FEATURE STORY

REPRINT April 2015

hfm
healthcare financial management association hfma.org

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changing the channel

strategies for expanding patient access

The changing healthcare marketplace requires organizations to examine access to care in new ways and to find strategies that can increase opportunities for patients to receive their services.

AT A GLANCE

Among the numerous strategies that organizations can employ to optimize patient access, several align with each of the domains of the patient-access framework:

- Implementing completely open schedule templates, with few restrictions
- Expanding use of patient navigator programs beyond the chronically ill
- Providing increasingly reimbursed telehealth programs in primary care
- Increasing use of comprehensive contact centers

It is time for healthcare organizations to accept that the traditional channels through which they have offered care do not meet the needs and expectations of many patients. More important, it is time for these organizations to do something about it. Offering patients access to the right care at the right time and in the right place is a goal that has long eluded hospitals and physician groups—and, indeed, the entire healthcare system. Readily accessible care is a bedrock requirement for a healthy population, and providing greater access to care and health information also is a critical component of reform efforts, value-based care, and population health management. To truly improve patient access, however, health systems and provider organizations must break down their existing frameworks for care delivery and adopt innovative strategies for redesigning how, when, and where care is provided.

Expanding Access to Retain Patients

The difficulties patients encounter when scheduling same- or next-day appointments for acute care, obtaining medical advice over the phone, and receiving care beyond normal office hours have become a clear source of frustration for them. These difficulties stem from many organizations' use of a decades-old, provider-centric gatekeeper model that clogs the patient pathway with tightly controlled appointment scheduling, restricted hours of operation, and limited numbers of care providers and settings. The inability to receive care when needed all too often drives patients to switch providers or abandon traditional office-based care settings: Physicians report accessibility issues as the chief reason behind patients' decisions to leave for other providers, according to the Altarum Institute Center for Consumer Choice in Health Care.[a] Such findings suggest that accessibility may play an even more fundamental role than clinical competency or other important practice components in determining whether a patient stays with a provider.

a. Altarum, "Fall 2011 Survey of Consumer Health Care Options," October 2012.

Exposed gaps in access are allowing a new wave of nontraditional competitors to flood markets with more convenient, low-cost care options and to lure patients away from traditional settings. Urgent care centers, retail clinics, subscription-based video consults, and phone- or web-based nursing resources are emerging as attractive options for patients who put a premium on convenience. Innovative companies, such as ZocDoc and Nuance (formerly Varolii), are reshaping the patient experience by using technology to help patients select providers, schedule appointments, and interact with care teams in ways that better meet patients' individual healthcare needs.

Losing patients through an inability or unwillingness to remove barriers to care has considerable consequences. Payers are increasingly linking financial incentives—and penalties—to an organization's ability to attract and retain patients and effectively manage the health of populations. As more patients take active roles in managing their care and find an increasing number of options to choose from, healthcare organizations need to respond by exploring new care delivery strategies that expand access and help them to retain patients.

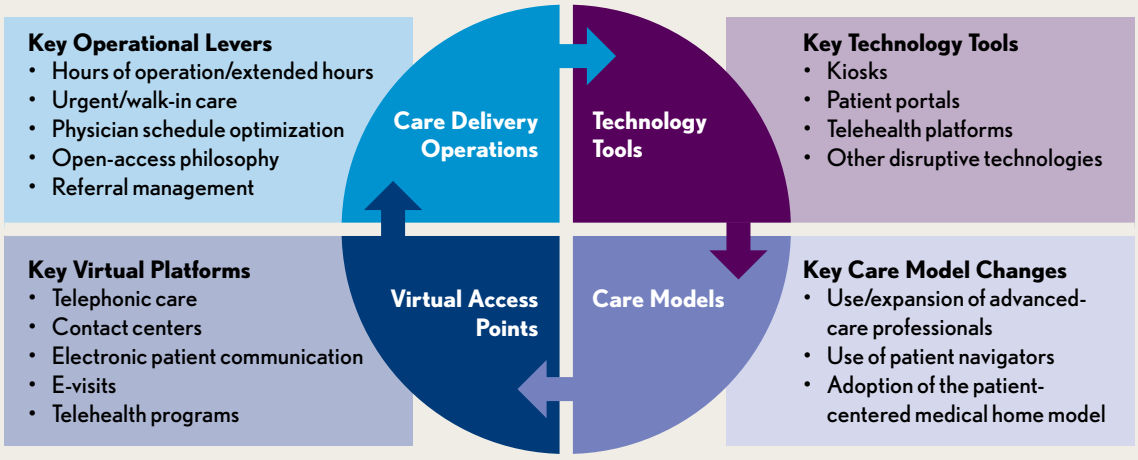
Building a Complete Framework for Patient Access

Designing and implementing care delivery strategies that align with the needs and expectations of patients and payers requires health systems to adopt a holistic view of how, when, and where care should be delivered. Using a complete framework for patient access provides a comprehensive way to organize patient-access issues and identifies opportunities for improvement by highlighting four primary, yet interconnected, domains: care delivery operations, technology tools, care models, and virtual access platforms.

