Healthcare Systems and Services Practice

The access imperative

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Improving outpatient access can deliver a triple win for payors, providers, and patients

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Long patient wait times, frustratingly high no-show rates, lack-luster call center performance, and under-utilized physicians—do these traits sound familiar? Although a small set of provider systems have boldly declared that they will guarantee same- or next-day outpatient access, the more common experience across the United States is long wait times and poor access to care. Given the pressures that reform and other industry changes are bringing about, including the shift of service volumes to the outpatient setting and increasing customer expectations, the ability to provide timely, consistent, and convenient access to outpatient care is becoming an increasingly important differentiator for providers. Furthermore, the transition to risk-based payment models requires timely access to outpatient services to ensure that patients are seen in the right setting at the right time.

Many provider executives believe that improving outpatient access requires substantial investments in clinicians, technology, infrastructure, or all of the above. However, our experience suggests that many systems can achieve substantial improvements with their existing resources and, as a result, can generate both significant near-term financial returns (often, a 10- to 20-percent improvement in outpatient profitability within 6 to 12 months) and improved customer satisfaction.

However, capturing this opportunity requires two distinct shifts that the typical employed-physician group could find both culturally challenging and operationally difficult to achieve: a change from provider- to patient-centricity and a move from highly variable practice operations to the disciplined adoption of best-practice operational standards. To succeed in the future, physician practices will need to have the customer orientation of a five-star hotel and the operational discipline of a factory floor.

Why access is important

Three dynamics are unfolding that make good outpatient access a top strategic item for provider CEOs:

The need to transform outpatient performance to enable future growth. Most provider systems lose large amounts of money on their employed-physician groups. (For example, the Medical Group Management Association has estimated that the median loss per employed-physician FTE is about $170,000 per year.[1]) The losses are due, in part, to a decline in physician productivity post-employment. Although these losses are often offset by referred inpatient volume, they make it difficult for systems to fund future physician practice growth and capture new patient volume. Improving outpatient access can be part of the answer—our experience has shown that better performance on access often facilitates improved clinician productivity (particularly in utilization, in which we have commonly seen improvements above 20 percent).

Increasing consumer expectations and choice. Consumers today are making a growing proportion of healthcare decisions on their own. For example, a recent consumer survey found that about 55 percent of respondents switched providers between instances of care, without a recommendation from the original provider.[2] As reform further stimulates consumer expectations, access will increasingly become a source

1. MGMA physician cost survey 2012 for "all multispecialty, hospital / IDS owned" physician practices.
2. McKinsey Advanced Healthcare Analytics Consumer Health Insights Survey, 2013.

