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Revisiting the access imperative

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Revisiting the access imperative

Challenges with access continue to frustrate consumers and stunt health systems' financial performance. Engaging clinicians and improving productivity are vital to address this dual issue.

Three years ago, in our article "The access imperative," we described a potential triple win for payers, providers, and patients based on improved access to care in outpatient settings.[1] We focused on what "good" access entails in terms of provider operations and consumer experience, and we outlined the critical capabilities required to deliver efficient, timely access: operational discipline, physician and workforce engagement and alignment, and customer-centricity. We concluded the article with a discussion of the value of getting access right.

Since then, the value that good access can deliver has become even clearer, and yet the hurdles to achieving good access remain. We have seen health systems improve outpatient profitability by 10% to 20%—and sometimes more—within 12 months of launching a concerted effort to increase outpatient access. Equally important, access improvements significantly increase consumer satisfaction and make it easier for health systems to engage with consumers and win their loyalty.

Yet evidence suggests that at many systems, access is getting worse, not better. Nationwide, average wait times for new patients to get primary care and specialist appointments have risen by about 30% since 2014.[2] Wait times today for new adult primary care appointments in large metro markets average almost 30 days and climb to more than 100 days in select markets (e.g., Boston).

One of the factors that may be contributing to the worsening access could be the growing number of health systems that have expanded their employed-physician models.[3] Increasingly, physicians are exiting private practice for greater stability, the potential for better care integration, and improved work/life balance. According to the American Medical Association, 2016 was the first time that less than half (47%) of practicing physicians owned their practices, down six percentage points from 2012.[4]

This matters because our experience suggests that employed physicians tend to have lower productivity than independent physicians do, which translates to less patient access. The lower productivity could also exacerbate looming physician shortages. According to the Association of American Medical Colleges, the demand for physicians will exceed supply in the range of 34,000 to 88,000 by 2025.[5] (The gap was only 10,800 in 2015.)

The problem is not intractable, though. Our research confirms that unused capacity exists among employed clinicians for many health systems, and that unlocking this capacity would address a key consumer frus-

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tration with healthcare delivery. And, as we discuss at the end of this article, effective solutions to improve access and increase productivity exist, enabling gains on the double bottom-line of consumer experience and financial results.

Imperative to improve productivity

As health systems increasingly employ physicians, the investments needed for care integration are rising, as reflected in the financial performance of many employed-physician practices. Industry surveys report that annual net losses per hospital-employed-physician FTE average around $140,000.[6] Our experience suggests that this figure reflects a blended average of primary care physicians (roughly $70,000 to $80,000 in losses), nonsurgical single specialists ($130,000 to $140,000), and surgical specialists ($180,000 to $200,000). To put into perspective what these sums mean for health systems, consider this: each of the 50 largest medical groups in the United States have over 500 physicians; the median is nearly 700 physicians.[7] Assuming that a median-sized group achieves the average net loss per hospital-employed-physician FTE stated above, the annual investment by the health system for this physician organization would be around $100 million.

Several factors contribute to the losses, including the fact that physician practices' ancillary revenues often move to hospital-based departments under employment models. Physician productivity differences are another critical factor. Our research suggests that median work relative value units (wRVUs) per physician FTE are at least 5%

lower at hospital-owned primary care practices than at independent groups. The productivity gaps between employed and independent physicians are even greater among specialists. Improving the productivity of the physician practices would reduce health systems' investments to support them.

Challenges to improving productivity

Health systems face three common challenges in improving physician practice utilization—and thereby physician organization economics:

Non-standardized scheduling templates. Considerable effort is required to reconcile disparate scheduling approaches across clinics and to digitize operations in a manner that increases transparency for physicians and clinic staff (and eventually patients) and also makes standard practices possible.

Suboptimal performance management, especially at the clinic level. The problems that must be overcome include:

- Measuring and managing to suboptimal metrics (e.g., prospective fill rates, third-next-available appointments) that do not reflect realized results

- Failure to adopt technologies that would reduce repetitive work (e.g., through automation or completion by consumers)

- Misaligned incentives, such as compensation models for the physicians and clinic staff that are not aligned with productivity and other performance metrics

- Mind-set issues, such as physicians' perception of excess paperwork and insufficient nursing and nonclinical support

Reliance on traditional access points for scheduling and engagement. Using clinic staff or call centers to book and follow up with patients is labor intensive, often results in missed connections, and can be mired in other barriers that lead to cancellations, no-shows, or increased complexity in other areas (e.g., revenue cycle). Consumers are also dissatisfied with traditional approaches. In our 2017 Consumer Health Insights (CHI) survey, almost three-quarters of the respondents said they preferred digital tools to either phone or in-person methods for everything from searching for a doctor to reordering prescriptions.[8]

While health system executives are often aware of these challenges, many underestimate the magnitude of the performance gap and are not aware of the specific causes and potential solutions. We analyzed data from more than 10 health systems with large, employed-physician organizations to investigate this issue further.[9]

Utilization in physician organizations

Our investigation focused on three specific questions:

- How do these physician organizations perform on fill rates?