An organization can employ numerous strategies to optimize patient access depending on its needs, capabilities, infrastructure, and technological capabilities. Beyond the laundry list of generally available approaches, certain strategies align with each of the domains of the patient-access framework.

Provide care delivery through open access. An elusive goal for many organizations is the optimization of physician schedules in a way that satisfies physician preferences and offers patients care when they need it. Open-access scheduling is a philosophy that has existed for years but is finding new life in the evolving healthcare environment as a way to balance the competing

PATIENT ACCESS FRAMEWORK



scheduling priorities of physicians and patients. This scheduling approach is based on the use of open schedule templates, few restrictions on appointment types, and the elimination of most future scheduling of appointments. The ultimate goal of an open-access strategy is to provide better service for patients by eliminating scheduling backlogs and allowing same-day appointments.

Some organizations benefit from a strict adoption of the open-access philosophy, but many others may need to modify the approach to create a scheduling structure that better meets patient and provider expectations. A modified approach may include a limit of fewer than five appointment types, standardization of scheduling rules within a specialty, and the allowance of future scheduling based on patient preference. Such modifications tend to improve patient, provider, and staff satisfaction with scheduling while retaining the efficient components of the open-access model.

The financial effects of open-access scheduling can include:

- Reducing no-shows, given that appointments are scheduled in close proximity to their occurrence (decreases of 5 to 15 percent, depending on the baseline)
- Decreasing staff workload associated with rescheduled appointments
- Improving revenue generation by tapping capacity that was previously unused due to inefficient appointment systems. (Open-access scheduling can reduce unused capacity by up to 20 percent, depending on baseline.)

Employ patient navigators. Patient navigator programs are designed to ease patient burdens and confusion by guiding patients through the complexities of the healthcare continuum. The basic role of the patient navigator includes providing support for high-level care coordination through steps such as connecting patients with social and support services, answering general questions about their care, and working with insurance companies. The more advanced roles of navigators are similar to those of case managers, offering assistance along each step of the patient journey. The more expansive assistance may include accompanying patients to initial consultations, tracking treatment plans and medication compliance, and providing after-hours support when physicians or clinical staff are unavailable. Patient navigators are most commonly used in patient-centered medical home models and as part of the care provided for conditions, such as cancer, that require access to multiple specialists.

Investments in the personnel required to perform such care coordination functions traditionally have been made for populations of patients who require chronic care and for whom healthcare organizations have accepted financial risk. Such investments aim primarily to keep patients out of the hospital and secondarily to keep them loyal to the organization.

The proliferation of other value-based payment initiatives has led a growing number of organizations to invest in patient navigators as a way to improve both patient access and care quality, and to contain costs. Navigators are especially important in managed care, which establishes incentives for organizations to control the total cost of care by providing and coordinating services to reduce the high cost of advanced services that may be needed after an untreated condition progresses.

SAMPLE OPEN-ACCESS TEMPLATE FOR PRIMARY CARE

	Traditional Scheduling	Open-Access Scheduling
Appointment types	Multiple types differentiated by specific reason for the visit	Limited types: Long, short, procedure, nurse visit
Master schedule	Pretemplated for each appointment type	Any visit in any available slot
Appointment intervals	Multiple intervals associated with each appointment	Choice of 15/30 or 20/40 schedule
Future appointments	Book appointments far into the future (e.g., 6 months)	Appointments are booked when needed, typically not further out than 2 to 3 weeks

For fee-for-service (FFS) patients, navigators can help ensure needed prior authorizations are obtained for diagnostic testing, medications, and ancillary services, which may limit the financial exposure of the organization.

Annual salaries for nonclinical patient navigators range from approximately $35,000 to $50,000.[b] Those costs require careful evaluation before an organization employs navigators in a predominantly FFS environment. Part of the financial analysis should include the potentially significant financial benefits that navigators may provide among certain populations (e.g., Medicare Advantage, Medicaid managed care) as a growing share of payments are tied to value.

Use telehealth platforms. Telehealth programs range from technically sophisticated e-ICU monitoring systems to pay-per-use primary care visits through video-conferencing technologies, such as Skype. Increasingly, organizations are recognizing that scheduling an appointment three to six weeks into the future is a non-patient-centered approach that is neither acceptable nor adequate for many conditions. The market is offering a growing number of nonconventional solutions to provide easy access to medical advice for acute, same-day needs through phone and web portals. Both health systems and nontraditional provider organizations (e.g., CareSimple, Carena) offer subscription membership plans, as well as one-time services at an affordable flat fee.

Concerns that these services may replace "true primary care" are similar to those expressed about urgent care centers 10 years ago and retail clinics more recently. However, the reality is that the market is demanding quick, easy access to care at a reasonable price. If health systems cannot meet this consumer need, other organizations are demonstrably willing to fill the void.

