



Learning and Leading in Access to Care: An Overview of Member Collaboratives from the AAMC and Vizient

Learning and Leading in Access to Care: An Overview of Member Collaboratives from the AAMC and Vizient

April 2019

Authors: Scott Shipman, MD, MPH; Julie Cerese, PhD, RN; Robert Dean, DO, MBA; Cindy Abel, MSN, RN; Nicole Spatafora, MS, BA

Disclaimer: The contents of this presentation are solely the responsibility of the authors and do not necessarily represent the official views of the U.S. Department of Health and Human Services (HHS) or any of its agencies.

The Vizient Practice Transformation Network is 100% funded with federal HHS funds provided by the Centers for Medicare and Medicaid Services Funding Opportunity Number CMS-1L1-15-003, Grant Number 1L1CMS331487-01-00.

The Coordinating Optimal Referral Experiences, or CORE, project was supported by a Center for Medicare and Medicaid Innovation Health Care Innovation Award, Funding Opportunity Number CMS-1C1-14-001, Grant Number 1C1CMS331324-01-00.

This is a publication of the Association of American Medical Colleges and Vizient. The AAMC serves and leads the academic medicine community to improve the health of all. Vizient strengthens its health care members' delivery of high-value care by aligning cost, quality, and market performance. To request additional copies or download copies of this report, visit aamc.org/publications or vizientinc.com.

© 2019 Association of American Medical Colleges and Vizient. May not be reproduced or distributed without prior permission. To request permission, please visit aamc.org/91514/reproductions.

Contents

Introduction	1
Synthesis of Experience and Lessons Learned	2
Access-to-Care Projects by the AAMC and Vizient	5
Transformation of Clinical Practice Initiative (TCPI)	5
Project CORE: Coordinating Optimal Referral Experiences	8
Care Continuum From Acute Episode to Clinic Performance Improvement Collaborative	11
Clinic Utilization: Improving Access to Ambulatory Care Collaborative	15
Ambulatory and Post-Acute Strategies to Reduce Readmissions Collaborative	18
Improving Care Access Through a Virtual Health Care Design Collaborative	21
References	25

Introduction

In the patient-centered vision of health care endorsed by Vizient and the Association of American Medical Colleges (AAMC), access is defined as providing the patient with the right care in the right setting at the right time. In practice, this vision is achieved by delivering high-quality, patient-centered care across the continuum; focusing on coordination of effective care and management of chronic disease; using technology and data to understand gaps and improve care; and conducting risk stratification in team-based care so patients can receive needed care from the provider who is best able to meet their needs.

This report will help leaders of health systems and ambulatory clinics understand several national efforts the AAMC and Vizient have conducted to improve access to care in similar settings across the country.

For the past several years — across numerous projects and collaborative engagements — Vizient and the AAMC have sought data-driven answers to the challenges facing their member organizations. Of course, identifying priorities for how to improve patient access to care depends on the needs of individual health care organizations and their patient populations.

Common approaches to improving patient access to care include:

- Increasing timely appointment availability, ensuring timely appointment scheduling, and reducing missed appointments.
- Optimizing referral rates from primary care to specialists.
- Improving the consistency and quality of communication between providers for better coordination of care.
- Reducing readmissions and unnecessary utilization of services by providing prevention and health-management strategies.

In addition to improving patients' health, better access to quality care improves patient and provider satisfaction and an organization's bottom line by driving more revenue alongside higher-value care.

Synthesis of Experience and Lessons Learned

The efforts of Vizient and the AAMC include the projects and collaboratives in the table below. In each of the six projects, participating health care organizations identified and sought to address challenges in meeting their goals for patient access to care. Academic health systems across the country experience similar challenges. One common challenge was creating a persuasive case for improving patient access. The assumption that all stakeholders, including health care providers, understand and prioritize efforts to improve patient access is not always a safe one.

Project Name	Purpose
Transformation of Clinical Practice Initiative (TCPI)	<ul style="list-style-type: none"> • Move from fee-for-service to fee-for-value environment. • Improve practice efficiencies.
Project CORE: Coordinating Optimal Referral Experiences	<ul style="list-style-type: none"> • Reduce low-value referrals, increase primary care comprehensiveness. • Improve specialty referral consistency and quality.
Care Continuum From Acute Episode to Clinic Performance Improvement Collaborative	<ul style="list-style-type: none"> • Improve patient transitions.
Clinic Utilization: Improving Access to Ambulatory Care Collaborative	<ul style="list-style-type: none"> • Increase appointment availability. • Reduce wait times.
Ambulatory and Post-Acute Strategies to Reduce Readmissions Collaborative	<ul style="list-style-type: none"> • Avoid unnecessary hospital readmission from ambulatory settings. • Reduce overall unnecessary hospital readmissions.
Improving Care Access Through a Virtual Health Care Design Collaborative	<ul style="list-style-type: none"> • Decrease wait times. • Improve patient outcomes in telehealth.

Across all six projects and collaboratives, Vizient and the AAMC have identified five common strategies that are key elements of efforts to improve patient access to care:

- 1. Keep the focus on the patient.** In patient-centered access, the emphasis is on providing the right level of care in as timely a fashion as possible to effectively meet the patient’s needs. Doing so efficiently requires patient risk stratification accompanied by offering flexible services and engaged health care personnel.
- 2. Actively engage providers and create collaborative, multidisciplinary teams.** Efforts to enhance access must consider



the impact on providers and adapt to local culture and conditions. This is best achieved through a commitment to early and ongoing provider engagement. In addition, coordinating and streamlining patient care requires well-developed multidisciplinary teams. Avenues for building engaged providers and strong teams include:

- Ensuring providers work at top of license.
- Involving key stakeholders, including frontline providers, early on and ensuring ongoing efforts to seek their feedback.
- Demonstrating consistent support and clear commitment from organizational leaders.
- Identifying physician champions who can promote organizational efforts to redesign care and improve patient access.

