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KATE BASTINELLI, HOST:

Welcome to P*erspectives*. I'm Kate Bastinelli from the Greater New York Hospital Association. I'm joined by my GNYHA colleague Carla Nelson, who will interview Doctor Scott Shipman, Director of Clinical Innovations and Primary Care Initiatives at the Association of American Medical Colleges. Today, we will discuss ambulatory care specialty access, including challenges, strategies to overcome them, and necessary leadership engagement and policy changes to support improvements.

Let's get started.

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CARLA NELSON:

So before we dive in, can you tell our listeners what we mean when we say ambulatory care specialty access?

DR. SCOTT SHIPMAN:

Sure, I suppose it makes sense to be sure we're talking about the same thing here today. So when I think of ambulatory care specialty access, I'm thinking about access for patients, and primary care providers by extension, to specialty care in the clinic setting, in the outpatient clinic setting. Traditionally, physician offices or the like would be what I'm thinking about here, so not so much urgent care centers, or ERs, or other places that are indeed ambulatory, really thinking about the clinic office space and visits therein.

NELSON:

That's helpful context, and if I could boil it down, I think what we're talking about today is timely access, right? The time from referral to when the patient either gets their appointment or attends their appointment, depending on how it's measured, and also the effectiveness of that referral, and that might mean communication between the providers, the information that goes between them. And I think those are the two things that are really the context for today. So, could you tell us a little bit about your role at the AAMC as it relates to specialty access and the work that you and your team have done in this space?

SHIPMAN:

Sure, I work in the area that is focused on health care delivery, principally other parts of our organization focused more on medical education, or research, or policy. I'm focused more on working with health systems and working with them to optimize care delivery models, and in many cases that means redesigning those models to be more efficient and/or effective. Within that we have done work focused on how team-based care models in the outpatient clinical setting, in the ambulatory setting, can be made more functional

to improve access to care, to improve comprehensiveness of care in the primary care setting, for instance, to improve efficiency in any clinical setting.

We've done work through an effort called Project CORE, which stands for coordinating optimal referral experiences to help to offset some of the demand for referrals through the use of e-consults, and to aim to standardize and improve the quality of information being exchanged between the primary care provider making a referral and the specialist. And we've worked with dozens of large health systems around the country implementing that model.

Our work in Telehealth is, in many respects, very much focused on optimizing access and enabling the convenience and effectiveness of Telehealth technology to serve access needs of patients and providers. And then, perhaps most specifically, we've done some work looking at best practices in academic health systems around the country as it relates to efforts to improve timely access for patients to clinic visits.

NELSON:

Thank you for that. We have an expert here on this topic so we know from our members at Greater New York that specialty access is a challenge and that it's very complicated. It's impacted by many variables, like demand, provider availability, incorrect referrals, no show rates. Is this consistent with what you see in the medical centers that you work with across the country and what are some other challenges that you've seen in your experience?

SHIPMAN:

Absolutely, those factors are pertinent to these challenges, and I will say that specialty access is a huge challenge for almost every health system in almost every specialty across the country. And it does come down some level to supply and demand. So thinking about the demand side of it, the first thing you mentioned, referral rates in the United States have been on a steep upward climb for years now with referral rates doubling in just a decade in recent years. And the supply has not kept pace with that growth, and so the simple math is that the demand is growing faster than the supply.

Supply, or availability, comes down to a variety of factors, most obviously, it's the workforce, the number of providers that you have. Beyond that, there can be a great deal of variability in the clinical effort that providers have. So you can't just do head counts and understand clinical availability, because in academic settings, specialists often have other responsibilities, whether they're teaching, or administrative, or research on top of their clinical responsibilities. And then even within clinical time, there can be variability, which we think is one of the problems that often makes solutions to access challenges evasive, and that has to do with variability in scheduling, templates, and availability.

And then finally, a factor that affects access is the prevalence of new versus established patients in a specialty practice. So, if specialists are seeing patients back recurrently, sometimes appropriately, sometimes because they're not sure whether they can send the patient back to primary care in many cases. That ultimately gums up the works for access for new patients to get in and makes new patients wait longer because those slots are already taken up by patients that are established in the specialty practice. So all of those factors affect availability.

