

When It Comes to Open-Door Access, Culture Matters

A proper foundation is necessary for access improvement efforts to be successful.

BY JOEL SAUER, MBA, AND GINGER BIESBROCK, PA-C, MPH, MPAS, AACC

Year after year, access is one of the top concerns we hear from cardiovascular (CV) programs and practices across the country. Certainly, it is a problem that is not easy to solve given the complex number of factors: clinically complicated patients, provider capacity, multifaceted scheduling protocols, the need for clinical protocol standardization, relative value unit targets, lean staffing, and antiquated phone systems, to name just a few.

At the same time, physicians and administrators know that providing open access is essential to delivering patient-centric care and driving growth in fee-for-service, value-based, and bundled-care models. Because of this, we observe many administrators and teams working diligently to make improvements to open up access, from rethinking scheduling templates and workflows and adding advanced practice providers (APPs) to the care team to implementing new technologies.

Why, then, aren't more programs achieving their open-door access goals? Why do we continue to hear from CV programs and practices that open door access is such an ongoing challenge?

Based on our work with hundreds of CV programs, we have developed a list of attributes we have found in high performing cardiovascular service lines (CVSLs) (Figure 1). We see a clear difference between the programs and practices that provide open-door access and the ones that can't seem to get there. What successful programs and practices have in common is that they have leadership and governance structures that embrace and support a *culture of access*, where the mindset of everyone in the organization puts the patient's needs first.

As Peter Drucker famously said, "Culture eats strategy."¹ If your organization tolerates individual provider scheduling preferences, doesn't utilize APPs to the top of their license,

or maintains scheduling templates that put finances ahead of patient needs, you don't have an access problem. You have a leadership and culture opportunity. Despite how well planned or managed your access initiatives and improvement efforts are, these efforts won't achieve success unless you have a culture of access to support them.

CULTURE OF ACCESS IN ACTION

Five years ago, the physicians at Sanger Heart & Vascular Institute (SHVI) were continuously receiving individual requests from staff such as, "Can you see this patient?" and "Can you fit this patient in?" The organization's approach to scheduling wasn't working. When, in a single clinic day, one of the group's seasoned physicians saw 35 return patients (and zero new patients), it signaled a tipping point. The physicians realized they had to look at new models.

SHVI set out to make changes that ultimately resulted in a culture of, *Yes, we are open*. According to SHVI President Geoffrey Rose, MD, FACC, the physicians began by framing this as a call to action: If you have an acute cardiac issue, we can see you today or tomorrow.

SHVI implemented a variety of changes to support this call to action. The first was a team-based care model that uses APPs to free up physicians to see new and established patients with acute problems. The group revised scheduling protocols and templates to include open slots for new patients. They removed barriers to postdischarge follow-up appointments so that patients leave the hospital with a scheduled cardiology follow-up appointment within 48 hours. The physicians also agreed to see referred patients when they are taking call.

These changes have permeated the culture at SHVI so much so that according to Dr. Rose, these days open access is not something physicians and staff really talk about. It's just something they do.

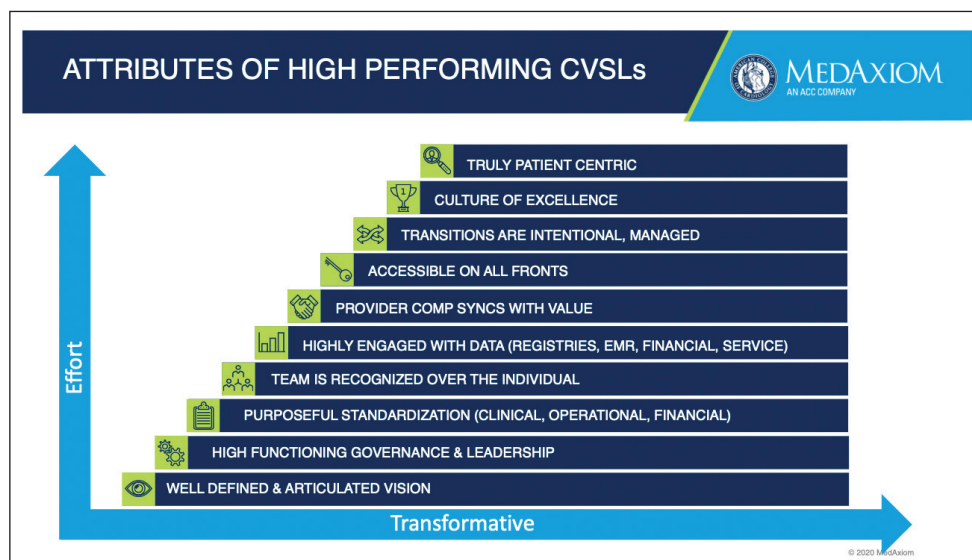


Figure 1. Attributes of high-performing CVSLs based on MedAxiom's work with hundreds of CV programs. EMR, electronic medical record.