- What are the primary drivers of unused capacity?

- How does utilization vary for specialties within these physician organizations?

Each of the physician organizations we analyzed employed at least 225 physicians,

including primary care providers and a range of specialists. We used total contracted hours to assess the overall capacity of the physician organizations. Not all health systems adopt this definition of capacity, but we believe it best accounts for all the time when a physician could be with patients. Because it excludes non-contracted hours (e.g., administrative, vacation, or teaching time), it represents the most direct way to compare across systems. We analyzed 12 consecutive months of data for each system.[10]

How do the physician organizations perform on fill rates?

We defined *retrospective fill rate* as the total hours with completed appointments divided by the total contracted hours of physician organization capacity. There was wide variability in fill rates across the systems we studied, ranging from 48% to 93%, with a median of 70% (Exhibit 1).

A primary reason that analysis of retrospective fill rates often prompts surprise among health system leaders is that many assess utilization using prospective fill rates, which look ahead to measure scheduled capacity. Because *prospective fill rates* often do not account for late cancellations and no-shows, they often overstate scheduling effectiveness and clinic utilization.

What are the primary drivers of unused capacity?

Scheduling into slots was the first problem we examined. After analyzing data from the first six systems for which we had complete prospective and retrospective fill rates for

EXHIBIT 1 **Many systems have ample room to improve retrospective fill rates**

Retrospective fill rates across health systems[1]

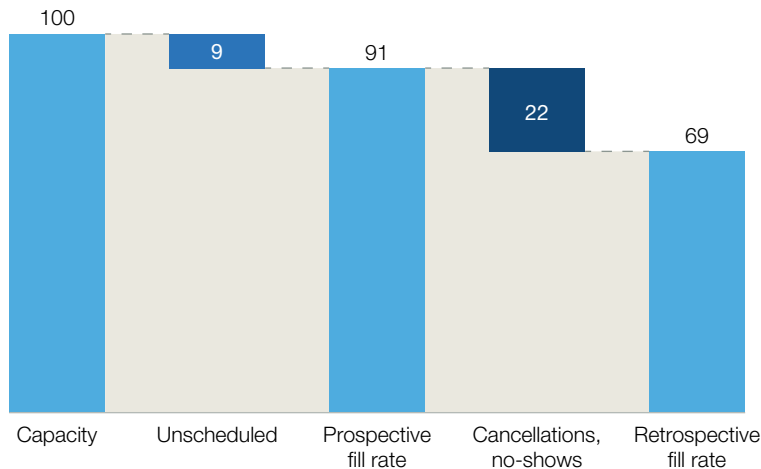% over 12 consecutive months for the systems surveyed
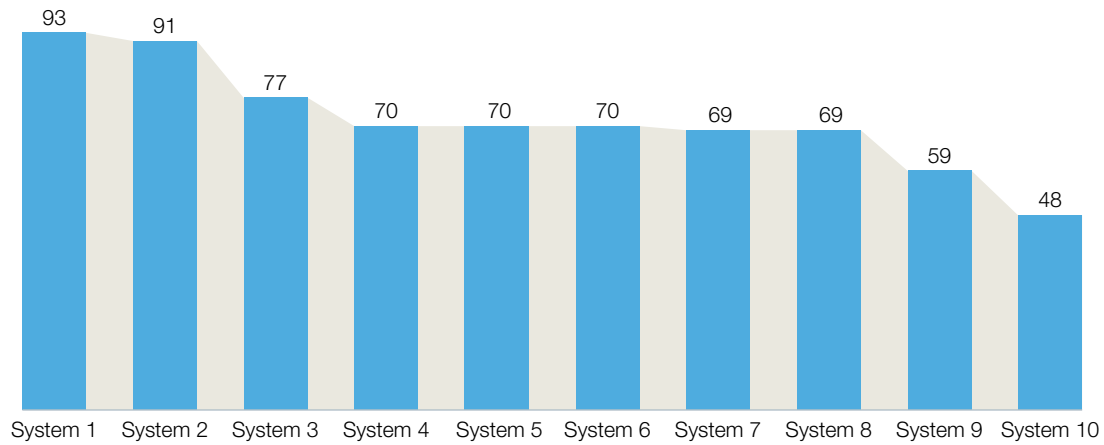
[1]The data from a few of the systems we studied was insufficient to allow us to calculate retrospective fill rates.