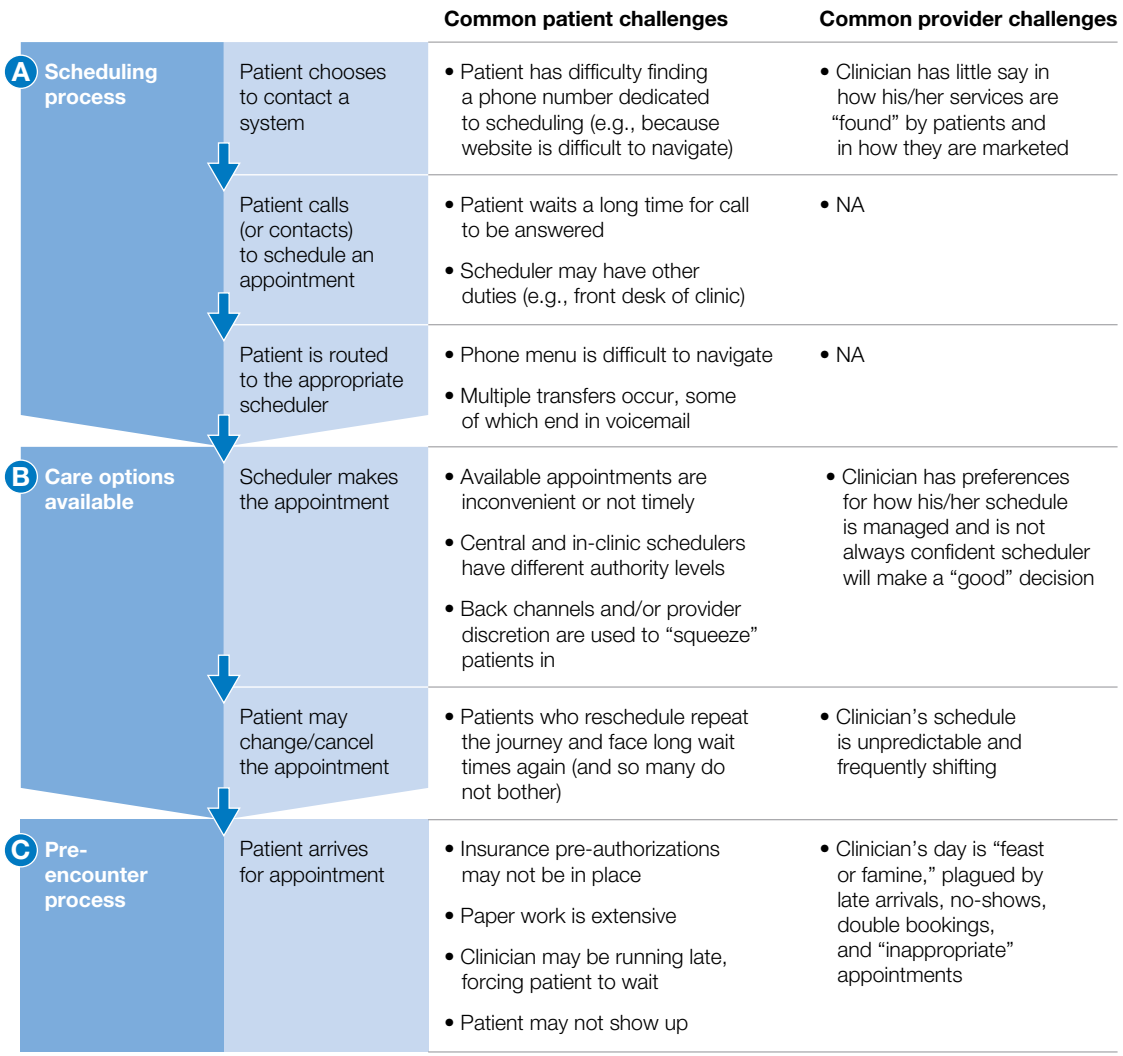
of differentiation. Consumers will demand that provider systems offer them both good basic access (short or no wait times) and more advanced amenities (e.g., convenient online booking, "concierge" access services).

The coming shift toward risk-based models that link payments to cost, quality, and patient satisfaction. Some provider systems are already moving toward care models that require them to take on the risk for managing total patient costs and quality of care. Maximizing the use of existing capacity to offer rapid (e.g., same- or next-day) access to outpatient care is important for keeping patients out of high-cost care settings. Furthermore, successful implementation of patient-centered medical home (PCMH) models requires providers to offer same-day visits, 24-hour nurse lines, and after-hours clinics.

What do we mean by access, and what does 'good' look like?

For patients, scheduling a doctor's appointment can feel like a step back in time. Now that flights and hotels can be booked at the touch of a button, complex banking transactions can be done 24/7 from the

Exhibit 1
A typical access journey.



comfort of home, and almost any consumer good can be delivered within days to one's doorstep, securing a doctor's appointment is often still a labor-intensive, low-transparency process with long wait times.