3. Standardize and systematize. Reducing variation in the delivery of care helps health care organizations provide efficient, effective, and cost-effective care. Well-defined and well-understood processes lead to consistent outcomes. Opportunities to standardize and systematize access-related operations include:

- A central scheduling function to get patients to the right care at the first opportunity.
- A coordinating function to help patients through transitions and phases of care and recovery.
- Standardized tools to coordinate and manage referrals to ensure that specialists get the right patients and have the right data when patients arrive in their office.

4. Prioritize data infrastructure and display to focus attention and track progress. The role of data in improving patient access cannot be overstated, given the complexity and number of interrelated factors that inhibit or enable timely access to care. A strategic plan that sets data integrity as an operational priority lays the foundation for tracking and reporting the metrics that are most useful for increasing the value and effectiveness of services. The use of daily visual management boards that show leading and lagging indicators improves staff engagement at the clinic level in continuous process improvement efforts to increase clinic efficiency and access.

5. Leverage technology to adopt innovative solutions. The world of health care is changing rapidly. Society has generally come to expect on-demand service and convenience, and individuals are

more familiar and comfortable with mobile technologies than ever before. Health care must adapt to ensure that access to quality care keeps pace with changing demands and expectations. As health care systems move to value-based care, organizations must seek evidence-based innovations in care that improve access for patients while enhancing value.

The following summaries highlight the projects led by Vizient and the AAMC, along with insights gained from each. They include lessons learned about how individuals and organizations together can help improve patient access to the right care in the right setting at the right time. Ambulatory care leaders should consider these projects in the context of their own health systems and use the examples provided to spark dialogue that moves them closer to achieving access-related goals for their patients and communities. Ultimately, other centers across the country can build on the programs described in this report and use the lessons learned to achieve efficient, effective access to care.

Access-to-Care Projects by the AAMC and Vizient

Transformation of Clinical Practice Initiative (TCPI)

In 2015, Congress replaced the Centers for Medicare and Medicaid Services (CMS) system for professional reimbursement in Medicare (Sustainable Growth Rate, or SGR) with the Medicare Access and Chip Reauthorization Act (MACRA). The intent was to transition from a straight fee-for-service reimbursement schedule to one based on health care value — that is, quality and cost. To help clinicians move to value-based reimbursement, the Center for Medicare and Medicaid Innovation (CMMI) sponsored a demonstration project, the Transforming Clinical Practice Initiative. Through a four-year grant, this initiative recruited clinicians nationwide to participate in transformation networks that would establish goals and processes to facilitate the move to value-based reimbursement. The ultimate objective was participation in Alternative Payment Models (APMs). Vizient, which has the largest Practice Transformation Network (PTN) in TCPI, focused on increasing patient access as one of several ways to improve the quality and cost of care.

What's at Stake?

Innovations in health care, especially strategies for moving from volume-based to patient-centered care, often remain in institutional silos. Without platforms for exchanging ideas and insights, many health care organizations only haphazardly encounter best practices and core competencies that can help them adopt organizational change to improve patient access to care — and to thrive as a business.

Indeed, many health care practices focus on the day-to-day provision of services: opening the doors, staffing the front desk, checking in patients, taking vitals, and maintaining schedules. As a result, many organizations miss opportunities to improve their practice so they can optimize patient health outcomes and see more patients.

TCPI has created a platform for sharing ideas and insights about practice transformation. Through the 29 PTNs, the TCPI community has shared successes and challenges and helped accelerate the move from volume to value for clinicians in the community.

Project Characteristics

As part of TCPI, Vizient provided technical assistance to clinicians, physicians, and advanced practice professionals to help organizations move from a fee-for-service environment to a pay-for-value environment.

In the pay-for-value environment, provider reimbursement is based on what is done and includes quality and cost as factors in its

reimbursement methodology. Priorities for improving clinical care and outcomes in TCPI include reducing readmissions and unnecessary utilization and providing more coordinated patient care with high levels of care-team continuity. TCPI measures *health care value* as the sum of efficacy, safety, and experience, divided by payer costs. Improved patient access affects this formula by improving efficacy, utilization, and patient experience.



Profile of an Upper Midwest Academic Medical Center

An academic medical center (AMC) in the Upper Midwest (UMW) that participates in the Vizient PTN had long patient wait times to see specialty physicians. Patients often had to wait 10 to 16 weeks for a scheduled appointment. Access for new patients to primary care providers (PCPs) was also longer than average. The AMC was losing patients to competing health systems because of the difficulty with access, and it also needed to improve care coordination. Each clinic scheduled its own appointments, which created barriers to access and coordination.

Through a PTN educational event, the AMC learned of another organization in the PTN that had similar challenges and had implemented a centralized scheduling system for all primary care and specialty clinics in its system. With PTN advisors facilitating, the two AMCs carried on discussions and made a site visit to talk with stakeholders about the implementation and change-management steps required to centralize scheduling. The staff of the UMW AMC believed their system could implement a centralized schedule to solve their access problem, but they needed support from their physicians and clinic management.