Source: The data analyzed was obtained from a third-party organization

EXHIBIT 2 **Prospective fill rates often overstate scheduling effectiveness**

Capacity utilization at six health systems[1]

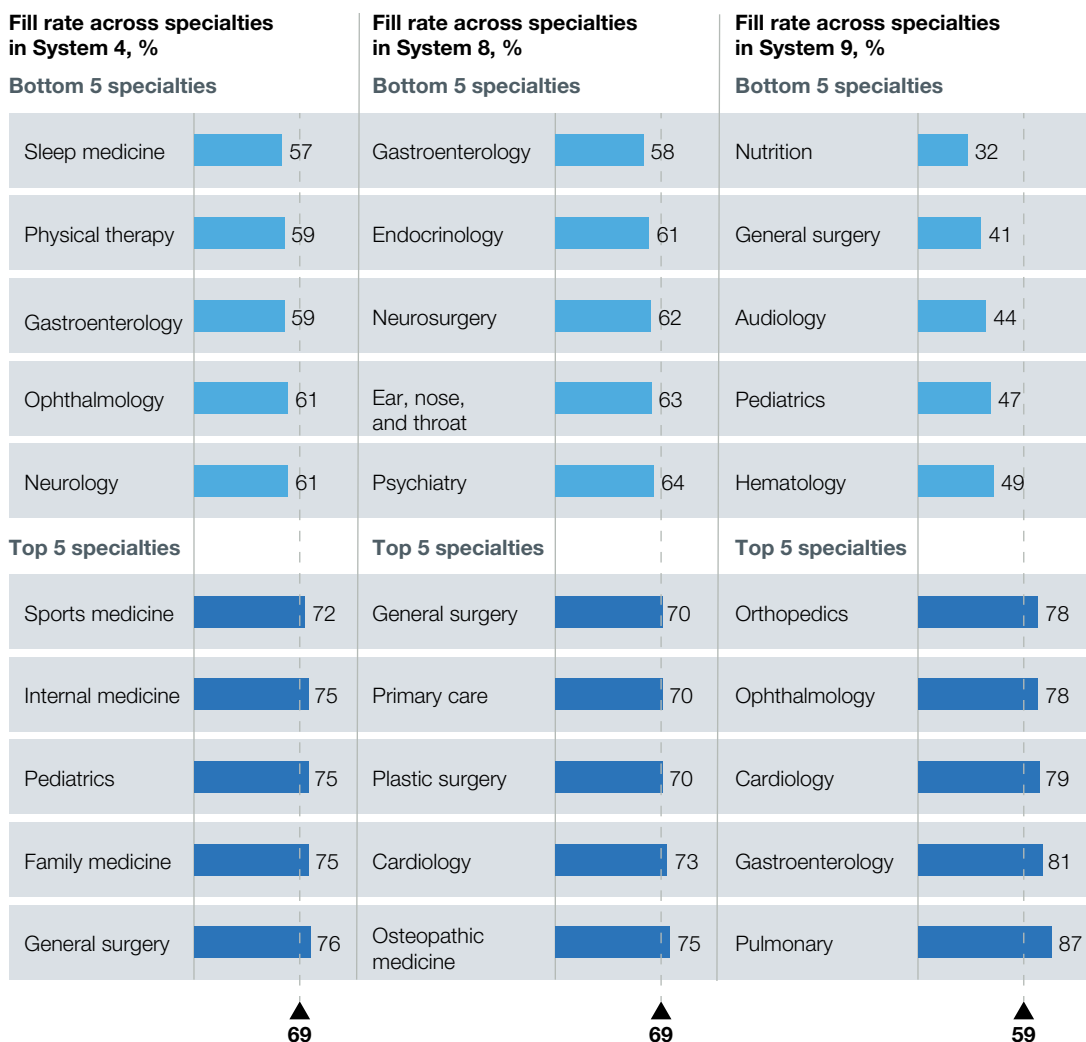% over 12 consecutive months for the systems surveyed

[1]The data from the other systems we studied was insufficient to allow us to calculate capacity utilization.

