistant from one clinic to the next to *perform the same job duties* required clearance and intervention from the Union. So, there were myriad roadblocks towards remedying the patient access problem, some of them adding no benefit to the quality and delivery of care (e.g., the "Union issue").

THE REMEDY

Predictably, as we plowed through the multitude of practices, we found a few organic and systemic items that hindered patient access. These were micro components (e.g., by practice) that practically translated into macro components (because they were systemic) and were overarching touching just about every specialty:

- Administration (the practice administrator) had no idea (generally) of the physician schedules throughout his or her clinics, such as who works when.
- Physicians were at liberty to amend/adjust their schedules at will with seemingly little oversight from the Chiefs and less-so from the Chairs. In many instances, those who "canceled" clinics were asked to "make up" a clinic, which is helpful (flexible) for the physician but needlessly stresses the human capital of the offices.
- There were (aforementioned) Union issues with staffing.
- There were inconsistent clinic "times" throughout the system; that is, some providers arrived at 8:30 a.m. to begin work while others came at 10:00 a.m. (but providers still finished their a.m. sessions at 12 p.m., regardless of when the clinic day started).
- Those specialties that had any remote "touch" with surgery had access issues getting patients to the table. The access problem presented a new conundrum: If you get the patient in for their visit, and they need surgery, how to get them into surgery?
- Reduction in rescheduling; the incidence of provider-driven rescheduling ran between 10%-28% of scheduled appointments.
- Schedules were not built too far out because providers changed them frequently.
- Referrals sat; the external referral process was slow.
- Some appointments ran up to two hours. Although the time may be necessary, defining clinical time and subsequent scheduling were indicated.

RESULTS

After over a year of work, we found issues reflecting the veritable "80/20" rule: that is, 20% of the issues were systemic and caused 80% of the access problems.

- Procedures were established from the Chief indicating:
  - Provider clinic time expectations for all providers
  - Limits to schedule changes (e.g., no changing a schedule every week)
  - Definition of clinic times (e.g., 8:00 a.m. to 12:00 p.m. is one "session")
  - Define new patient and established patient visit slots (e.g., length of time)

Short of going outside of our parameters, results were slow but attainable:

- Added a new provider in cardiology, which immediately addressed much of the backlog. This provider had no academic commitment and was on board purely to see patients (his wife, another physician, had taken an academic appointment with the system).
- Explored methods to expand physician-complement *availability* by ensuring that advanced practice professionals (APPs, i.e., nurse practitioners and physician assistants) work to their full scope of care.
- By examining technology solutions, introduced:
  - e-consults
  - telephone follow-ups
  - video conferencing
- Add referral coordination staff and modify practice space to handle greater capacity and efficiency.
- Grew number of APPs throughout the system.
- Quantified visit growth via E&M visits (no "downstream" revenue contemplated, which would've added further fee-for-service revenues).
- Ensuring that clinical commitments were met. There was variability from week-to-week and month-to-month in appointments available by the provider. Capacity improved merely by asking providers to adhere to their clinic commitments.
- Determined that EMR training during rollout was substandard; the client formed an internal team to offer "immediate" response time to providers coupled with one-on-one training designed to enhance provider skills with vignettes, etc., and reduced lag days (defined as from date-of-service to date-of-entry of the charges).

CONCLUSION

Resolving and improving patient access in a health system is a complex, multi-dimensional process that encompasses examination of every area of operations, regardless of the organizational structure of the entity. Rarely is one factor the source of a larger problem; rather, one weak link merely gives a glance into systemic issues. Further, when the evaluator is charged with a limited review and given distinct boundaries, the probability of successful remediation is reduced. However, as noted in Figure 1, below, *minor* changes, in a large organization, can yield sizable results.

Patient Access - Patient Visits			
Old Model	New patients	Established patients	Total per week
1/2 session per week	1	4	5
New Model	New patients	Established patients	Total per week
1/2 session per week	2	5	7
% change:	100%	25%	40%
Annualized*	46	46	92
System pickup**	36,800	36,800	73,600

* Assumes 6 weeks of PTO per year; per provider

** If *only* 50% of providers meet the meager goals above, pickup could be enormous.

Nevertheless, Coker met the challenge and tight parameters of this exacting client. The challenge with this project is that we were not there for the long-term. Yet, the results were very clear in clinics where actions were deployed immediately. For instance, in one specialty clinic (although this went against the grain of our engagement), the addition of a sub-specialist who wanted only to see patients was an enormous factor in addressing the problems. The deployment of "set" scheduling to yield more visits was another improvement. With changes to some of the fundamentals in the clinics, a "different" way of thinking about the issues at hand, and economies of scale, we were able to, given the current provider complement, increase new patient visits and revenue.

In this case experience, we determined many obstructions, and we had multiple solutions to propose. We are confident in our work and our ability to help our client achieve its goals, and though we put measurable improvements in place, we had more to offer. It's difficult to push a boulder uphill.