The leadership had learned that one big barrier to moving to centralized scheduling was the loss of control over scheduling by the individual clinics. Clinic practitioners and management were concerned that centralized scheduling could lead to inefficiencies because it would not be possible to consider physician preference and practice patterns. They feared that either practitioners or patients might have to wait even longer than they had before.

The UMW team addressed this fear at the beginning of implementation by letting each clinic tailor the centralized schedule to its own physician preferences and practice patterns. The team also established regular review of clinic scheduling and operational results. As a result, in the first year, the centralized scheduling system did improve access. The number of new-patient visits to primary care increased by 17%, and specialty new-patient visits increased by 9%. An additional benefit of this change is that case management and care coordination staff now have scheduling visibility that improves their service to patients.

Vizient's PTN efforts include improving care coordination, managing chronic diseases, using data and risk stratification in team-based care, and improving the efficiency of practice operations.

Project Impact

Vizient's PTN successfully enrolled more than 26,000 clinicians by the end of year two of the four-year grant. The PTN is working to reduce all-cause 30-day readmission rates by 7% and has reduced emergency department visits by 10%. Moreover, this initiative aims to reduce unnecessary testing and procedures in participating organizations by 15%. It is on target to exceed the goal of \$320 million in reduced costs by the end of the project period.

Common Barriers

To keep the business running, many practice organizations focus on the day-to-day: scheduling, throughput, documentation in patients' electronic health records, revenue cycle, staffing, prescription renewal, and referral management. Although each is important to the business of running a health care organization, focusing on these concerns too narrowly may limit a provider's ability to identify data-driven opportunities to improve.

Key Take-Aways

- **Patient:** Employ patient-engagement advisors and councils to gather customer input to improve the scheduling and throughput processes of a practice and thereby increase capacity for improved access.
- **Teams:** Increase efficiencies and job satisfaction through efforts to make sure each team member works at top of license. Optimize team-based care to ensure that appropriate practice panels are developed and practice capacity increases.
- **Data:** Track data, including measures such as time to first available appointment, to understand practice performance. Define performance goals and measure practice efficiency to focus the team on improving processes to achieve desired outcomes.
- **Systems:** Engage care coordinators or case managers to guide patients through different phases of care. Use good referral-management systems and centralize scheduling to shorten wait times and improve patient access.
- **Innovate:** Use integrated data scorecards to demonstrate value and isolate opportunities to improve. Leverage IT and software-based solutions that can improve access and patient engagement.

Project CORE: Coordinating Optimal Referral Experiences

What's at Stake?

Unacceptably long wait times and inadequate quality of communication and coordination between providers are common deficits in today's care. Patients bear the brunt of these shortcomings, including gaps and redundancies in care, lower-quality care, and higher costs. For health systems, poor specialty access for outpatients not only creates barriers to high-value care, but it is also bad for the bottom line: it can lead to more patient no-shows, referrals of patients to external competitors, and a weakened position for negotiations with payers demanding timely access for their beneficiaries.

Project CORE was established by the AAMC to support academic medical centers in improving access, quality, and efficiency of care at the interface of primary care and specialty care.

Project Characteristics

In 2014, with funding from the CMMI through a Health Care Innovation Award, the AAMC launched Project CORE at five academic medical centers across the country. Each institution implemented the model systemwide, including at all their adult primary care practices and 15 or more specialties.

Project CORE focuses on improving patient access to care through innovative tools built into the electronic medical record (EMR), along with efforts to ensure better communication and coordination of care between providers. First, participating institutions install clinical tools — called eConsults and enhanced referrals — in the EMR. Then, participating PCPs and specialists engage in active dialogue to establish specialty- and condition-specific templates for eConsults and enhanced referrals, thus creating standard processes for care and common expectations around communication and coordination systemwide. Finally, participants implement quality assurance processes to ensure fidelity to the intended use and effectiveness of these tools.

eConsults enable providers to seek asynchronous specialist input for patients who otherwise do not need to establish a relationship with the specialist or have a face-to-face visit with them. When PCPs need a specialist's guidance but anticipate that they can continue to manage the patient's care, they submit an eConsult order via the EMR and can expect a response within one to three days. eConsults thus promote more comprehensive care in the familiar setting where patients already

receive their primary care. Both the PCP and the specialist receive clinical credit (typically in the form of relative value units (RVUs) for each completed eConsult), which encourages the providers to use an eConsult when appropriate for patient needs.

Enhanced referrals improve the workflow for ordering referrals in the EMR for patients who require a specialist's in-person care. Keys to the enhanced referral include consistently clear questions from the PCP to the specialist, decision support to ensure that PCPs and specialists are on the same page before the referral takes place, and co-management of expectations to clarify the care roles of each provider over time.

The Project CORE implementation process focuses on establishing and strengthening a culture of community and trust between PCPs and specialists. This is achieved through template-design efforts; co-management conferences, which create space and time for dialogue between providers about patients and conditions they share with one another; and regular check-ins to demonstrate an ongoing commitment to meeting the needs of PCPs and specialists alike.

