APPD CONFERENCE

Four Lessons Learned Impacting Academic Practice Plans

May 4, 2019

History of Access Advisors

1996	2002	2012

Andersen Healthcare Consulting
KPMG Healthcare Consulting

-Front-end revenue cycle design focus
-Implementing within various cultures
-Gained project management experience

Emory Healthcare - Atlanta, GA

Created the patient access department within Emory that:
-Consolidated then Optimized Access Centers.
-Consolidated then Optimized Capacity Mngmt.
-Developed numerous access prioritization strategies across specialties to target growth.

MBA: Emory Goizueta School of Business

Access Advisors, LLC

Founded company to develop a proprietary *Patient Access Playbook™* and teach academic medical centers the science to transform patient access operations, increase revenue, and engage with and promote happy providers.

Client Partners

Four Learned Lessons in Access

Topic
cFTE Expectation vs. the aFTE Reality
Giving Providers Reasons to Adopt & Adapt to Change
Management Model that Builds Internal Competencies
Evolving from Data Toward a Playbook

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cFTE Expectations vs the aFTE Reality

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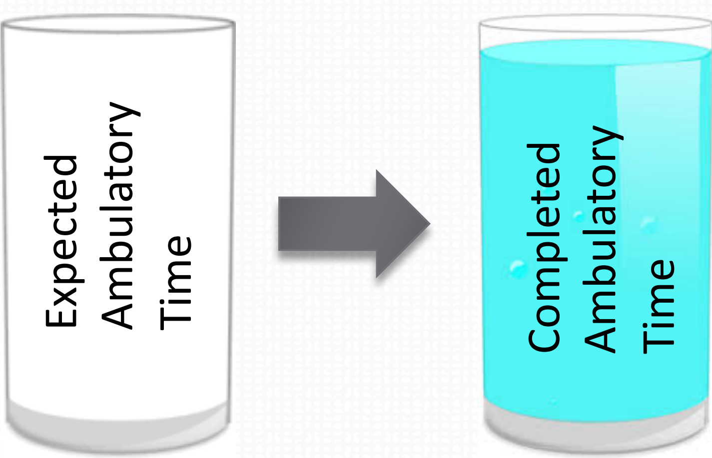
First Things First…
Changing the View: Access Optics

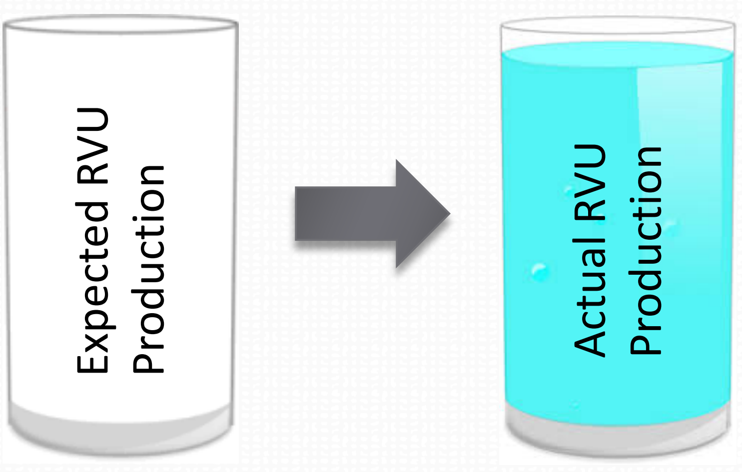
“RVUs can be the Enemy of Access”

Create provider expectations that assures patients’ access to providers AND promotes provider productivity.

Patient Access to Providers



Provider Time Productivity



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Supply of Provider Capacity

The following breakdown shows the various capacity opportunities that typically exist within provider's schedules.

Optimizing the Clinic Time of the Academic Medical Mission

Blue Space – the amount of ambulatory clinic time committed and clinic resourced but is lost due to clinic cancellations not rescheduled, applicable time not built into the schedules, and various other reasons.