You mentioned no shows, and our research has shown that as wait times increased, no shows increase. So it's sort of a circular problem. No shows are obviously problematic because that's a potential space for someone to get care that's needed that ends up being wasted, and there's a lot of efforts that health systems use to try to reduce no shows, or at least identify patients who are likely to be no shows in an effort to either over schedule their providers or have the patients actually show up. There's lots of factors that can drive no show rates up, but they are problems that are pervasive everywhere.

NELSIN:

So I want to go back and dig into the piece that you were talking about where patients might stay with their specialist, right? We know that sometimes they don't return back to primary care, and we talk about that a lot in our own conversations in the context of provider communication and improved referral communication. So can you talk a little bit about that? The importance of the provider-to-provider communication in improving specialty access.

SHIPMAN:

In today's way of practicing medicine, primary care providers and specialists rarely interact with one another, rarely know one another, and therefore really don't have an understanding of what preferences are around managing patients, and capabilities are for managing patients. When primary care provider today refers a patient, whether it's through a fax or through an order in the medical record, they're often putting very limited information in there about the reason for referral, let alone any information about what they perceive the specialist role should be longitudinally, whether they're comfortable having the patient sent back to be managed by primary care after that referral, or whether they're hoping the specialist will kind of take over management of that.

Specialists who are trying to make sure that they're providing good care for patients, and also who are often trying to be good stewards of the relationships that they do have with referring PCP's, don't want to dump on the PCP and send patients back that the PCP is uncomfortable managing. That's not good for good patient care if the patient doesn't have high quality management going forward, and it may be that that PCP, if they wanted the specialist to continue to manage the patient, would find a different specialist in the future if the patient sent back.

We've had some research done at a couple of different institutions, one at UCSF, looking at adults, and one at Dartmouth Hitchcock, looking at children, asking primary care docs and specialists for actual patients who are being managed longitudinally in the specialty practice. Whether these patients could be managed exclusively in primary care. And up to a third of patients who are managed chronically in specialty practices in these two examples, both the PCP and the specialists have agreed that the patient can be managed exclusively in primary care. And yet, because they never talked to each other about this, the patients continue to be seen in specialty care.

If you're looking at practices where up to 80% of patients that are scheduled are established patients with a specialist, that means that at baseline only 20% of available visits are available for new referrals coming in. If a third of those established patients, both the PCP and the specialist agree could come back to primary

care for ongoing management, that would free up a ton of capacity overnight for the specialty practice for new patients to get in. But because we don't have effective mechanisms for the PCP and the specialist to communicate those preferences, or that appropriateness, it doesn't happen.

So I think it's a really important area that's a really complex one, because not only are there the disconnects in communication between the PCP and the specialist, there's also patient considerations and patient demand that fact in here, and there has to be a degree of ensuring that patients are comfortable with the plan to return to primary care.

So it's not that it's an easy problem to solve, but it's such an important one with such capacity for being a problem solver with timely access challenges.

NELSON:

It seems to me that when we're talking about hospitals and health systems that do share an electronic medical record, for example, or may be located very close to one another, the primary care and the specialties are located close to one another, and they share email domain, it seems that there's opportunity in this setting to make improvements and to get at some of these issues that you raise about patients being seen longitudinally in the specialty setting. So, what can hospitals focus on to make improvements there? What can they do?

SHIPMAN:

Part of the need is to have data that allows them to understand the scope of the opportunity. Most health systems, but not all, are routinely looking at things like established-to-new ratios of patients by specialty and by provider to see if there are particular outliers where there's a greater than average opportunity to either better understand the problem or target solutions.

I think beyond the data there is a need for really a systematic approach and a standard approach to ensuring the possibility at least for effective communication between PCPs and specialists. Some of that's cultural, some of that setting expectations, some of that has to do with leveraging the EMR to facilitate ease of use. Most clinicians don't think of ease of use when they think of the EMR, and so we need to help to streamline clinical workflows in the EMR around referrals.

And then I think there needs to be pathways for effective direct provider-to-provider dialogue around patients. Some of the work that I mentioned in Project CORE that we do aims to specifically do these things working with PCPs and with specialists equally to identify where those opportunities are and use the EMR and the referral communication as a specific means to optimize clarity and align expectations between PCP and specialists, both about what's needed when a referral happens, as well as where patients should be managed longitudinally.