Source: The data analyzed was obtained from a third-party organization

all physicians and clinics, we found that unscheduled slots accounted for almost 10% of the gap to full capacity (Exhibit 2).[11] We then identified a difference between prospective and retrospective fill rates of around 20%, a result of cancellations with greater than 24 hours' notice that were not backfilled, late cancellations, and no-shows.

How does utilization vary for specialties within the physician organizations?

Variability in retrospective fill rates exists not only across health systems, but also within physician organizations at the specialty level. Among the systems for which we mapped variations by specialty,

EXHIBIT 3 **Retrospective fill rates across specialties vary significantly within systems**

Fill rate across specialties in System 4, %

Bottom 5 specialties

Specialty	Rate
Sleep medicine	57
Physical therapy	59
Gastroenterology	59
Ophthalmology	61
Neurology	61

Top 5 specialties

Specialty	Rate
Sports medicine	72
Internal medicine	75
Pediatrics	75
Family medicine	75
General surgery	76

▲ 69

Fill rate across specialties in System 8, %

Bottom 5 specialties

Specialty	Rate
Gastroenterology	58
Endocrinology	61
Neurosurgery	62
Ear, nose, and throat	63
Psychiatry	64

Top 5 specialties

Specialty	Rate
General surgery	70
Primary care	70
Plastic surgery	70
Cardiology	73
Osteopathic medicine	75

▲ 69

Fill rate across specialties in System 9, %

Bottom 5 specialties

Specialty	Rate
Nutrition	32
General surgery	41
Audiology	44
Pediatrics	47
Hematology	49

Top 5 specialties

Specialty	Rate
Orthopedics	78
Ophthalmology	78
Cardiology	79
Gastroenterology	81
Pulmonary	87

▲ 59

Source: The data analyzed was obtained from a third-party organization

we observed significant disparities—differences between specialties as high as 20%—even among the physician organizations with retrospective fill rates near the median overall (Exhibit 3). This variation underscores the importance of disaggregating performance at the physician or clinic level to analyze performance factors, including schedule templates and panel sizes (which tend to be physician-driven) and scheduling turnover (which tends to be clinic-driven), to identify root causes and propose solutions.

Improving front-door access is an essential part of an integrated growth strategy, especially given the imperative for health systems to expand both their share of lives and share of wallet among consumers ages 45 to 64

Impact of patient access performance on health system economics

As we discuss in the main article, improving patient access can strengthen care delivery, increase patient satisfaction, and enhance patients' health. Improving access also has bottom-line impact: improving health system economics. To understand its potential impact, consider these illustrative calculations:

Potential revenue per primary care physician

Total revenue per primary $125
care appointment
                                   ×
Number of appointments per day 20
                                   ×
Numbers of days worked per year 240
                                   =
Potential revenue per $600,000
primary care physician

Implications
- Closing half the gap between median and high performance on retrospective slot utilization would equate to an additional 600 visits—and $75,000 in direct revenue—annually

- The additional visits have the potential to enable better care coordination via referrals to aligned specialists and facilities

- Given that family physicians and internists generate, on average, $1.5 million to $1.8 million in net revenue for affiliated hospitals, the additional visits could bring in as much as $300,000 in indirect revenue[1]

EXHIBIT   **Impact of better scheduling on revenue**

	Unscheduled appointments, %	Cancellations and no-shows, %	Retrospective slot utilization, %	Estimated revenue per primary care physician, $
Survey median performance	10	20	70	420,000
High performance	1–2	3–4	95	570,000

[1]Merritt Hawkins. Each physician generates an average $1.56 million a year per hospital. April 12, 2016.

with commercial insurance. Among consumers with chronic disease in this demographic group, more than 90% of the value of inpatient and hospital-based outpatient claims are, on average, with a single health system.[12] Providing access to consumers as they seek it will be essential to compete early on for these consumers and to attach them to the health system for the long term.

Consumers' mind-sets and behaviors

Although most health systems today are looking for ways to improve consumer experience, the solution likely to deliver the greatest gains to the broadest cohort of patients—which could also have tremendous positive financial benefit—is obvious: making it easier to access care. As part of McKinsey's CHI survey in 2016, we asked a panel of nearly 3,000 adults about how they engage with healthcare delivery.[13] The results, which underscore the importance consumers place on access, can inform how health systems should respond. Highlights include:

Main site for consumer engagement. Respondents used primary care more than any other site of care—75% reported routine primary care visits in the previous 12 months and 40% reported non-routine visits.