Grey Space – clinic visit slots the system resourced and providers have blocked out

Unfilled White Space – open clinic visit slots the system resourced and providers want filled

Filled White Space – filled clinic visit slots the system has resourced and providers want filled

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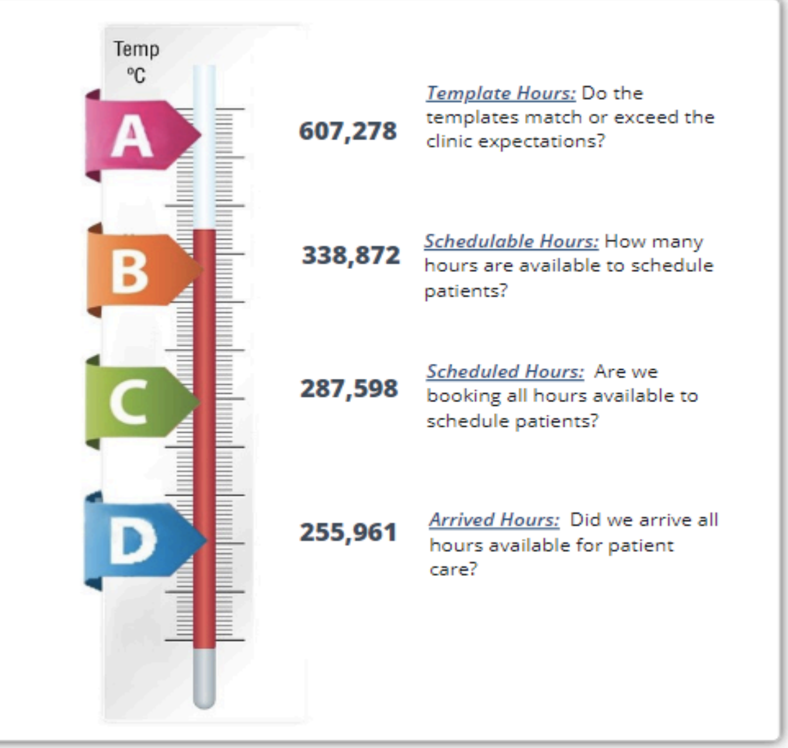
What is “aCFTE” and Why Is It Important?

- While cCFTE is usually a number derived on contractual/anticipated clinical effort, aCFTE is the actual ambulatory effort provided
- Many organizations are not able to review monthly, relying on wRVUs to track production – which is different than ”Capacity



Provider Capacity

Month	Template Hours	Schedulable Hours	Scheduled Hours	Arrived Hours
Dec-2017	40,651	20,111	15,904	14,711
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Aug-2018	43,399	22,771	19,169	17,792
Sep-2018	38,376	21,190	17,862	16,492
Oct-2018	43,992	25,294	21,496	19,911
Nov-2018	39,800	21,620	18,793	17,344
Dec-2018	35,740	20,575	19,426	15,835
Jan-2019	39,935	26,951	25,668	19,297

173.8 aCFTE of 181.5 Provider cCFTEs

Key Capacity Considerations

- Measure Specialists time outside of O/R
- Are NPs/PAs capacity at top of license?
- Critical information for budget season
- It’s not about wRVUs, it’s about time, to help cover staffing, overhead, real estate costs

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Giving Providers Reasons to Adopt & Adapt to Change

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What Provider's Want

To be Part of the Conversation

- Ability to share insight on the practice
- Understand the access goals of the organization
- Conversations can be individual or grouped

To Have Reasonable Control of Their Day

- Understand baseline clinic data and how it compares
- Where are their outliers and what changes are needed
- Options available to "control" the flow of the day
- Implementation requires NO cheat sheets or memorization

To See the Types of Patients They Want to See

- Academic providers prefer to see a specific subset of patients
- When applicable, templates can be built to accommodate this AND assure that schedules are filled