Provider Experiences With the CORE Model

"I was in the process of referring [the patient] to [the] orthopedic clinic; however, with the enhanced referral, it recommended X-rays and an eConsult, which I did. This worked very well and helped prevent an unnecessary referral visit." — Primary care provider testimonial about enhanced referral for orthopedic surgery

"As a dermatologist, I enjoy doing eConsults. Hopefully, this service will lessen the number of patients needing to be seen in Derm Clinic, thereby improving our overall access." — Specialist eConsultant

"eConsult is a great system! My clinical question to Endocrinology was answered quickly, and even included recommendations for further evaluation and guidance for interpreting the tests. I was impressed with the thorough response and fast turnaround. My patient was very appreciative of the ease of the process and the expertise offered by the specialist." — Family medicine resident

Project Impact

More than 16,000 eConsults were completed at the five pilot institutions during the period funded by the CMMI grant, resulting in a marked reduction in referrals from participating PCPs. In some specialties, up to half of all specialty consultation shifted to eConsult, replacing unnecessary in-person visits. Over the three-year course of the project, PCPs who used higher-than-average rates of eConsults showed a statistically significant 13% decline in referral rates to all participating specialties, compared with

their peers with lower-than-average rates of eConsult use. This increase in comprehensiveness in primary care was accompanied by high levels of provider satisfaction with the CORE model.

Adoption of eConsults for low-acuity, relatively straightforward questions led to decreases in specialty visits for patients served by the model and in wait times for patients who did need to see a specialist. Overall, the program led to statistically significant advantages for participating specialties: a 17% reduction in patients' no-show rates, a 5% increase in new patients scheduled, and an increase in RVUs and charges for new patients seen in specialty practices who were referred by PCPs participating in the CORE model.

For patients, Project CORE has provided more-timely guidance from specialists, more-focused and efficient appointments, lower out-of-pocket costs, and the security of receiving more care in their medical home. Indeed, the likelihood that patients received specialty input in 14 days or fewer was 84% higher in the final year of the project than in the two years before the project launched. Patients personally avoided an average of \$100 in out-of-pocket and opportunity costs for every eConsult that averted the need for an in-person visit with the specialist. Further, patient satisfaction surveys demonstrated that patients were just as satisfied with specialist recommendations from eConsults as from in-person visits with the specialist.

Based on the success of the pilot through the CMMI grant, Project CORE has expanded to 27 academic medical centers that implemented the model as of September 2018, with more than 1,600 eConsults completed monthly.

Common Barriers

Challenges included engaging busy PCPs and specialists in co-management meetings aimed at enabling them to discuss their common challenges and care preferences, as well as better ways to share care for patients. The solution to that challenge was typically to build these sessions into standing meetings rather than seeking another new meeting time. For sites with widely distributed networks of PCPs, it was sometimes a challenge to engage physicians who were farther away, especially if they did not feel a particular affinity to the academic medical center despite being affiliated with it. Having physician project leaders travel to those practices helped partially overcome that barrier.

Key Take-Aways

- **Patient:** Improve access by facilitating effective and efficient communication pathways between PCPs and specialists. Reduce patient costs and increase convenience by shifting from in-person specialty care to eConsults when appropriate.
- **Teams:** Engage key stakeholders early and throughout the process. Build a model that is responsive to feedback from PCPs and specialists. Establish and strengthen communication, trust, and a sense of community between providers to ensure buy-in and resilience.
- **Data:** Ensure a high-reliability model of eConsults by having a robust, data-driven quality assurance component. To support sustainability and engage payers to reimburse for eConsults, measure and communicate the impact of the program.
- **Systems:** Improve referral communication and coordination through brief, focused clinical guidance at the point of care using specialty- and condition-specific templates. Set standard expectations for provider communication, including clearly worded clinical questions from PCPs and expected response components from specialists.
- **Innovation:** Embrace a gradual shift away from face-to-face care models when appropriate. Optimize provider-to-provider communication and coordination through the EMR.

Care Continuum From Acute Episode to Clinic Performance Improvement Collaborative

What's at Stake?

Patients with complex care needs who require care across different health care settings are vulnerable to experiencing poor outcomes and readmissions as a result of ineffective transitions of care. Too often, the technology, data, and systems of one provider do not connect with others. In addition, health care providers frequently do not have enough access to the data or the ability to analyze them to see how key strategic changes can yield significant results. One study found that 80% of medical errors involved miscommunication during the handoff between providers. Another found that 20% of patients experience adverse events within three weeks of discharge and the vast majority of those events were preventable.^{1,2}

Project Characteristics

The Care Continuum From Acute Episode to Clinic Performance Improvement Collaborative was a nine-month project led by Vizient, with 14 participating academic health systems. The collaborative's work focused on helping participants standardize the bundled practice of transitioning patients from acute care to the clinic environment, with a goal of reinforcing the right care at the right time in the most affordable setting.

Participating organizations convened a multidisciplinary team from acute and ambulatory settings to develop a care-transition plan that addresses the needs of the patient across the continuum. Care-transition teams often included hospitalists, PCPs, nurses, case managers, pharmacists, and social workers.

Throughout the project, participants shared solutions, policies, procedures, and tools to improve overall transitions of care across the continuum with a specific focus on preventing emergency department revisits and overall readmissions. Measures for this collaborative included 30-day-readmission data, along with the number of patients who had a second emergency department visit within seven days of a previous emergency department visit.

Project Impact

Participating organizations found that improving care transitions not only yields positive results for individual patients receiving treatment but also streamlines organizational operations, opening up more space for other patients to access health care in a timely manner.

Some team members were critical to success. By adding a social worker to the care-transition team, organizations were more equipped to screen for social determinants and successfully connect patients with community resources to help support their care. The inclusion of a pharmacist on the team addressed the importance of reconciling medication upon admission and at discharge. Moreover, giving a voice to these health care providers on the multidisciplinary team led to innovative approaches to care delivery.

Several organizations established relationships with ride-share services or paramedics to transport patients to and from clinic appointments. Organizations also developed medication-to-bedside programs to fill prescriptions, and they provided patient education about their

medication — including why they are taking it, how to take it, and what happens if they don't take it — before discharge as a strategy to reduce emergency department revisits and readmissions.