Patient satisfaction. Specialists received the highest patient satisfaction scores of any provider (63% of the respondents gave them a rating of 9 or 10, on a scale of 1 to 10). Adult primary care followed closely (60%), while a lower proportion of the respondents gave very high scores to hospitals (55%) and urgent care centers (44%).

Lack of preferred providers. Fewer than 60% of respondents reported having an adult primary care provider they "use for almost all their care"; nearly 30% reported that they do not have a preferred primary care provider at all. These percentages are similar to those that respondents reported for hospitals—yet primary care is a type of care they engage with far more frequently.

Desire for appointment availability. When asked to select the criteria that matter most to them when choosing a primary care provider, respondents highlighted "appointment availability" and "appointment times that meet your needs" as two of the top six factors, among 20 available options (Exhibit 4).

Consumers' experience searching for and booking appointments with primary care and specialist practices was a specific focus within the 2016 CHI survey. Regarding primary care, respondents reported:

Booking. While 75% said they had attempted to book an appointment, only 57% were able to do so. Among those who did book appointments, the majority (68%) did so via phone; only 14% were able to book online. (The remaining 12% booked in person.)

Convenience. Three-quarters of those who booked appointments were able to get a convenient time; the other quarter were unable to do so, usually because it took "too long to get an appointment." Among those able to book appointments, about one-quarter reported that weekend and evening slots were available; another 10% reported either weekends-only or evenings-only availability. The remainder said that their primary care practices offered neither weekend nor evening appointments.

Time to appointment. Nearly 70% of the respondents who booked an appointment for primary care got one within two weeks, with just over 30% given an appointment within one week (Exhibit 5).

Results with specialists largely echoed these findings, with two notable differences. First, more respondents (72%) were able to book appointments after searching. Second, 82% were able to get an appoint-
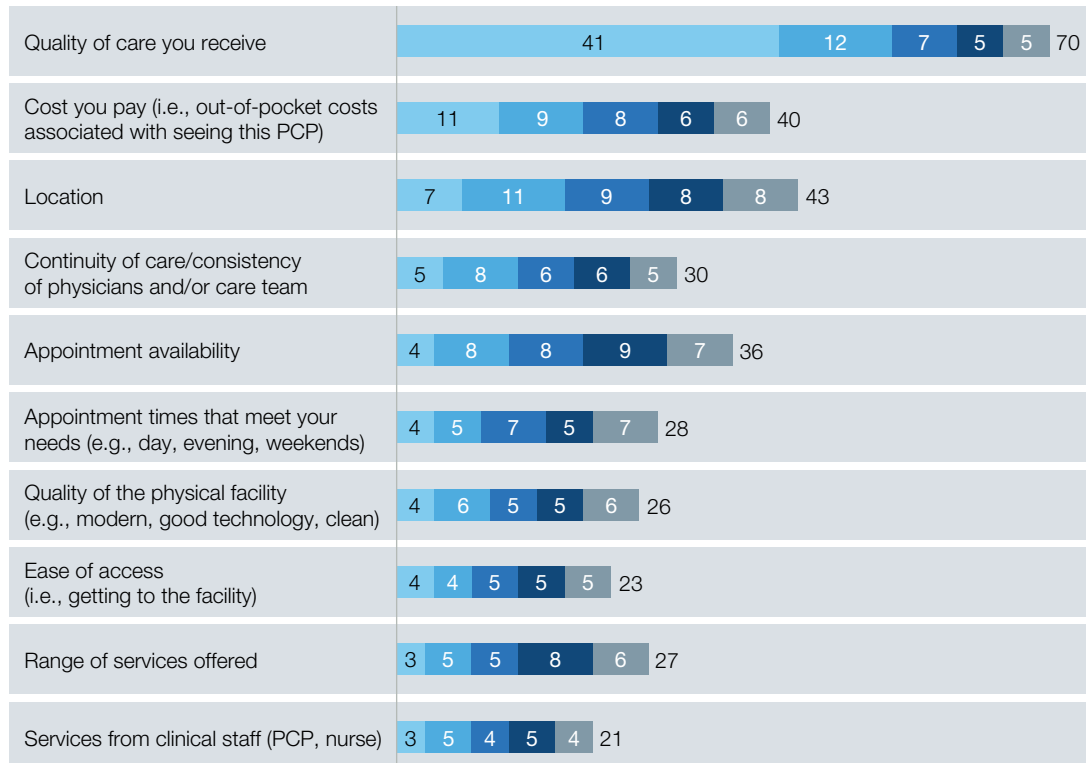
ment at a convenient time. However, only 70% of the respondents could get an appointment within two weeks, and nearly two-thirds of the specialists had no weekend or evening hours.