Access encompasses every step of the "journey" patients must go through in order to engage with a chosen clinician. It includes:

- **The scheduling process:** what channels are available for scheduling (e.g., phone, online); how straightforward and pleasant the process of making an appointment is (e.g., attempts needed, transfers, hold times); how quickly and effectively a scheduling inquiry is addressed; and how easy it is to reschedule or cancel an appointment
- **The care options available:** how many days patients must wait to receive care, and whether the available care meets their needs (e.g., clinician continuity, day of week/time of day, language, gender)
- **The pre-encounter process:** how easy the clinic is to find; how efficient the registration process is; how long patients have to wait beyond their scheduled appointment time to enter an exam room; and how long they have to wait to see a clinician once in that room

Exhibit 1 illustrates a typical patient access journey and describes common pitfalls from both the patient's and provider's perspectives. Exhibit 2 lists the core metrics that define what good access looks like throughout the patient journey. Collectively, these elements determine how patients seek, access, and

Exhibit 2

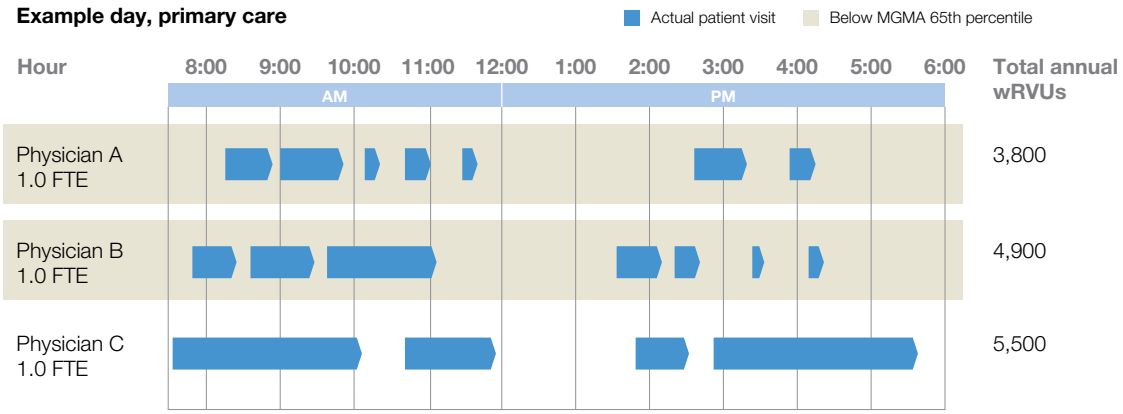
Defining what good access looks like—some indicative metrics.

These should be considered "basic" metrics. Advanced metrics could include provider continuity levels, schedule "fill rate," and unnecessary ER use.

	Access metrics	Example indicators of good access
A Scheduling process	Patient or provider satisfaction with accessibility and navigation ease	90+% satisfaction (measured through post-contact surveys)
	First contact resolution	70+% of cases resolved with only 1 contact
	Abandon rate (phone channel)	Less than 5% of calls disconnected before reaching live representative
	Average speed of answer (phone channel)	80% of calls answered by a scheduler within 20 seconds
B Care options available	Patient or provider satisfaction with appointment time	90+% satisfaction (measured through post-contact surveys)
	Average lag days for new/urgent appointments	7 days or less between scheduling and appointment time
	Next-day access availability for new/urgent patients	90%+ of new/urgent patients offered 48-hour availability
C Pre-encounter process	In-clinic wait time	<15 minutes from scheduled appointment time of time to first contact with provider
	Patient satisfaction with in-clinic experience	90+% satisfaction (measured through post-contact surveys)

Exhibit 3
In many cases, excess clinician capacity exists today.

Typically, >30% of visits do not take place as originally scheduled



MGMA, Medical Group Management Association; wRVU, work relative value unit.
Source: Disguised client example

receive care (e.g., whether they seek care from the "right" channel rather than from a higher-intensity site than is required, such as an emergency department) and whether they will actually attend their appointment.

What it takes to transform access

The primary driver of poor outpatient access, including long wait times, is not lack of resources. In our experience, most provider systems that start evaluating their outpatient performance find that 10 to 30 percent of their clinicians' capacity is unused or under-used (Exhibit 3), yet long patient wait times persist. Thus, the challenge lies not in capacity constraints, but rather in gaining transparency into the true level of capacity supply and demand. Only in this way can the two be efficiently matched—hour by hour and day by day—to maximize the system's performance. However, matching supply and demand is often difficult because of patient behaviors (e.g., no-shows, failure to complete pre-work prior to the appointment), clinician behaviors (e.g., multiple complex scheduling templates, freezing slots), and call center capabilities (e.g., lack of empowerment to make scheduling decisions). As a result, many provider systems think that the challenge is overwhelming and are unsure where to start.