Timely and systematized follow-up with patients via phone and an in-person clinic visit improved patients' understanding and their ability to adhere to the recommended care plan. One effective practice is to conduct a follow-up phone call within 24 to 48 hours after discharge to check on the patient's condition, answer questions, and establish compliance with the care plan instructions. Organizations used risk-stratification tools to identify patients at high risk for readmission and contacted those patients first. They also developed a process to flag these patients in the EMR for easy identification and prioritization for phone call follow-up. Nurses and residents conducted these follow-up phone calls using a standardized script and template.

It was also important to ensure a patient follow-up visit in the clinic within seven to 14 days after discharge. A successful strategy was to schedule the clinic follow-up appointment when the patient is being discharged from the hospital. With this approach, patients left the hospital with a secured clinic appointment, which helped smooth the transition into the clinic setting.

Community care clinics and discharge clinics — staffed by hospital physicians and residents — were developed for patients who may not have an assigned PCP but needed to be seen after discharge. These clinics are often developed to ensure timely access to follow-up care because it can be difficult to arrange for such follow-up in a primary care or specialist office. Teams that demonstrated success throughout the project had strong, committed physician champions who helped bridge the communication gap between the acute-care team and the PCPs and ambulatory teams.

Overall, the 14 participating organizations had 52 fewer readmissions than projections that were based on baseline rates, thus avoiding \$757,425 in costs. The aggregate results revealed a reduction of 30-day all-cause readmission rates from 11.7% during the baseline period in 2016-2017, to 11.5% after the 2017-2018 intervention. Some organizations that submitted data from several months after the end of the project saw a reduction in their emergency department revisit rates, but, on average, these rates increased slightly, from 9.4% to 9.5%.

Profile of a Southeastern Regional Medical Center

A regional medical center implemented several of the leading practices reviewed during the collaborative. The center focused on improving timely follow-up in the clinic setting and expanding care-management and transition services in the emergency department. For example, the center implemented a clinic appointment hotline with messaging capability for evening and weekend calls and developed a community care clinic staffed by resident and hospital physicians who would see patients discharged from the hospital in a timely manner and according to leading practice. In addition, they embedded a care-management team into the emergency department that included a social worker.

At the conclusion of the collaborative, there was a decrease in the emergency department seven-day revisit and readmission rates. This team had early success in preventing hospital admissions by connecting patients with their community care outpatient clinic and with community resources to support their care. The medical center had an increase in the number and proportion of clinic appointments for high- and moderate-complexity patients.

Common Barriers

Among participating ambulatory clinics and acute health systems, several challenges frequently emerged. For example, initially, it was difficult to identify the ambulatory clinic partners that could support the initiative to improve transitions from the acute episode to the clinic. Identifying a physician champion helped overcome those challenges. Ambulatory clinic stakeholders were included in the redesign of processes, ongoing meetings, and discussions to refine improvements. Clinics often faced challenges integrating EMRs or had limited availability for follow-up appointments. On the patient side, some failed to attend follow-up clinic visits or faced barriers to care stemming from a variety of social determinants.

Key Take-Aways

1. **Patient:** Support adherence to prioritized follow-up — telephonic and clinical.
2. **Teams:** Establish multidisciplinary care-transition teams and assign physician champions. Use staff such as social workers and pharmacists to support coordination of care.
3. **Systems:** Standardize processes including making follow-up phone calls, scheduling appointments, and identifying high-risk patients. Develop an outreach script.
4. **Data:** Use risk-stratification tools to identify and connect with patients at high risk for readmission.

- 5. Innovate:** Use community-based and alternative care-delivery models for follow-up care. Screen for social determinants in the outpatient setting, and involve ambulatory care physicians in hospital committees.

Clinic Utilization: Improving Access to Ambulatory Care Collaborative

What's at Stake?

According to a 2017 survey, it takes an average of 24 days to schedule a first-time appointment with a physician, a 30% increase from when the survey was taken in 2014.³ Despite patient desire — and need — for appointment availability and minimal wait times, getting access to care remains a challenge.

Project Characteristics

The Improving Access to Ambulatory Care Collaborative, led by Vizient, was a nine-month project from July 2017 to March 2018 designed to help organizations understand barriers to patient access and implement strategies to increase appointment availability and reduce wait times.

During the project, teams collaborated with 30 health systems to define their workflows, establish accurate data reports, understand barriers to changing schedule templates, and implement standardized processes and policies that would increase appointment slots and improve productivity. Participants tracked and reported on the percentage of new-patient visits and the percentage of new patients seen within 10 days of scheduling an appointment.

Decreasing patient no-show rates and decreasing provider bumps (appointments rescheduled at a provider's request) were focus areas for many teams, while other teams worked to improve the referral processes within their organizations.

Teams focused on reducing the number of patient no-shows applied several strategies. No-show rates by provider and location were analyzed to identify whether no-show rates varied by day of the week, physician, or location. These data helped teams tailor their workflow and approach to addressing no-shows. Technology enabled automated appointment reminders — both texts and calls. Including a no-show policy in welcome letters to new patients and reviewing the policy annually were believed to be important in reducing no-show rates.

Project Impact

Participants found several ways to increase appointment availability and reduce patient wait times. For example, streamlining and optimizing provider scheduling templates and using risk-stratification tools helped improve patient access to care.