Not only has this been good for patient care, but also, metrics indicate success in other areas as well. According to SHVI, the ratio of new-to-return visits is top decile, patient satisfaction scores are in the top decile, and physician engagement is above the 80th percentile.

SHVI is a living example of what we mean by culture of access. Every decision the organization makes is through the lens of, "Yes, we are open—if you have an acute cardiac condition, we can see you today or tomorrow." That call to action is the underpinning of the group's ability to truly offer open-door access.

CREATING A CULTURE OF ACCESS

To create a culture of access requires five key elements.

Governance and Leadership Structures

Leadership drives the organization's vision and culture of access by carefully managing physician behavior, decision-making processes, and operations. Decision-making, voting procedures, and committee structures are sanctioned by physicians and put in writing. Systems exist for addressing conflict, dealing with change, and holding physicians and leaders accountable for behaviors that are outside of group norms.

Dyad Leadership

The balanced approach of dyad leadership combines the vision of the physicians with the insight and execution abilities of administration. In health care, a successful dyad leadership team includes physicians who establish the clinical vision for the organization and administrators

who can then execute that direction. Success requires both sides working collaboratively and in lockstep at every level, with leadership that holds the organization accountable to its goals of accessibility.

Patient Centricity

Organizations that have a culture of access consider the patient at every decision point. They create accountability for ensuring patients get access when they need it because it is the right thing to do—from get-

ting through to the patient on the phone and scheduling a timely appointment to engaging in shared decision-making with the provider during the visit and accessing follow-up care afterward. Organizations that are serious about creating a culture of access consider the patient's perspective on each agenda item in physician meetings. They may even have patient focus groups to provide insights for improvement.

Empowered Team-Based Care

Many CV programs are seeing access improvements and financial benefits of adding APPs to the care team. In fact, data collected from MedAxiom member programs indicate that the typical annual contribution margin per new CV patient is between \$800 and \$1,200. Yet, we still see many CV programs adding APPs to their teams but not optimizing these professionals to the top of their license. If your culture views APPs as expensive nurses or uses them in roles akin to scribes, the team-based care model won't improve access.

In a culture of access, physicians realize and support the full benefit of the team-based model. They are intentional when introducing APPs to their patients, framing them as colleagues who will take good care of them, manage their medication titrations, and see them after their procedure. APPs are empowered members of the team and perceived by physicians as highly trained and capable clinicians.

Performance Management

Physicians must be involved in creating metrics, and everyone must be held accountable for monitoring perfor-

mance. From scheduling wait times to next third available appointment (this is a common access measure in health care) to patient satisfaction scores, metrics are necessary for making improvements that open up access.

CV organizations that have a culture of access will review a leadership scorecard that includes operational metrics, patient satisfaction, and physician engagement. Some of the key operational metrics they review are percent of total for new and established follow-up and annual visits; number of patients blocked versus seen per day; and no-show rates by condition, physician, and group total.

THE FOUNDATION FOR FAST PIVOTS

MedAxiom uses a framework to support CV programs in their improvement efforts. It scales in a pyramid the 10 attributes we observe in high-performing programs, indicating the priority and level of effort for each.

"Well-defined and articulated vision" and "high-functioning governance and leadership" are the first two building blocks of this 10-attribute pyramid. Both take considerable time and effort to cultivate. Skipping their development and heading straight for operational improvement and team building is a big mistake. As you move up the pyramid, each attribute is less and less likely to succeed, unless it has the support of a well-developed level underneath it.

Without effective governance and leadership structures to support the organization, you cannot build a culture in which operational and other improvements succeed. Rules will become wishes with no infrastructure to monitor and ensure adherence. Those at the top and throughout the organization need a clear roadmap of where they're going. In a culture of access, this includes a patient-centric approach and a way to formulate, operationalize, disseminate, and adopt it. A cardiology leader said it best, "Without effective governance and leadership, nothing else matters."

For example, when the COVID-19 pandemic began roaring through our hospitals and practices, programs needed to act fast to accommodate patients who needed to be seen but in a way that was safe. Because it had established venues and protocols for decision-making, one CV practice was able to quickly set up task forces at the very start of the crisis. One of these was a virtual visit task force that was empowered to come up with a plan for how patients would be scheduled and screened to determine who needed a phone visit, telemedicine visit,



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or in-person visit. Because it had governance and leadership structures already in place, this practice had a cultural foundation on which employees and providers could implement change and pivot quickly.

CONCLUSION

Providing open-door access is something we do poorly in health care. If your program or practice is serious about solving access challenges, it must have governance and leadership structures in place that support a *culture of access*. Before you reimagine provider schedules, templates, and care protocols, and before you add APPs, you must be sure your culture truly puts patient needs first. Without this foundation, access improvement efforts will not be successful.

Achieving success requires a coordinated effort and strong dyad leadership from physicians and administrators. It also requires an empowered, team-based care model, an unwavering focus on patient-centricity, and effective performance management. Such shifts require a long-term commitment from leadership and physicians and a mindset shift for everyone in the organization. ■

1. Drucker P. Work and Tools. *Technology and Culture*. 1959;1:28.

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