Nevertheless, efficient matching can be done. A provider system that wants to do this on a sustainable basis must have three interrelated capabilities (Exhibit 4). We describe below what it takes to develop these capabilities and transform outpatient access.

Patient-centricity

Provider systems that want both customer loyalty and "efficient" customer behaviors (patients who come at the right frequency, at the scheduled time, and with the necessary pre-work completed) need to make the entire patient journey as simple, pleasant, and user-friendly as possible. Specifically, there are four areas provider systems *must* get right to be truly patient-centric:

No-fuss scheduling. Patients should be able to schedule either by phone (with minimal wait time and great first-call resolution) or online (with 24-hour access and real-time visibility into the appointment

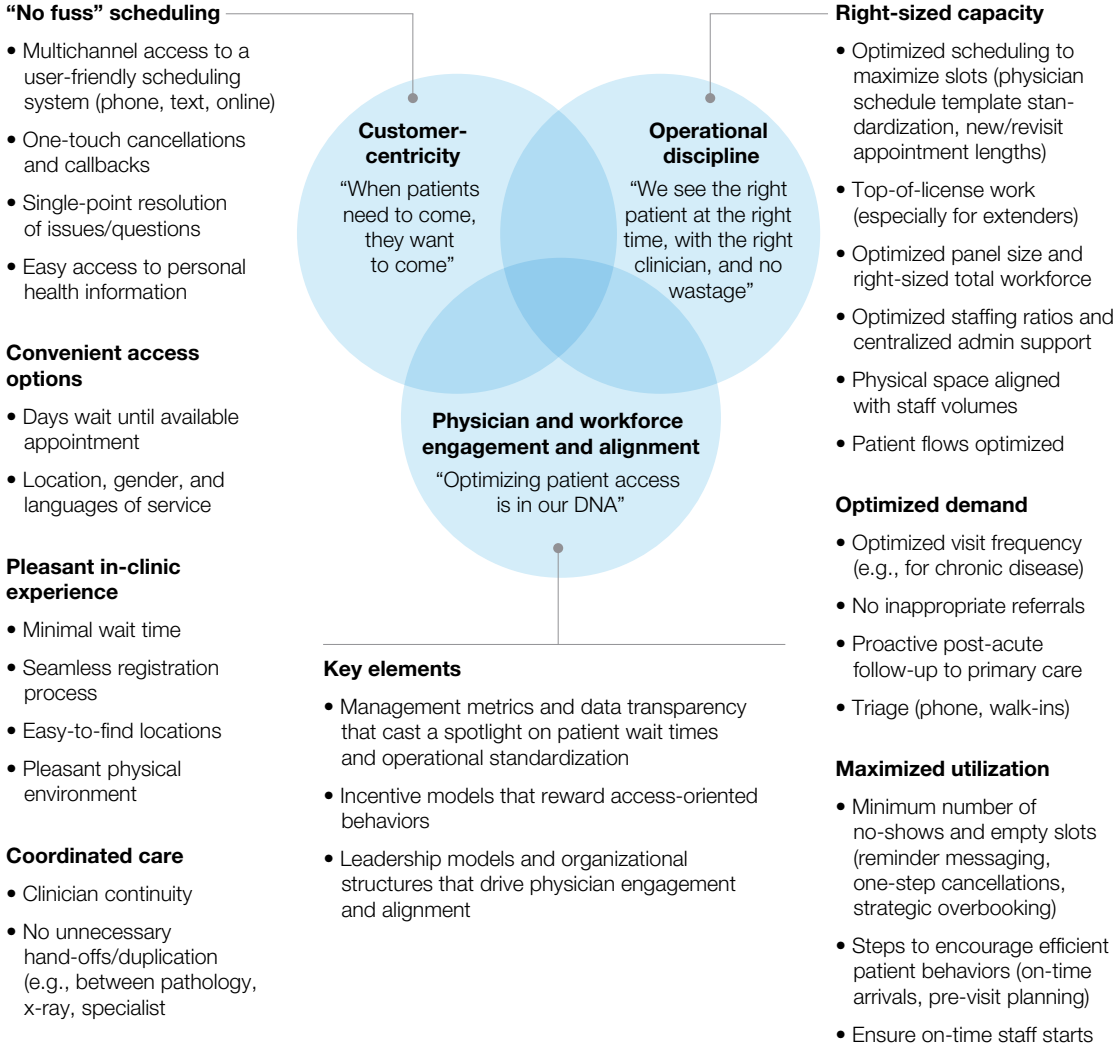
options available). Whenever possible and appropriate, they should be able to see the same clinician. In addition, provider systems should have multichannel reminder notice capabilities (e.g., email, text, voicemail), a streamlined process for cancellations or rescheduling, and advice on transportation and arrival planning.