To standardize processes among physicians and providers, participants used dedicated, multidisciplinary scheduling-optimization teams. Core responsibilities of those teams included evaluating scheduling templates, serving as a liaison between clinical and information technology staff, writing reports, troubleshooting, and conducting quality control, testing of new templates, and analytics. Team members also served as trainers and project managers for rolling out new schedules.

Profile of a University Team in the Mountain West

A university team focused on predictive modeling and using data to identify patients at risk and reduce no-show rates. The project's team included a clinic manager, a guest relations specialist, a system-quality leader, an access coordinator, a statistician, an enterprise data warehouse architect, and a business intelligence analyst. The team focused on creating a data warehouse, analyzing the data, and building a reporting tool to track progress. Multiple variables — such as social determinants, previous no-shows, mean wait times for the clinic, and the number of emergency department, outpatient, and inpatient encounters — were included in the predictive model.

The team chose two pilot locations. Each day, the business intelligence tool published a report identifying the 10 patients on the following day's schedule who were most likely to no-show based on the predictive model. A guest relations specialist would call patients from this list to remind them of their appointment the next day and then document in the EMR whether contact was made, whether the patient kept or rescheduled the appointment, and other variables.

Overall, the pilot program showed great results in improving no-show rates during the intervention period. In one location, if no contact was made by the guest relations specialist, or if a voicemail was left, the no-show rate was 28%. If the guest relations specialist connected with the patient, the no-show rate dropped to 11%, a 60% improvement. If a patient needed to reschedule, the team found that they were able to fill the next day's appointment with a waiting patient 80% of the time. The guest relations specialist was able to contact 47% of the patients selected to receive a call. The overall effect of risk-stratifying patients was positive, as the practices were able to identify patients more likely to no-show and focus on contacting them, which eliminated the need for making lower-yield calls to all patients.

Although the specific focus of these teams varied from organization to organization, several components were consistent across successful teams, such as (1) including an internal expert on the EMR scheduling platform, (2) ensuring that someone from the clinic's administration is on the team, (3) assigning a physician champion to support the team's efforts, and (4) having strong support from senior leadership. In addition, these teams were successful when data sharing was transparent, processes were clearly and simply stated, a strong quality assurance process was in place, and regular team meetings were held to review the revised schedule.

Over the nine-month study, collaborative participants increased clinic revenue by \$90,178 total. Participating institutions that self-reported data saw a 16.3% increase in the number of new patients seen, with eight out of 10 showing improvement. Participants demonstrated an 8.8% improvement in the percentage of new patients seen within 10 days of the date on which their appointment was scheduled.

Common Barriers

The collaborative had to overcome common barriers such as providers unwilling to revise or standardize processes. Some were hesitant to change the organizational culture, and others were unable to adhere to scheduling protocols. Technology was also a common barrier, with many health systems lacking accurate data or otherwise unable to use technology to improve scheduling processes.

Key Take-Aways

- **Patient:** Use data from the clinic to identify and anticipate patients at risk of no-show, and proactively backfill appointments.
- **Teams:** Ensure that multidisciplinary teams collaborate effectively through regular touchpoints, and assign physician champions.
- **Data:** Start with two to three clearly defined access metrics that are assessed consistently across providers.
- **Systems:** Create a systemwide provider-bump policy with a formal process to request and approve provider bumps.
- **Innovate:** Use risk stratification and predictive analytics to identify and contact high-risk patients.

Ambulatory and Post-Acute Strategies to Reduce Readmissions Collaborative

What's at Stake?

Readmissions cause a huge burden to health care systems, and each year nearly one-fifth of Medicare beneficiaries discharged from a hospital — totaling 2 million — return within 30 days.⁴ Medicare beneficiaries with more than five chronic conditions have a readmission rate nearly three times higher than beneficiaries with one or no chronic conditions.⁵ For each readmission, patients experience greater exposure to hospital-acquired conditions and pay more out-of-pocket. Readmissions put health care providers in a reactive rather than a preventive posture toward patient care. As health care systems continue the transition from volume to value, readmissions undermine the ability to meet quality targets and mitigate penalties.

Project Characteristics

The Ambulatory and Post-Acute Strategies to Reduce Readmissions Collaborative, led by Vizient, helped organizations identify groups of patients to apply strategies to reduce readmissions across acute, post-acute, and ambulatory care settings. The majority of participants aligned their focus areas with national priorities. Members identified patient populations that align with Medicare's diagnosis-based, penalty-focused populations of patients with heart failure, chronic obstructive pulmonary disease, or pneumococcal pneumonia. They also looked at groups of patients who were discharged to skilled nursing or home health.

Reducing readmissions requires a multifaceted approach. Understanding the data is the necessary first step. The collaborative helped organizations identify who is at risk of readmission and used a whole-person approach to understand the causes of utilization — in particular, the role social determinants play in health care outcomes and readmissions. People spent time analyzing the readmissions patterns and identifying patients at risk of high utilization. Traditional, diagnosis-based readmission-reduction strategies were combined with whole-person transitional-care strategies focusing on the individual's unique social determinants of health.

A second necessary step is to understand at-risk patients' needs and address them with strategic use of an organization's assets. For example, an organization may develop flags in the EMR for high-risk patients to help providers risk-stratify patients across care settings. Similarly, organizations can establish partnerships with community resources to connect patients to local services that provide support and

meet needs beyond clinical factors. Finally, organizations can develop relationships and collaborative partnerships with post-acute providers to ensure that patients' care plans and follow-up care are managed wherever the patient seeks care, from inpatient to ambulatory settings.