Given the volume of unscheduled slots and the frequency of cancellations we uncovered in our analysis, many hospital-owned physician organizations appear to have capacity to enhance access, a key determi-

EXHIBIT 4 **Care quality and access have the strongest influence on why patients choose primary care providers**

■ Most important ■ 2nd-most important ■ 3rd-most important ■ 4th-most important ■ 5th-most important

In choosing a primary care provider (PCP), which of the following are most important to you?

% of respondents, (n = 2,809)

Quality of care you receive	41 · 12 · 7 · 5 · 5	70
Cost you pay (i.e., out-of-pocket costs associated with seeing this PCP)	11 · 9 · 8 · 6 · 6	40
Location	7 · 11 · 9 · 8 · 8	43
Continuity of care/consistency of physicians and/or care team	5 · 8 · 6 · 6 · 5	30
Appointment availability	4 · 8 · 8 · 9 · 7	36
Appointment times that meet your needs (e.g., day, evening, weekends)	4 · 5 · 7 · 5 · 7	28
Quality of the physical facility (e.g., modern, good technology, clean)	4 · 6 · 5 · 5 · 6	26
Ease of access (i.e., getting to the facility)	4 · 4 · 5 · 5 · 5	23
Range of services offered	3 · 5 · 5 · 8 · 6	27
Services from clinical staff (PCP, nurse)	3 · 5 · 4 · 5 · 4	21

Source: 2016 McKinsey Consumer Health Insights Survey

nant of consumer experience. Adopting operational improvements to achieve this goal and then managing ongoing patient loyalty should help fill physician practice panels and improve productivity. Moreover, a consumer with commercial insurance and one chronic condition has, on average, annual healthcare spending of nearly $8,900.[14] If a health system can attract such consumers into their physicians' clinics and manage the consumers' needs within their system, the financial returns can be significant.

Approach for moving forward

Addressing physician practices' performance requires an end-to-end view that integrates physician preferences, best practices in clinical-level operations and

consumer engagement, and central service infrastructure (e.g., technology platforms, call centers). It also requires setting a high bar and aligning the culture behind devotion to a consumer-first service mind-set. Our recent experience suggests that there are four key dimensions to transforming practice performance:

Introducing standards, tools, and capabilities

Many health systems invested capital to acquire practices, then under-invested in the time and resources required to integrate these acquisitions and enable high performance. As the number of employed-physician practices expanded and more new providers were hired, systems have often been left with myriad software solutions, policies, procedures, and norms for

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EXHIBIT 5 **A sizeable number of patients must wait more than two weeks for physician appointments**
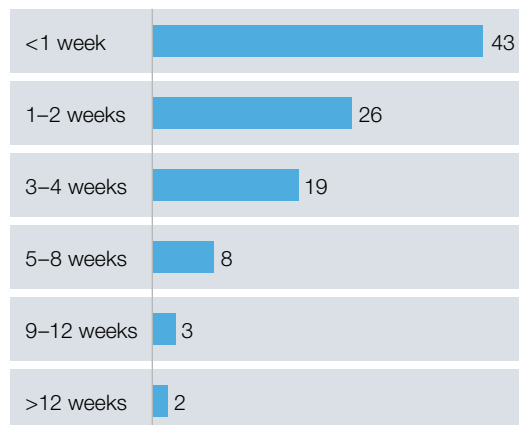
How quickly could you get an appointment with a…

% of respondents

Primary care provider, (n = 269)

<1 week	31
1–2 weeks	39
3–4 weeks	23
5–8 weeks	4
9–12 weeks	1
>12 weeks	2

Specialist, (n = 302)
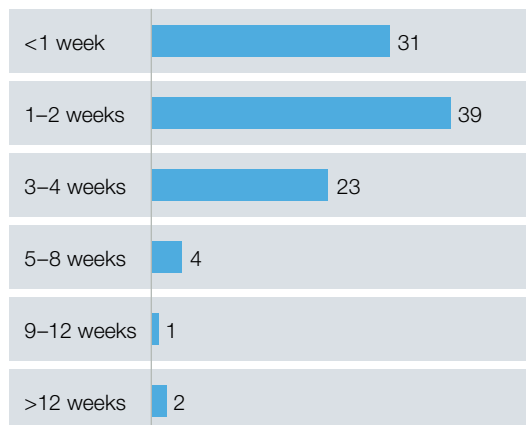
<1 week	43
1–2 weeks	26
3–4 weeks	19
5–8 weeks	8
9–12 weeks	3
>12 weeks	2

Source: 2016 McKinsey Consumer Health Insights Survey

practice performance. In recent years, many health systems have started—and continue—to integrate and standardize operations, with a focus on:

Schedule template standardization, including setting best-practice appointment lengths, eliminating discretionary blocked time, and defining an approach to double-booking (to remove this decision authority from the individual clinic-level operators).