To Have Full Schedules

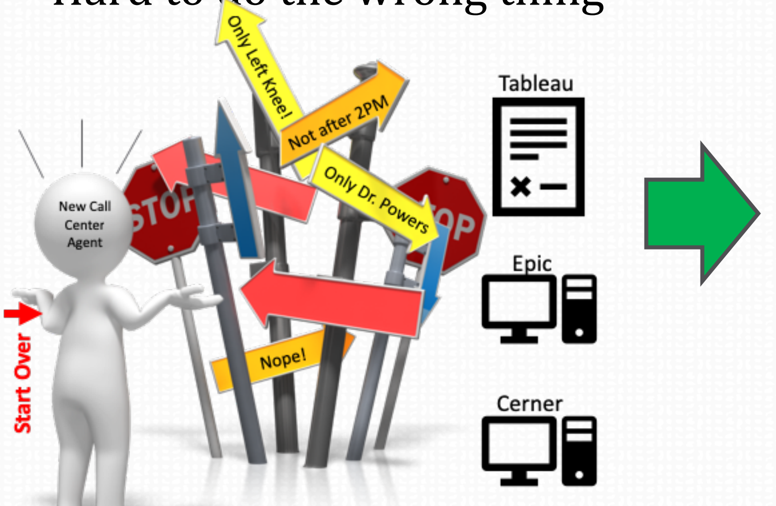
- Avoid ups and downs of the typical clinic day
- Implement tactics to improve the schedule fill rate
- Busy while in clinic so does not seep into academic/teaching

Provider Customization with Standardization

Proactively partner with providers to identify options that can be customized to allow autonomy at the provider level without sacrificing scheduling complexity or accuracy.

Intentionally Design Templates

-Easy to do the right thing
-Hard to do the wrong thing



Provider Customization w/ Schedule Automation

Visit Durations AUTO
Placement of Visits AUTO
Visit Limits AUTO
New/Established Ratios AUTO
Session Start/End Time AUTO
Green Light Patients AUTO
Template Recurrence AUTO
Hidden-Release Slots AUTO
Reserve w/ Switch AUTO

Determine system targets and then design templates to meet that target

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OPTIMAL PROJECT APPROACH

1) We Heard you!

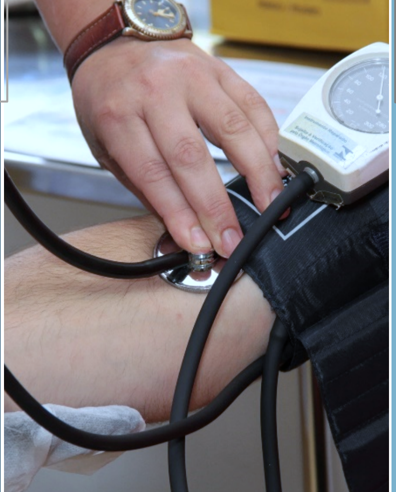
Align project to be about improving provider clinic day

3) Access Stories

What are the 4-5 access stories for the organization.

2) Organization Objectives

What are the organizational access targets? (Benchmarkable)



4) Provider Choice

Engage providers to present options to improve clinic day.

Builds the Foundation for Access Optimization and Successful Call Center Consolidation