Strategies for reducing readmissions involved (1) ambulatory care models and population health strategies with a focus on the impact of social determinants, (2) multidisciplinary, multilayered care-team approaches, and (3) technological advancements such as remote monitoring and telehealth. Performance indicators include seven-, 14-, and 30-day unplanned readmission rates and 30-day emergency department revisit rates.

Profile of a Mid-Atlantic Academic Medical Center

An academic medical center located in the Mid-Atlantic developed a framework for identifying high-impact ways to address readmissions. One low-cost, effective intervention this organization pursued was to establish a community program using emergency medical personnel to address a lack of resources for navigating and following up with patients' post-acute care. With a multidisciplinary team and post-acute partners, a real-time patient-identification, needs-assessment, and communication plan was put in place.

A pilot study was conducted with paramedicine emergency medical service providers visiting patients with a primary diagnosis of congestive heart failure who had been discharged to home or home health. The pilot began in April 2017, and the average 30-day readmission rate for patients participating in the program was 10%, which was 50% better than nonparticipants' readmission rate. A year later, in April 2018, average 30-day readmission rates for patients enrolled in the pilot study decreased by 1% compared with an increase of 40% for nonparticipants.

Project Impact

As part of the collaborative, participants engaged stakeholders throughout the organization and among patient and family advisors and demonstrated buy-in from the highest levels of system leadership. Their efforts identified several tactics and strategies for reducing readmissions.

A population routinely identified as one to focus on was high utilizers, defined as patients with a targeted condition admitted more than five times in a year. To define root causes and understand whole-person needs and the unique characteristics of high utilizers, teams conducted in-depth patient interviews. The powerful findings from the interviews were shared with a multidisciplinary team that designed a comprehensive transition-of-care plan to address the care needs of individual patients. The multidisciplinary teams consisted of navigators, pharmacists, social workers, dietitians, nurses, physicians, and palliative care providers.

Another population identified as one to focus on was post-acute-care patients. To improve transitions of care for this population, participants developed strategic partnerships with post-acute-care providers, such as skilled nursing facilities, home health services, rehabilitation facilities, and long-term acute-care hospitals. Targeted interventions included completing follow-up phone calls, conducting warm handoffs with circle-back techniques, and reinforcing the treat-in-place approach. These partnerships established a forum for ongoing education, discussions of leading practices to reduce readmissions, and data sharing to help drive quality improvement. The partnerships also established a culture of shared ownership and created a trusting environment for transparently sharing opportunities for improvement.

In addition to demonstrating the benefits of expanding post-acute-care and community partnerships, the collaborative demonstrated the value of extensive patient education and outreach. Specifically, the use of navigators during and after discharge — for managing transitions across care settings, making follow-up phone calls with patients and families, and coordinating ongoing care plans — helped decrease the number of patient readmissions.

Profile of a West Coast Academic Medical Center

An academic medical center on the West Coast has automated a referral process by developing an EMR queue managed by population health care managers. When patients are discharged from a network skilled-nursing facility, the population health care managers implement transitional-care workflows to link the patients with their PCP. Patients receiving transitional-care services after hospital discharge are tracked in a transitional-care dashboard and a skilled-nursing-facility dashboard. The transitional-care dashboard tracks discharges, primary care phone calls completed within two days of discharge, and primary care visits completed within 14 days of discharge. Within a six-month period, the number of patients receiving no follow-up visit with their PCP decreased from about 250 to 125, or 50%. The skilled-nursing-facility dashboard tracks referrals, acceptances, and placements by payer. It also looks at discharges, emergency department visits within 30 days, and 30-day readmission rates by skilled nursing facility.

Areas identified as opportunities for further analysis include evidence-based risk assessments, care-transition infrastructure, and advanced analytic approaches to address social determinants of health.

Common Barriers

Issues faced by participating organizations include unavailable or unclear data or methodologies for identifying high utilizers, which made identifying the key opportunities for keeping them out of the hospital more difficult. In addition, patients faced challenges including a lack of transportation, housing, and access to behavioral health resources.

Key Take-Aways

- **Patient:** Connect patients with community resources that can support their care plan.
- **Teams:** Establish multidisciplinary teams to support transitions-of-care plans, including navigators and social workers, to identify interventions based on the causes of high utilization.
- **Data:** Track readmissions over time and across settings, and address causes of high utilization based on a whole-person model of care.
- **Systems:** Connect patients with cross-continuum providers, community resources, and post-acute-care providers to support and meet shared goals for patients' care plans.
- **Innovate:** Develop a predictive method for identifying those at risk of becoming high utilizers.

Improving Care Access Through a Virtual Health Care Design Collaborative

What's at Stake?

In a time when employee health benefits are being cut, many employees see telemedicine as an added modern and convenient health care benefit. Ninety-six percent of all large employers indicated they will make telehealth services available in states where it is allowed, and 56% plan to offer telehealth for behavioral health services.⁶ Telehealth offers a promising approach to improving convenience and accessing care for patients. In response to growing demand, health systems are increasingly exploring and investing in telehealth services.

Project Characteristics

The Improving Care Access Through a Virtual Health Care Design Collaborative, led by Vizient, focused on maximizing efficiencies across primary and urgent ambulatory sites of care by using virtual technologies to decrease wait times and improve patient outcomes. To help design the initial program structure and development, collaborative participants

engaged a multidisciplinary team, supported by executive leadership, of clinical leaders and people working in information technology, finance, quality and risk management, credentialing, security and compliance, and patient experience.