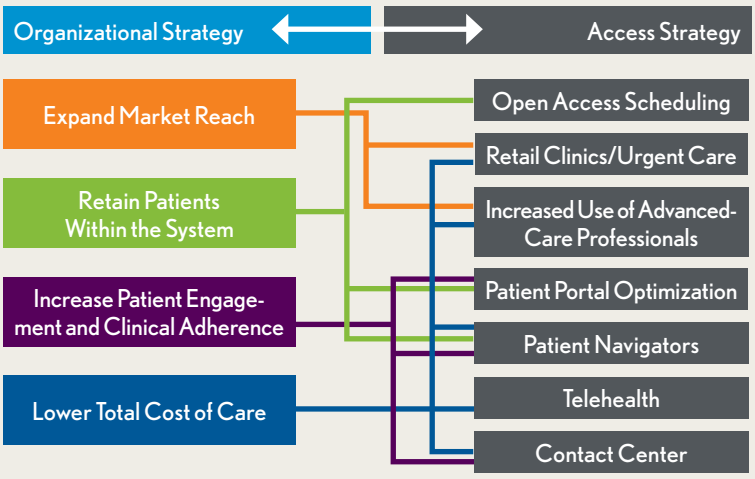
As they do with the expanded use of patient navigators, traditional FFS payments may act as a barrier to the expansion of telehealth. Guidelines issued by the Centers for Medicare & Medicaid Services (CMS) call for these services to be paid only in cases where the originating site is outside a metropolitan statistical area (MSA) or is in a designated health professional shortage area. In addition, the originating site must be a medical facility—and not the patient's home.[c] However, CMS is moving toward paying providers for patient care management activities that do not involve face-to-face contact.[d]

Medicaid programs tend to provide more expansive coverage for telehealth, but regulations vary significantly by state. Twenty-three states do not specify a patient setting or location as a condition of payment; 21 states have parity laws that require comparable coverage and payment to that of in-person services.[e]

Organizations that successfully implement primary-care-based telehealth programs have found that a combination of modest subscription fees and utilization of all clinical personnel at the highest level of their licensure can ease the financial disincentive to provide virtual care.

b. In situations where clinical navigators are required, annual salaries are $75,000 to $90,000.

ALIGNING ORGANIZATIONAL PRIORITIES WITH ACCESS STRATEGIES



c. Centers for Medicare & Medicaid Services, "Telehealth Services," December 2014.
d. Robeznieks, A., "The Right Direction," *Modern Healthcare*, July 13, 2013.
e. Thomas, L., and Capistrant, G., *State Telemedicine Gaps Analysis*, American Telemedicine Association, September 2014.

Offer patient contact centers. Patients face numerous restrictions when attempting to contact caregivers over the phone (e.g., limited hours, having to leave messages, missed phone calls). Comprehensive contact centers (either in-sourced or outsourced) were once reviled as the antithesis of patient-centered care, but organizations are turning to them to manage the increasingly complex task of efficiently connecting the patient to the right provider. Patient contact centers are capable of housing a broad range of services, including clinic operations, postacute care coordination, clinical services, and e-care facilitation.

When utilized effectively, these contact centers provide both clinical and nonclinical support to patients both over the phone and online. Groups with more than 100 providers have found that contact centers can answer patient phone calls more expeditiously and achieve greater levels of service than can multiple care sites. In addition, contact centers that coordinate referral services in a centralized fashion can significantly reduce denial rates and patient leakage. In our experience, organizations that have implemented referral centers within a contact center have been able to reduce payment denials relative to prior authorizations and improve referral follow-through rates. Contact centers also can provide a hub for virtual patient interaction, such as chat functions.

Nonetheless, contact centers typically require significant initial capital, primarily to fund the telephony technology and facilities. Initial investments by organizations that have implemented contact centers have ranged from $500,000 to several million dollars, depending on the size and scale of the operation. A rough estimate of ongoing call-center cost is approximately $1 million for every 500,000 patient interactions, assuming net additions of space and technology are required.[f]

f. Figures are based on ECG experience. Investment varies significantly based on telephony platform selected, whether facility space is available and built within the organization, and whether existing staff FTEs can be repurposed.

The ROI associated with contact centers is provided through:

> Increased appointment fill rates
> Improved patient satisfaction from reduced telephone wait times
> Expanded opportunities for economies of scale in staffing
> Decreased referral leakage
> Reduced denials related to prior-authorization components

Responding to the Patient-Access Imperative

Patients' healthcare needs and expectations are evolving, as are the ways in which payers are reimbursing care and providing incentives for more cost-effective care delivery approaches. Although many industry observers agree that delivering patient care more efficiently and effectively is necessary, successfully expanding access to care requires more than good intentions. It requires fundamental changes in how our system of care is organized. As Henry Ford once said, "If you always do what you've always done, you'll always get what you've always got." Although healthcare organizations are increasing their efforts to improve patient access, many patients are likely to feel that what has been achieved is not good enough. Adequately addressing the health of populations and remaining competitive in the marketplace require healthcare providers and organizations to reexamine their care delivery strategies and embrace new approaches for expanding access to care. ■

About the author

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PATIENT CONTACT CENTER SERVICES

Services provided by patient contact centers include:

> New-patient registration
> Patient appointment scheduling
> Referral management, including preauthorization for services
> Physician on-call support
> Nurse triage and advice
> Outbound-patient outreach for health maintenance (e.g., mammograms)
> Hospital discharge coordination
> Patient portal support
> Clinical and nonclinical chat functions