NELSON:

I'm so glad that you mentioned that work, that's exactly what we've been working with you on, and a handful of our members. And I've seen first hand the benefits of some of these conversations when you bring the

PCPs and the specialists together to talk about their pain points and potential opportunities. And it's been really amazing to see the solutions that they come up with and the agreements that they come to, that they might not have otherwise done absent these meetings and this initiative. So I'm glad you mentioned that.

SHIPMAN:

And I might just underscore the importance of that. As simple as it seems to get PCPs and specialists in dialogue about these issues and opportunities for improvement, it almost never happens unless we really focus on the issue and prioritize the issue. I'm not talking about the return to primary care for patient issue here, I'm talking about the alignment of expectations and the quality of communication and coordination between primary care and specialty care.

It's almost an afterthought today, unfortunately, and the practice of medicine is so busy for everyone and everyone's trying to meet the backlog of patients that they have, and meet or view expectations, and all these things that are a real part of practice today.

But because of those things, we don't have relationships between primary care and specialty care, we don't have the space for understanding where care is breaking down that simple conversations could often solve. So making the time, and having the place and space for that communication between primary care and specialty care—and it's not a one-off deal, there needs to be sort of an opportunity for ongoing revisiting perspectives of PCPs and specialists to make sure that the needs of both are being met as effectively as possible.

NELSON:

It's a perfect segue into the role of leadership and how hospital leadership can support this. And I know that AAMC and your colleagues at Vizient published a framework for optimizing ambulatory access and described an engaged leadership. So what does this mean and what recommendations do you have for hospital leadership that want to improve specialty access for patients?

SHIPMAN:

Engaged leadership really is an important driver of an effective culture as it relates to optimizing access in ambulatory care. The leadership needs to recognize that the signals that they send to providers, to administrators, to staff as it relates to access being a priority, translates into all of those levels of a health care system, equally prioritizing access. And along with it being a priority, there have to be the necessary resources, often driven by leadership, to enable the space for primary care and specialty care providers to come together.

The taking a half hour or an hour to have dialogue on a recurring basis, or that you don't generate revenue during that time, it does really matter, and there are downstream benefits that will create ROI.

The other places that leadership are critical around access are really setting the system strategy around access, and that involves resource allocations certainly, but it also involves understanding where clinical redesign efforts are needed to help to optimize access. Continuing to just push harder on the same model

that has been ineffective at enabling access is not going to enable access, it's just going to get people burnt out. So needing to step back and understanding that there needs to be a strategy for optimizing access.

And then leadership at the top needs to make sure that there is an accountable substructure of leadership really focused on access and optimizing access with accountability to metrics that are clear and prioritized by the leaders and measured by those who are accountable for access. The places that we've seen that have done the best job in optimizing access have a very clear infrastructure for access leadership within the organization, whose job it is to set the standards for access goals, and then have the resources needed to put those changes into place, and then hold the providers and staff, etc. accountable to meet those goals.

NELSON:

The last question for today is just thinking about engaging hospital leadership, and if you had to plead your case to a hospital leader, and tell them why they should prioritize initiatives that support improvement to specialty access, what would you say to them and what are some steps that they could take today?

SHIPMAN:

Well, I think for most health systems, there is a recognition that access timely access to specialty care is less than they'd like it to be. I would say that it's important to consider the multiple levels at which that suboptimal access affects your health system and the patients you serve. Tt certainly has effects on the bottom line, it certainly has effects on provider satisfaction, it very directly has effects on patient satisfaction, and then it also causes problems for quality. Patients who need to see a specialist in a timely manner who can't, will get sicker. So all of those factors, all of those are affected by this prevalent problem. The solutions to the problem take a serious, engaged leadership, they take identifying people who are accountable for changing, they take a willingness to think differently about how care is delivered, and there are opportunities today to better understand your access gaps or to optimize access, stated more positively, that starts with looking at data critically, and it also requires clinical redesign efforts.

So it takes a concerted effort, it takes some time, but that time is paid off, ultimately, with getting the right patients in to see the specialists, better triage, a clearer sense of which patients can return to primary care, and simply better alignment so that patients, when they're referred from a PCP to a specialist, can get the most effective care at that first visit.

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BASTINELLI:

Thank you for joining us today. Until next time, this has been *Perspectives*.

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