Outside-the-Box Access

Transforming the Patient Ambulatory Experience

BY ELIZABETH W. WOODCOCK, M.B.A., FACMPE, CPC

On the transformative edge of modern-day health care, group practice leaders recognize the importance of access to the ambulatory enterprise in the patient's journey to quality medical care. Increasingly, key stakeholders are identifying the associated risks, advantages, and benefits of strategies to transform patient access in the ambulatory enterprise by opting for close examination and critical thinking outside the box.

The measurement and monitoring of new-patient lag are factors crucial to successful operations, revenue enhancement, and the patient experience.

A comprehensive review of cutting-edge trends espoused by members of the Patient Access Symposium® reveals the measurement and monitoring new-patient lag—and seven additional business-critical issues—as factors crucial to successful operations, revenue enhancement, and the patient experience. The ambulatory enterprise launches the patient's velocity to care, and group practices are in the driver's seat to create and sustain value by transforming that journey.

Catch Up and Stay Caught Up

Is there a magic number of days to new-patient access? Group practice leaders must first develop their own operational definition, standardizing the meaning and implications of lag time in their organization. Consider the following definitions, steps, and issues inherent in identifying new-patient lag time:

- Days from date patient or referring physician initiates appointment request to date of scheduled appointment
- Days from date patient or referring physician initiates appointment request to date of arrived patient visit
- Days from date of patient or referring physician's preference for appointment to actual date of appointment

Define your measurement period. Determine whether you will use calendar days or business days as your form of measurement. Current thinking recognizes calendar days as the way patients and referring physicians view access, and business days as how practices interpret access. High-performing practices take into account the customer's perspective.

Determine your preferred metric. Measure new-patient lag time, accounting for various nuances in the patient's quest for access. High-performing practices

recognize the barriers erected—and often unaccounted for—by requirements for completion of a designated form by a referring physician, capture of insurance authorizations, or receipt and review of the patient's complete medical record. As historic workflow is deconstructed to consider format, access expectations are assessed from the customer's perspective. Identify opportunities for improvement and streamline the process.

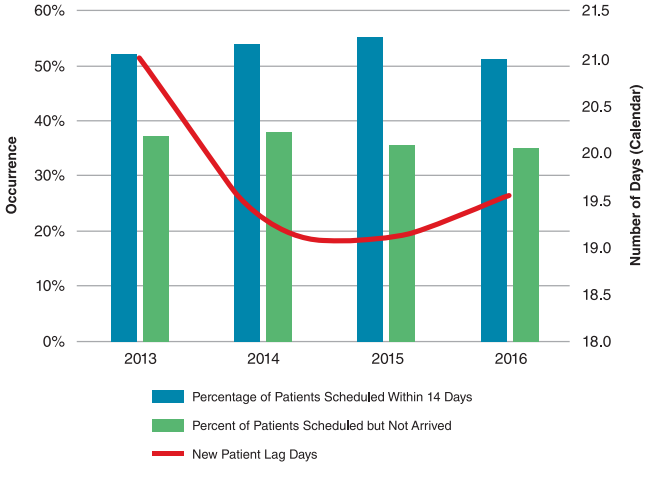
Choose a new-patient lag time target. Will your goal be 7, 10, or 14 days—or more—to accommodate new patients? Will the target vary by specialty? Will you accommodate certain patient cohorts, such as members of your accountable care organization, in a streamlined or more timely manner? Will market dynamics related to supply, changing reimbursement models, or strategies of an affiliated hospital influence your goal? Once identified, how will you manage the gap between your target lag time and your current state?

Variances can uncover a possible imbalance in supply and demand, leading to physician recruitment opportunities or revisiting relationships with insurance payers that control demand. High-performing practices create a "heat map" of supply/demand variances in new-patient lag compared to their targets, overlaid with perceived experience based on patient surveys, referring physicians, employers, and other stakeholders queried about what they believe is reasonable.

As leaders consider the steps on the patient's journey to care, the seven strategies listed below are approaches Patient Access Symposium® members use to tease out the details, allowing for individual nuance, challenges, and circumstance.