Convenient access options. Great access goes beyond having a single appointment available within a reasonable time period. It is the ability to offer patients choice in appointment times (e.g., before or after work, on weekends) and other options (such as the ability to specify an individual clinician, the clinician's gender, or the language to be spoken). All of these elements make a material difference to the customer experience and can make the difference between a patient choosing to pursue or forego care in a given situation.

Pleasant pre- and in-clinic experience. The registration process should be efficient and seamless (e.g., patients can complete and store registration details online before their visit). Time in the waiting room should be minimal, and once in the exam room, patients should see a physician promptly. Patients should not be asked to provide the same information repeatedly and should always know where they are in the care delivery process.

Exhibit 4

Delivering efficient, timely access requires three interrelated capabilities.



Coordinated care. Patients should be given assistance to ensure that all necessary pre-work, including diagnostic testing, is completed before arrival. Diagnostic results should be easily transferrable between clinicians, and clinician continuity should be assured whenever appropriate. Innovative (at-risk) care delivery models offer more comprehensive care coordination services, such as transportation for clinician and diagnostic appointments, appointment scheduling for referrals/consultations, and on-site pharmacies.

Operational discipline

The prerequisite to providing exceptional care is a disciplined, efficient operating system designed to optimize patient access. This capability has three key elements:

Right-sized capacity. This is typically the fastest and most direct lever that can be pulled to improve patient access (and practice performance). However, it requires that physicians "offer up" the appropriate number of available appointment slots. In many provider systems today, hundreds of customized physician schedule templates are used, which makes it very difficult to schedule or reschedule appointments, optimize physician productivity, and leverage staff across practices. The customized templates should be replaced by a standardized schedule template rigorously designed to ensure that, for example, set times are allocated for new patient and follow-up visits and inappropriate schedule blocks are removed. We have found that by engaging physicians to update and standardize their schedule templates, 10 to 30 percent additional capacity can be liberated rapidly. Over the long term, this type of physician engagement can enable provider systems to limit in-clinic administrative staff and, in effect, use centralized call centers and online tools to manage schedules.

Provider systems can also increase capacity by ensuring that advanced practitioners, such as physician assistants and nurse practitioners, are used effectively. High-performing physicians should create principles and guidelines for how these practitioners should be utilized (by specialty) to maximize the time they spend practicing "at the top of their license" rather than performing administrative tasks (e.g., entering data into electronic medical records).

Optimized demand for appropriate outpatient care. Physicians and advanced practitioners should make certain they are providing appropriate outpatient care that is in line with clinical guidelines and reduces inappropriate utilization. For example, they should optimize the visit frequency of their patients with chronic disease (e.g., diabetes, congestive heart failure, chronic obstructive pulmonary disease, or hypertension) based on disease acuity to ensure that they are providing appropriate outpatient management and lowering emergency room and hospital utilization.