Call center optimization, including introducing single call numbers, reducing hold times, adding interactive voice responses, and improving staff scripting.

Third-party scheduling integration, for example, by using Zocdoc, Amion, QGenda, or Clockwise.MD, as well as by using automated appointment reminder tools, such as text messaging solutions.

Standardization and transparency into appointment availability support both call center and third-party scheduling because it enables those channels, separate from the individual clinics, to book appointments. Engaging these channels opens the front door wider for consumers, but implementing their use is no small matter; it can take large health systems as long as 12 to 18 months, depending on their starting points.

Supportive changes—such as having providers practice at the top of their licenses, setting standards for which providers see different types of patients, and enhancing collaboration between the clinics and call center and IT support teams—often also need to be undertaken in tandem with schedule optimization. The operational and cultural changes required to achieve all these goals speak to why change often requires patience and time to materialize.

Establishing ongoing performance management

Executing and sustaining a clinic-level transformation requires strong performance management enabled by real-time data. We have often found that physicians and clinic staff working in a practice purchased by a health system operate as though they were still in an independent practice—without sharing data or interfacing regularly with the health system. Key elements needed to implement strong performance management include:

Defining the metrics to track. As few as possible should be used, and the selected metrics should be those best tied to the system's desired outcomes. In our experience, the set of metrics should include specific measures of productivity (e.g., total wRVUs, out-of-network referrals) and scheduling (e.g., retrospective fill rate, short-notice and no-show cancellations), as well as assessments of patient satisfaction, revenue cycle results, and new physician ramp-up performance. Some health systems focusing on the financial implications of low productivity have even quantified the opportunity (in terms of the number of additional wRVUs or the anticipated increases in revenues) to highlight the gap between current performance and their goals. The selected set should enable both the system and any practice being studied for acquisition to establish baseline performance (especially on key metrics) and to agree on targets, ideally based on comparisons with internal and peer benchmarks.

Supplying useful data to advise the clinic teams' decisions. In addition to selecting metrics, the health system and practice need to create processes for data collection and sharing. Reporting should be done on a daily and/or real-time basis. At a minimum, each clinic should have visibility into its own performance and, for comparison, the system's aggregate performance or, perhaps, other individual clinics' performance. The full clinic staff, not only its leadership, need to be able to access and understand the data.

Developing a governance and operating cadence in the clinics. The basic infrastructure should include huddles that cascade from the front-line clinic teams to physician organization leadership. For large systems, the best practices we have observed involve:

• Daily huddles around metrics in each clinic

• Weekly problem-solving sessions with front-line teams and clinic managers to address ongoing issues

• Weekly leadership meetings in which all clinic leaders and the physician organization management team review changes in key performance indicators and offer support to solve issues raised by the front-line teams

Improving practice leadership and operating models

Until recently, many individual and small group physician practices sustained themselves as small businesses. Upon joining large employed groups, the physicians and clinic staff often fail to adapt their operating models. This cannot continue. For many health systems, large employed-physician organizations now represent business units with hundreds, if not thousands, of employ-

ees and revenue figures above $500 million annually. Thus, when health systems bring the physicians and clinic staff on board, it is crucial that they set appropriate expectations—and health system leaders must be more direct than ever before.

For example, improving consumer satisfaction may require offering evening and weekend appointments, and physicians may have to accept that their incentives will be based on reported consumer satisfaction, not just productivity. In addition, physicians and clinic staff should expect to work in pods with expanded panel sizes, with an understanding that each clinic will operate as a team. The practices will need to hold individual providers accountable for any failure to respect patients as consumers (e.g., by arriving late to appointments) and to promote the effective use of scheduling technologies—and other new technologies—deployed across the system. Health system leaders may even consider introducing individuals from consumer-oriented industries into clinic staff and practice leadership roles to help accelerate the culture changes often required.