Management Model that Builds Internal Competencies

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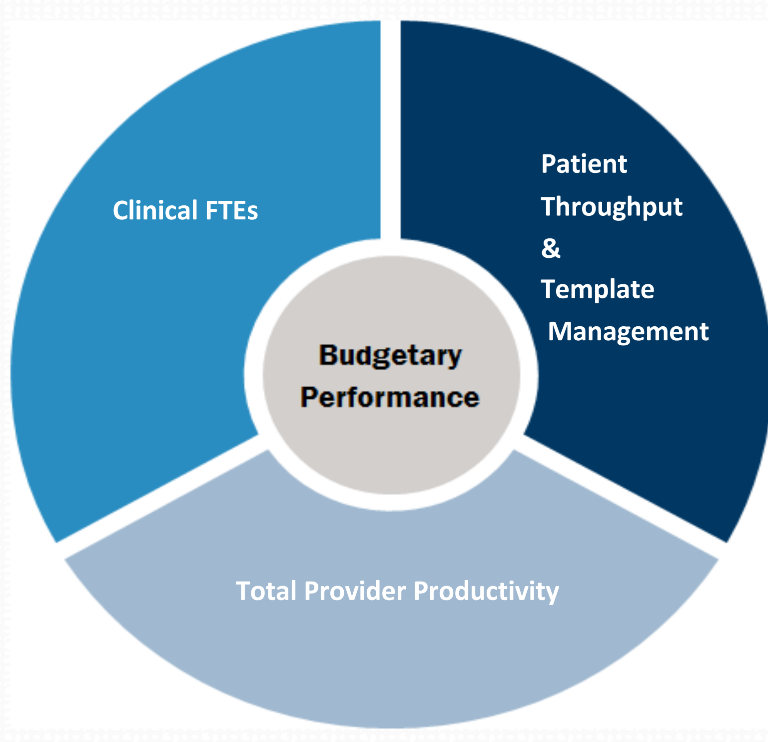
Access Improvement Strategy

Standards and Expectations

Currently, Access improvements are driven by individual specialties vs. Group-wide expectations

- Many Specialties pursue change focused on internal processes, care models, etc. with varied timing, measurement and impact
- Understanding if the clinical effort budgeted is actually being reflected in the scheduling process
- Designing the means to reflect actual capacities in the budget process



Establish and Communicate Access "Guiding Principles" to create pathway toward budget and strategic growth targets

- Governance to "set the path" for expectations
- Define a core set of Access metrics to report across all Specialties, providers, locations
- Include Access metrics in board materials / agenda
- Evolve Guiding Principles into Access Policies & Procedures
- Position Finance Committees to assist

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Access Performance Strategy
Proposed Guiding Principles

Effective October 1, Specialties will initiate efforts toward pursuing these Guiding Principles

Group-wide Expectations	Impact
Specialties will reconcile expected patient contact time (ambulatory) to scheduled templated time	▪ *Budgets that tie to the operational capabilities of the Specialty/location/provider team and represented in the Scheduling system*
Providers should achieve median productivity performance or higher: – Includes AHPs using Care Models – New Hires should achieve median performance after 12 months	▪ *Creates uniform expectations for every service line* ▪ *Provides additional capacity to improve market share* ▪ *Helps with defining when and where provider recruitments are necessary / warranted*
Specialties will supply the number of ambulatory patient appointments needed to meet budgeted performance*	▪ *Develops a new expectation to meet budget and manage supply of services* ▪ *Can help reduce actual to budget variation* ▪ *Brings into focus new tactics such as no-shows management & AHPs to top of license use*

*In-patient Specialties excluded. Procedural Specialties will apply to O/P ambulatory revenue targets

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PDC Access Governance Model

Proposed Future Organizational Chart

PDC will take direct ownership for change and results through a centralized management model, with FY14 Incentive Plan impact (TBD)

PDC Board

Vice-Chair Access Council
Board Sub-Committee

PDC COO

ACT Director
(PDC-funded)

Full Time Assistant

Assistant Director

Assistant Director

Appointment Centers

Ambulatory Capacity Team

Dept Schedulers

Dept Schedulers

Dept Schedulers

Dept Schedulers

Master Scheduling Analyst

Capacity Operations Analyst

Templates & Standards Manager

Training Standards Liaison

Department Business Managers will engage in the improvement process and team with both the Access Director and Vice-Chair

ACT will leverage existing internal service departments (Performance Services Group) where possible to speed delivery of services

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Access Performance Strategy

Engagement Across the Organization

Clinical Department

TACTICAL-OPERATIONS

Activities allowed at the clinic level. For example:
- Opening Days / Slots
- Closing Days / Slots

Consolidated Capacity Management

STRATEGY-OPERATIONS

- Initial Build of Template
- Template Structure Changes
- Visit Type Duration Changes