In addition, they should make sure that their hospitalized patients receive clear, complete discharge instructions and suitable follow-up care. Studies have shown that up to 40 percent of written hospital discharge instructions do not contain explicit outpatient follow-up plans[3] and that 30 to 40 percent of patients do not receive the follow-up care recommended by physicians after an inpatient admission.[4] Our experience suggests that provider systems that proactively address this need double their outpatient follow-up rates and ensure appropriate care for their patients along the care continuum. Developing these capabilities has an added benefit: it prepares provider systems—and the clinicians within them—to participate in population health delivery models (for which these capabilities are essential).

Maximized utilization of appointment supply. Once the schedule templates have been standardized, strategic overbooking can ensure that booking rates compensate for no-show and cancellation rates without creating crunches. At one busy public adult medicine clinic, for example, no-show rates were above

3. Sunil Kripalani et al. Deficits in communication and information transfer between hospital based and primary care physicians: implications for patient safety and continuity of care. *JAMA*. February 28, 2007; 297(8):831-841.

4. Carlton Moore et al. Tying up loose ends: discharging patients with unresolved medical issues. *Archives of Internal Medicine*. 2007; 167(12):1305-1311.

40 percent, yet the clinic did not overbook. The clinic introduced a system in which pods of physicians all double-booked new patients in the same time slots, and "double-shows" were triaged against no-shows so that no single physician faced a crunch. The change increased practice throughput by 35 percent within three weeks.

No-show rates should also be managed with strategically timed pre-visit reminders (e.g., via email, text, voicemail) combined with customer-friendly rescheduling and cancellation options. These tactics have been shown to halve no-show rates quickly.

Exhibit 5 illustrates the type of near-term impact that can be achieved with operational discipline.

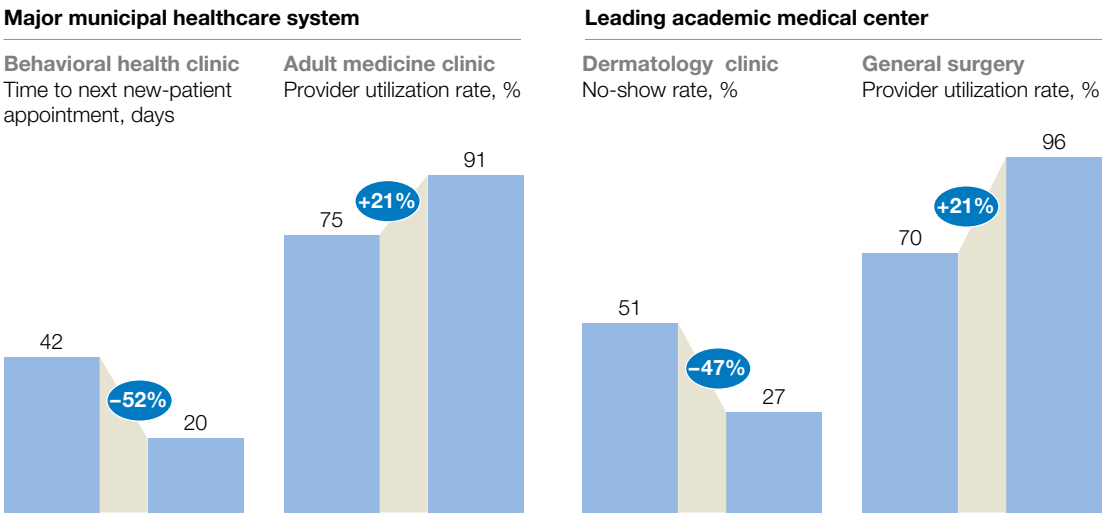
Physician and workforce engagement and alignment

The steps described above require significant operating model changes for most provider systems. Although the transformation steps are easy to describe, they are difficult to achieve because they are so closely entwined with practice culture. Operating model changes will be successful only if implemented in tandem with a fundamental redesign of a system's practice management and incentive models. Three components are necessary:

Management metrics and data transparency. Practice managers and individual clinicians need to have daily visibility into operational, clinical quality, and financial performance metrics (e.g., days to next appointment, patient satisfaction, clinician productivity, schedule fill rates). These metrics should be included in weekly or monthly performance reviews and dialogues.