Key performance indicators included the number of virtual visits per provider hour, telehealth wait times, the time from patient initiation of a virtual visit to the time they are connected with the provider, and the clinician and patient satisfaction scores. Throughout the collaborative, participants used those data to recognize and target opportunities for improvement, such as bridging primary care delivery gaps and providing timely and convenient access for all patients, especially in rural populations.

Profile of an East Coast Academic Health System

A major urban university participating in the collaborative focused their project on making virtual urgent care available to new and existing pediatric patients. This required developing a process enabling parents and guardians as health care proxies to access a patient's health record using a virtual process. The team's goal was to remove the barrier of requiring the proxy to be physically present at an ambulatory clinic or practice location to sign the consent forms granting the proxy access to a patient's health record.

The university team developed and implemented a mobile scheduling app for virtual urgent care visits for parents and guardians who had already granted proxy access. The team also established a patient access call center to help schedule virtual visits for proxies who had not yet been granted access as a patient proxy.

Marketing has been a large focus for this team. The team has marketed to existing patients through their patient portal while being conscious about not exhausting their audience with an overload of promotional efforts. The team has seen some early return on investment for their virtual urgent care services. This effort is ongoing, and continued growth in virtual health adoption by patients is anticipated. The program will also measure patient satisfaction results as it grows.

Project Impact

Successful virtual health care models shared several characteristics:

1. The team of stakeholders had to choose a technology platform, an operational model, and metrics for evaluation and assessment.
2. The virtual health strategy needed to align with the organizational goals and the regulatory landscape, and facilitators needed to understand reimbursement, compliance, and licensure requirements for telehealth services.

3. Collaborative participants used certain techniques to get physicians to adopt and accept the virtual health strategy. For example, physicians were included in the planning discussions and were asked to provide clinical input into how to improve the process and the program goals. Similarly, designating a physician champion to lead the virtual health and broader access initiatives with the clinical team was crucial to the success of the program.
4. A long-term marketing strategy was key to keeping access initiatives top-of-mind for patients and providers alike. To further increase program visibility and ease of access, some participants used mobile apps to remotely monitor patients and installed kiosks in community locations where patients could engage remotely with the sponsoring health system.
5. Given the complexity and challenges of implementation, virtual care efforts were most successful when they were closely tied to the health care system's strategic plan. This helped ensure that necessary resources were allocated and that leadership was aligned to support virtual care efforts.

Preliminary baseline data suggest that the variability in the volume of virtual health visits may be related to how robust or mature an organization's telehealth program is. To measure this, in addition to collaborative-specific metrics, one organization has been tracking the number of new mobile app downloads. The number of new accounts established within their virtual urgent care app has also been tracked to gauge patient awareness, satisfaction, and access and marketing success. During a recent eight-week marketing campaign, there were 200 new app downloads and 100 new accounts were created. The organization has seen a 38% increase in urgent care video visits and a 48% increase in app enrollments since the campaign launched in September 2018.

Common Barriers

Barriers to improving health care access through virtual care include shortcomings in the system's technologies, infrastructures, partnerships, and virtual services. Also, although video visits provide an alternative venue for care, the necessary resources and support may not be available. Each organization had unique provider and consumer challenges to improving technology integration, restructuring programs, developing a growth strategy, or aligning provider incentives.

Key Take-Aways

- **Patient:** Allow patients to register themselves for services and provide robust online support for customers.
- **Teams:** Identify a physician champion with influence and a passion for patient access to health care.
- **Data:** Engage stakeholders in identifying metrics for evaluation and assessment, establish a baseline, and conduct assessments at regular intervals to identify gaps and opportunities for improvement.
- **Systems:** Proactively check network connection to avoid disruptions to service.
- **Innovate:** Develop a governance structure for virtual services.

References

1. AHRQ. Readmissions and Adverse Events After discharge. PSNet (Patient Safety Network). Agency for Healthcare Research and Quality website. Published June 2017. psnet.ahrq.gov/primers/primer/11/readmissions-and-adverse-events-after-discharge. Accessed May 3, 2018.
2. Riesenber LA. Shift-to-shift handoff research: where do we go from here? *J Grad Med Educ*. 2012;4(1):4-8. doi:10.4300/JGME-D-11-00308.1. www.ncbi.nlm.nih.gov/pmc/articles/PMC3312531/. Accessed May 3, 2018.
3. Merritt Hawkins Team. Survey of Physician Appointment Wait Times. Sept. 22, 2017. www.merrithawkins.com/news-and-insights/thought-leadership/survey/survey-of-physician-appointment-wait-times/. Accessed March 15, 2019.
4. American Hospital Association. Examining the Drivers of Readmissions and Reducing Unnecessary Readmissions for Better Patient Care. www.aha.org/guidesreports/2018-02-09-examining-drivers-readmissions-and-reducing-unnecessary-readmissions. Accessed March 15, 2019.
5. Lochner KA, Goodman RA, Posner S, Parech A et al. Multiple chronic conditions among Medicare beneficiaries: state-level variations in prevalence, utilization, and cost, 2011. *MMRR*. 2013;3(3). doi: 10.5600/mmrr.003.03.b02.
6. National Business Group on Health. Large U.S. employers project health care benefit costs to surpass \$14,000 per employee in 2018, National Business Group on Health Survey finds [press release]. August 2017. businessgrouphealth.org/news/nbgh-news/press-releases/press-release-details/?ID=334. Accessed March 7, 2019.



**Association of
American Medical Colleges**

655 K Street, NW, Suite 100, Washington, DC 20001-2399
T 202 828 0400
aamc.org



Vizient
290 E John Carpenter Freeway, Irving, TX 75062
T 972 830 0000
vizientinc.com