DEPARTMENT GOALS

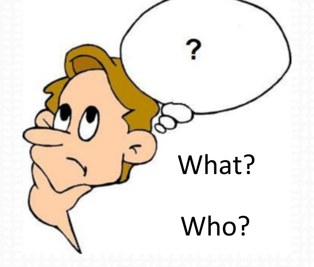
SYSTEM STRATEGY

BEST PRACTICES

IS Department

IS TECHNICAL

Activities controlled at the system level. For example:
- System Security
- Department "Approval" & Build
- Visit Type "Approval" & Build



Security Lockdown

SYSTEM ACCESS STANDARDS

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Evolving from Dashboard Toward a "Playbook"

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STRATEGIC EXECUTION

ORGANIZATIONAL STRATEGY & OBJECTIVES

Measure Discuss Hope Present Track Adjust Hope

Daily Fires What do I do Today? How Can I Make Difference?

OPERATIONAL TACTICS – “GETTING IT DONE”

Today:
Everyone has a Dashboard

Future:
Digital Playbooks

“The Alexa for Access”

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Level 1: Snapshot Overview Access

- Key Questions Answered -

- ✓ *Do Patients Have Timely Access to our Services?*
- ✓ *Are we efficient with Clinic Appointment Time?*
- ✓ *Are Patient Schedules flexing with Demand?*
- ✓ *Do we have competitive patient access across our various locations?*
- ✓ *How do we compare to benchmarks?*

"The Alexa for Access"

Insights2Access
Executive Dashboard

February 2019
(Last Monthly Update)

Growth

New Pt Lag Days

3 Month Avg	Last Month
14.2	15.6

Efficiency

Total Arrived Visits

3 Month Avg	Last Month
42,650	40,428

Access Algorithm

Algorithm Overall Score

3 Month Avg	Last Month
66.93	59.52

Patient Panel

Schedule Utilization Percentage

Nov	Dec	Jan	Feb
71.1%	72.4%	73.9%	75.2%

Productivity

Overall Provider Productivity

Nov	Dec	Jan	Feb
35.8%	32.6%	39.1%	35.1%

Play Book

Playbook Completion Percentage

18%

Play Book

Management Action Plan - Top 5

1. Eliminate 'blind scheduling' to involve the patient during the appointment selection process.
2. Double-book a return appointment on new patient appointments (i.e., provider with established patient while nurse is starting with new patient).
3. Assure appointment reminder system responses are worked consistently.
4. Implement 240 minute standard session duration across providers and schedulable mid-levels.
5. Replace one return patient slot with a new patient slot for each session.

Level 2: Drill Down to Providers

Are we Efficient with Provider Appointments?

Template Performance

- ✓ *Actual Utilization and Template Performance*

Patient Per Hours

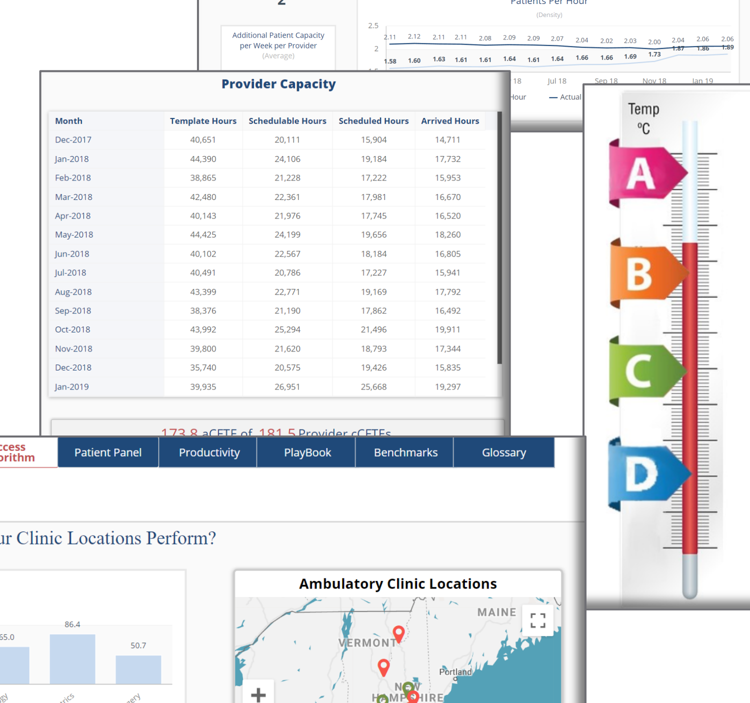
- ✓ *Scheduled and Actual Arrivals per Hour*