Improved incentive models. While many provider systems link compensation with overall productivity, access is rarely focused on specifically. (Blunt metrics, such as group or geographic relative value unit averages, do not provide sufficient detail.) To enhance clinicians' attention on access, provider systems should add such metrics as fill rate, patient satisfaction, and standards compliance to their compensation calculations. This change will give physicians (and clinic managers) greater clarity into what is required to achieve optimal access levels.

Exhibit 5
Operational improvement can be both fast and significant.



Source: Representative clinic-level data from two systems that underwent an access transformation

Leadership and change management. It is critical that executives, administrators, and physicians be equipped with the capabilities and skills needed to implement large-scale change and shift culture and mindsets. During such transformations, these groups must have—or develop—both solid technical skills (e.g., the ability to create a playbook on how to construct an efficient schedule template) and strong change leadership skills (e.g., the ability to engage and have difficult conversations with other physicians). It is particularly important to engage selected physicians as leaders of these transformations so that they can model the behaviors required to improve patient access and feel as if they have autonomy over their clinical practice.

The value of getting it right

While the value that can be derived from a transformation focused on improved outpatient access depends on the starting point of each provider system, we have consistently found that most systems improve outpatient profitability by at least 10 to 20 percent within 12 months of launch. The transformation allows the systems to reduce the operating losses of their medical groups and help fund future physician practice growth, as well as capture newly insured patient volume. At the same time, it reduces wait times and improves customer experience and satisfaction. Exhibit 6 provides examples of the financial impact that can be achieved.

Exhibit 6

Access transformation can deliver significant impact within 6-12 months.

Situation and context	Key actions	Impact
Academic medical center launched an outpatient access transformation	• Defined a system-wide, mission-based vision • Optimized central infrastructure (e.g., call center, referral protocols) • Engaged clinics in bottom-up diagnostic and design to achieve system vision • Tracked results and held weekly performance dialogues	• Within 6 months, AMC achieved: ◦ 10% margin improvement ◦ >10% volume increase that decreased wait times and improved utilization
Large safety-net system launched an access improvement program in primary care, specialty care, and mental health	• Baselined performance across practices • Engaged clinicians, schedulers, and administrative leads to set targets and define solutions • Implemented basic scheduling, process flow, and referral practice changes • Tracked results and reviewed them weekly with clinical leadership	• Within 6 months, system achieved: ◦ 15% margin improvement ◦ 36% average wait times reduction ◦ 19% increase in average provider utilization
For-profit provider system improved access and physician productivity across outpatient practices, ASCs, and urgent care	• Developed a web-based dashboard with key access and productivity metrics at specialty, practice, and physician levels • Standardized physician schedule templates • Adopted standard processes to reduce cancel/no-show rates and increase fill rates	• Within 12 months, system achieved: ◦ ~18% margin improvement ◦ Improved customer service and satisfaction levels ◦ Minimized hold times, cancel/no-show rates

ASC, ambulatory surgery center.

Source: Representative results from three systems that underwent an access transformation

Furthermore, a transformation focused on outpatient access provides three distinct advantages that efforts centered on productivity or population health alone cannot offer:

- **Improving patient access is an inherently motivating goal.** Taking a patient-centric approach to reducing wait times resonates strongly with all key stakeholders involved in the transformation: the clinical staff, administrative staff, call center staff, and patients themselves.

- **Improving access can generate near-term results with little up-front cost.** As discussed, an access transformation rapidly produces financial results and reduces wait times. In addition, it can provide early positive momentum to propel other change efforts.

- **The "advanced" capabilities developed during an access transformation create the foundation for success in population health management.** Improved outpatient access is a prerequisite for achieving PCMH status. Provider systems can design the pace and sequence of their access transformation to match any desired transition to broader population health capabilities, while still maximizing the benefits captured under current payment structures.

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For most provider systems, the need to transform the efficiency and effectiveness of their outpatient services is clear. The "burning platform" for change includes both the immediate need to reduce operating losses and the future need to build the capabilities required for effective population health. In healthcare, only rarely do the interests of patients, providers, and payors align. A transformation that focuses on rapidly improving access to outpatient services can achieve that triple win.

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