FIGURE 1

Key Performance Indicators: Paient Access



1. Monitor KPIs

Monitoring new-patient lag isn't adequate to provide leaders with a complete portrait of patient access. Carefully determine metrics used to routinely track and monitor patient access. In essence, by defining key performance indicators (KPIs), you influence the culture of your organization. KPIs to adopt for patient access include:

- New-patient volume and new-arrived patient visits—as percent of total arrived visits
- Percent of new patients scheduled within 14 days of booking—a capacity measure—as well as percent who arrived, which is useful for operations management
- Appointment status: arrived, cancelled, no-show, and bumped—each measured as percent of total scheduled appointments and monitored based on scheduling horizon
- Fill or use rate—expressing number and percent of visit slots occupied as percent of available slots
- Clinic sessions—number held and hours included compared with providers' clinic commitment
- Bumped clinics—percent of physician-directed cancellations, accompanied by number of patients who were lost compared to those who were impacted but agreed to reschedule
- Performance—of your group's critical access-related operations, including call center and self-scheduling

Which of these measures should you define as mission critical? Which will alert leadership to emerging challenges to patient access if performance gaps are identified? Consider the who, what, where, and when of relevant KPIs. Who will gather and report the data? Which data will be captured, and with whom will it be transparently shared? Where will the data reside? When will data will be captured and for what time period? (See Figure 1 for select KPIs and corresponding benchmarks.)

It is compelling to consider what this data feed offers. Not only do data serve as input for key metrics, they also provide the foundation for predictive analytics to enhance finding the ideal supply-and-demand balance. Given the importance of patient access, investing in business intelligence produces a positive return and continues to do so far into the future.

2. Maintain a Laser Focus on the Impact of Access Strategies

Undoubtedly, new-patient access is critical for today's group practices as this cohort initiates the

journey to a course of care. Yet, as workflows are constructed to accommodate its steadily rising numbers, leaders must pause, at times, to contemplate how altered processes impact access for established patients.

Steps to identify the balance point to meet patient demand include adopting predictive analytics to project the number of established visit slots required by identifying the demand using disease-specific models. Deploy advanced practice providers to take on new roles, and secure collaborative agreements between referring and consulting physicians to effectively and appropriately manage patients as their journey continues. Construct care teams to support patients' medical, behavioral, and emotional needs. Secure virtual visits to reduce established-patient face-to-face visit volume, with teleconsultation among physicians to support coordination and collaboration for successful journeys of care.

In addition, consider conducting outreach for certain patient cohorts to adopt a continuity-of-care model comprised of remote monitoring; alerts to the care team; and nurse, peer group, community leaders, and other stakeholders managing "between-scheduled-visits," in addition to the promotion of self-care. High-performing groups determine patient graduation or repatriation strategies to transfer care back to referring physicians and adopt sophisticated scheduling techniques, such as pivoting a new-visit slot from two established-patient slots (and vice-versa) when predetermined conditions exist.

Practices are creating urgent care capacity to accommodate patients' acute clinical needs—or developing close affiliations with urgent care centers in the community with streamlined access points. Some are placing employees in high-volume sites, such as the emergency department, to rapidly schedule patients for a specialty visit, thereby unlocking the potential to decrease hospital admissions. If capacity is limited in primary care, groups can partner with community health providers to ensure that access to care embraces all patients.

The struggle to accommodate new patients without negatively impacting service quality for established patients reminds us that the biggest challenge is hardly a new one: to ensure that patients are not only captured but cared for quickly, safely, and appropriately.