Patient Visit Duration

- ✓ *New and Established*

Capacity

- ✓ *Template Performance*
- ✓ *aCFTE and cCCFTE evaluation*



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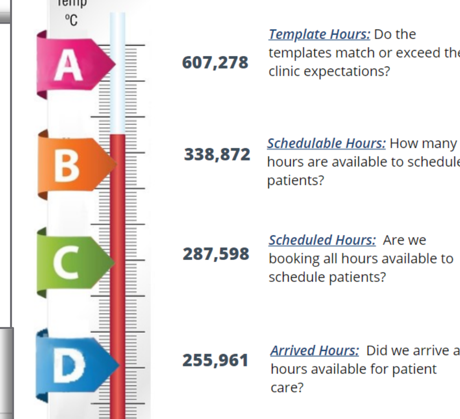
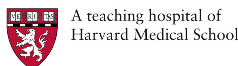


The Alexa for Access

Level 3: Playbook – The Tactics



Patient Access Playbook™

Best Practices and Industry Standards

Capacity Management Implementation Check-List

Access Improvement / New Patient Growth / Patient Experience Enhancement Initiative

DIVISION	**TARGET DATE**	**RESPONSIBILITY**
ADDITIONAL NOTES		

✓	BEST PRACTICE / INDUSTRY STANDARD	Associated Principle	Go-Live Date	Effort
	CAPACITY IMPROVEMENT			
☐	Complete/Validate cFTE analysis by provider.	TD-1		Green
☐	Remove any system based restrictions/rules placed to limit appointment availability (i.e., "no back-to-back new patients", etc.)	TD-7		Green
☐	Eliminate "blind scheduling" to involve the patient during the appointment selection process.	SO-1		Green
☐	Assure appointment reminder system responses are worked consistently.	SO-8		Green
☐	Confirm schedule availability is available and bookable a minimum of 6 months and a maximum of 13 months in the future.	TD-12		Green
☐	Offer next available appointment across providers or when multiple practice locations exist, factoring in patient preferences (i.e., Enterprise Wide Scheduling).	SO-1		Yellow
☐	Standardize/Simplify visit type and assure visit type durations accurately reflect the time a provider personally spends with the patient.	TD-8, TD-9		Yellow
☐	Double-book a return appointment on new patient appointments (i.e., provider with established patient while nurse is starting with new patient).	SO-4		Yellow
☐	Eliminate any blocked, frozen or unavailable slot strategies completely or at least 72 hours prior to clinic to improve access to care.	TD-7		Yellow
☐	Implement staggered sessions start-times to improve the patient and provider clinic-flow and eliminate front-desk and MA bottlenecks.	TD-14		Red
☐	Reserve specific visit type that is reserved for direct scheduling from Care Connection hotline.			Red

# of Additional New Patients per Week per Provider to Meet Benchmark (Average)
2

Unfilled Hours per Week per Provider (Average)
2

Additional Patient Capacity per Week per Provider (Average)
6

The Alexa for Access

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Tactical Level Benchmarks

Benchmarks at the Provider Level

- ✓ *# of Patients Per Week Needed to Meet RVU Benchmarks*
- ✓ *Provider Visit Durations by Sub-Specialty*
- ✓ *Patients Per Hour*
- ✓ *New Patient %*

Academic Specific Benchmarks

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Thanks for your Time Today!

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