Managing referrals to support care continuity and productivity

As health systems resolve operational challenges around access, other issues must be addressed to realize the full potential from the improvements. One is referral management. Many systems continue to see significant out-of-network referrals from employed-physician practices to independent physicians or competitors, even when they have appropriate providers for the services required. Often, the referring physicians cite scheduling delays as the proxi-

mate cause; however, lack of awareness of and relationships with their peers within the system is often the root cause. Engaging a health system's physician relationship management function can help. In addition, analyzing referral data for the sources of leakage—especially between primary care and specialists—and then being prepared to propose alternatives can drive behavioral change. Communicating expectations to the specialist clinics, including the need to send patients and information back to the referring primary care provider, is also critical.

Additional functions within health systems can also help support productivity improvements. For example, digital marketing teams can make consumers aware of physicians once those with sufficient capacity have been identified. Continuity of care efforts can also help. For instance, patients who visit the emergency department who need a specialist follow-up or who do not have a primary care provider can be given appointments with employed physicians, an approach that not only improves productivity but also addresses patients' needs and ensures more integrated care.

As these activities suggest, significant blocking and tackling are often required—across people, processes, and technology—to optimize practice operations. The difficulties involved explain, in part, why some health systems see lagging results and underscore the value for those that succeed.

• • •

In recent years, many health systems have employed significantly more physicians, especially primary care providers, to improve

Defining the metrics used to assess physician utilization

Appointment cancellation rate: Total appointments cancelled divided by total appointments booked per physician FTE; can be as high as 30% for large groups

Capacity: Contracted hours per physician FTE (excludes administrative time, vacation, teaching time, etc.)

No-show rate: Non-cancelled appointments when the patient did not appear for appointment divided by total non-cancelled appointments per physician FTE; can be as high as 20% for large groups

Prospective fill rate: Scheduled appointment hours divided by contracted hours per physician FTE

Retrospective fill rate: Total hours with completed appointments divided by the total contracted hours of physician capacity; can be 20% to 30% lower than prospective fill rate for large groups

Short-notice cancellation rate: Appointments cancelled within 24 hours of scheduled appointment divided by total appointments booked per physician FTE; can be as high as 15% for large groups

care coordination. Too often, however, the acquired practices have not evolved from small businesses to professionally scaled, customer-centric enterprises. As a result, productivity has declined, operations have not improved, and access remains a challenge. Solutions relying on training more physicians could take a decade to affect patient access, and policy changes to expand mid-level providers' scope of practice face legislative hurdles. Therefore, maximizing the operating efficiency of large employed-physician organizations is an urgent need if health systems are to meet their dual goals of improving patient access and finan-

cial performance. Systems that succeed in making this transition, and quickly, can expect to win consumers and engage with them effectively, aligning them closely with their physicians—and the health system. ⚬

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FOOTNOTES

[1] Kumar P et al. The access imperative. McKinsey white paper. February 2015.

[2] Merritt Hawkins. 2017 survey of physician wait times. September 22, 2017.

[3] Select states (e.g., California, Texas) have specific prohibitions that preclude hospitals from employing physicians for the purpose of practicing medicine. Alternate frameworks exist in these states (e.g., medical foundations in California, 501(a) corporations in Texas). For simplification, we have used the terms "employed physicians" or "employed providers" throughout this article, regardless of the precise legal structure involved with aligning these physicians with the associated health system.

[4] American Medical Association. Updated data on physician practice arrangements: Physician ownership drops below 50 percent. AMA Economic and Health Policy Research. May 2017.

[5] IHS. 2017 Update: The complexities of physician supply and demand: Projections from 2015 to 2030. Final report prepared for the Association of American Medical Colleges. February 28, 2017.

[6] Finnegan J. Costs up, revenues down for medi-

cal groups, survey finds. Fierce Healthcare. January 9, 2018.

[7] SK&A. *Top 50 Medical Groups: Market Insights Report*. January 2016.

[8] McKinsey 2017 Consumer Health Insights Survey.

[9] The data was obtained from a third-party organization and did not include any information about specific patients.

[10] The 12-month periods differed for the various systems, but all occurred between January 2015 and July 2017.

[11] Results were similar for the other systems we studied, but we had insufficient data from these systems to permit precise and comprehensive analysis.

[12] Bauman N et al. Chronic disease excellence: "Service line 2.0" for health systems. McKinsey white paper. April 2018.

[13] McKinsey's 2016 Consumer Health Insights Survey was conducted in April 2016. All of the data points cited in this section were drawn from the survey's results.

[14] Bauman N et al. Chronic disease excellence: "Service line 2.0" for health systems. McKinsey white paper. April 2018.