3. Use Data to Manage Referrals Effectively

Myriad processes exist for referral management. Some groups focus on leveraging technology by creating automated efficiencies from current manual processes; others form centralized referral management units; still others link referral management with a centralized call center, erecting a separate, focused referral management unit. Some groups have embedded the function as a fully integrated component of patient scheduling. Group practice leaders may wish to:

- Create two tracks—a streamlined track for internal referrals, involving direct scheduling into appointment templates with embedded guidelines, and a secondary track for external referrals that need to be processed and managed
- Fast track—for network-based or high-volume referring physicians who can make a request from their electronic health record or via their custom smartphone application, directly scheduling into the practice's system or receiving priority, same-day processing
- Determine which patient records are needed for external referrals and identify a preferred means to obtain them, ideally seamlessly through secure, electronic means
- Develop proprietary software to automate and track status at each stage in the referral processing workflow, or evaluate specialized vendor solutions in this space

While access strategies often focus on patients, high-performing practices value prioritizing the referral source as well. In addition to gains in efficiency, careful attention to this relationship eases the burden of inappropriate referrals, poor use of limited capacity, and patients frustrated by unsuitable referrals.

Regardless of the nature of the referral—from a physician or self-referred—it is likely that patients who want to be seen will be seen, but groups often find the need to prioritize (and perhaps even shift) demand, particularly in the case of provider shortages.

In this context, how can that process take place without exacting an exorbitant cost or resulting in barriers that block timely access? What data can you gather to determine appropriate patient access? Who triages the patient to determine suitable time and point-of-access to best handle the journey of care?

High-performing practices have created protocols for managing referrals, designating those in need of consideration via standard, monitored workflow. Through algorithms carefully crafted in collaborations between referring and consulting physicians, innovators integrate this process into the referral itself, eliminating the need to gather, handle, and pass information from one point to the next.

4. Invest in the Pre-arrival Process

Patient financial clearance is a prerequisite in today's reimbursement environment, and patient access is intrinsically linked to payment. If the patient does not have insurance with which the physician is contracted, if authorizations have not been identified and secured prior to services, and if time-of-service payments have not been captured, the practice's financial health may decline. Leaders may want to consider the following when merging access and financial concerns:

- Who should conduct patient financial clearance? Should this reside in the front office or be conducted during the scheduling process? Should a separate business office conduct this prior to the visit, or should this be integrated into the scheduling workflow?
- What reporting relationship or work oversight should employees have with finance?
- What is the scope of patient financial clearance? Should it include insurance verification, benefits eligibility, time-of-service payment, past financial history, credit history, and/or price estimations?
- What tools can you harness to ensure that the process is efficient—and, most importantly, accurate?
- Should schedulers collect patient balances at time of scheduling? What about unmet deductibles?
- Should you secure referrals and authorizations before granting access, or does access initiate this process?

As patients bear increased financial burden for their health care, high-performing practices recognize the value of improving process efficiency as well as transparency. Historically bifurcated from the scheduling process, these financial considerations are being united with patient access. No longer does finance represent a barrier or a step to overcome before access commences. Instead, innovators recognize that once patients are financial partners in their journey to care, access translates into an opportunity for revenue gain.

5. Move Work Out of the Office, into the Home

Space constraints are a constant reality for many groups. In consequence, teleworking for employees involved in patient access, particularly those who handle telephone calls, may prove a win-win for both the organization and the employee. Practices that introduce teleworking into their organizations should consider the following:

- Identify the technology and security needs for hardware and software
- Create a seamless patient transition regardless of the employee's location; in essence, teleworkers should have the systems and tools to manage the caller whether they are based at a centralized call center or at home
- Implement employee supervision and oversight and include performance metrics in the system for speed-to-answer, auxiliary time, and other factors
- Fully integrate teleworkers into the care team; consider asking them to work from the office on a set number of days per month, include teleworkers in staff meetings, and expect teleworkers to be active contributors to the team

Teleworking options for group practices are vast, and they are expected to grow exponentially in the future. Given the nature of handling protected health information and aligning with the clinical team to handle appointments appropriately, recognize that embracing this trend requires thoughtful planning—and exceptional leadership.

6. Manage the Call Center—Where Every Minute Counts

As with any function in health care, no perfect model exists to house patient access functions. The definition of patient access varies from group to group. Beyond scheduling, which functions should reside within the access infrastructure? High-performing practices recognize that access isn't limited to booking appointments. Instead, they incorporate the patient's financial relationship into the practice (including registration), then appropriate resources to construct scheduling templates and execute capacity-management strategies. Others extend access to incorporate all inbound communications, both telephonic and electronic. Given the vast array of potential responsibilities, staff deployment is essential to consider when building or reengineering access strategy.

What is the work scope of your practice's access infrastructure, both now and in the future? Is a call center—perhaps better termed an access center—your primary deployment strategy? Will you transfer existing employees, often based in locations spread throughout the organization, to it? What if, as happens in most circumstances, existing employees serve the practice in other roles? Are they appropriately skilled to function in the new role of access center agent?

Is the access center the front door to your practice, receiving all inbound calls, or does a dedicated

telephone number or automated attendant direct only callers inquiring about an appointment? Does the access center schedule visits for both new and established patients? Or, does it schedule new patients exclusively, thereby managing new referrals and serving as a new-patient access navigator?

Will it accommodate both patients and referring physicians or just one of these key stakeholders? Can your access center schedule ancillary testing services such as imaging and laboratory? Will it accommodate procedure scheduling? Will pre-authorizations be secure? If not, how will you communicate this information, and who will manage it?

If your access center manages all inbound calls, how will you process non-scheduling calls by the center's employees—via warm transfer or electronic message to the clinical site? Most importantly, how will you hold clinical site teams accountable to receive communications and respond in a timely manner? As workflow and response times prove increasingly challenging to manage, nurses are embedded in access centers to manage clinical triage and serve as a resource to call center agents. Depending on state law, pharmacy technicians are hired to receive and manage prescription renewal requests centrally.

Patient access can extend far beyond booking appointments, yet even the basics of centralized scheduling usher in a host of questions. Before experiencing all of the twists and turns, group leaders recognize that basic decisions are necessary—not only in terms of what the infrastructure will incorporate, but how it will be financed and where it will reside within the organization.

Answers to these important questions vary, even in high-performing practices. Some choose to centralize scheduling only; others filter all communications into a consolidated access center; some charge all expenses back to clinical sites (typically based on the number of dedicated employees or call volume); still others finance it centrally. Some place all access-related activities under the practice's operations infrastructure, while others integrate it into finance. With an eye toward creating a value-based operation, group leaders nurture the access infrastructure, regardless of its composition.

7. Grow New-Patient Self-Scheduling

Self-scheduling has been around for years, but only recently has it taken hold in large multispecialty groups with a long tradition of managing hundreds of appointment types created to determine the "right" patient visit slot. Efforts to clean up schedules have led practices into the promised land of delegating the determination to the customer requesting it. As the vast array of visit types is streamlined—in some cases to just one or two—self-scheduling becomes a reality. In addition to pursuing self-scheduling for established patients, most commonly via the organization's portal, numerous practices are opening the door to a similar self-service menu for referring physicians. Furthermore, innovative, seamless new-patient acquisition strategies are replacing historical workflows that largely featured barriers to overcome. The results reflect an engaged patient as well as the opportunity to improve revenue: failure-to-show declines dramatically with self-scheduled patients.

Commensurate with the growth of self-scheduling, high-performing practices are attacking their own self-scheduling opportunity: that of referring a patient internally. A task that typically requires two internal employees to process simply begs for performance improvement. Point-of-service scheduling is a realistic possibility, as a growing legion of innovators seeks to deliver embedded algorithms designed to ensure that the patient gets the right appointment—with the right provider—without the existing web of expensive, manual intervention.

Dedicated Compassion

Strategies for enhancing patient access in the ambulatory enterprise continue to evolve, with group practice leaders constantly absorbing fresh advances into the mainstream. With the right approach—one consistently dedicated to compassionately meeting the needs of each individual patient and the referring physician advocating on his or her behalf—everyone involved along the spectrum of care comes out a winner.

Author and speaker ***Elizabeth W. Woodcock, M.B.A., FACMPE, CPC,*** *is the founder of Patient Access Symposium®.* *The author wishes to thank* ***Deborah Walker Keegan, Ph.D., M.B.A.,*** *of Medical Practice Dimensions for her contributions to this article.*