IMPROVING ACCESS TO HEALTH CARE

6 Practical Solutions to Address Challenges

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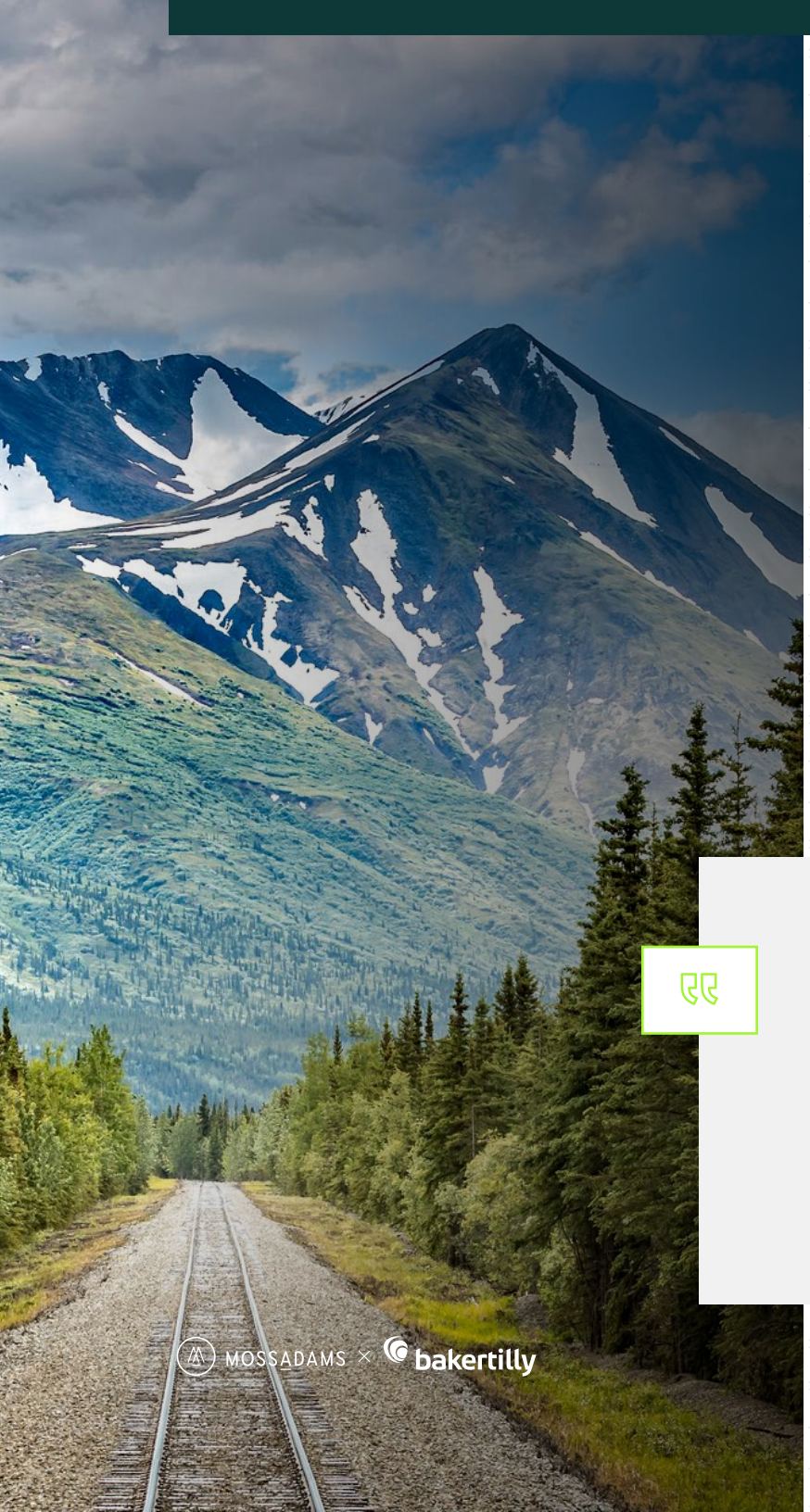
Health care systems need innovative and efficient solutions as they address pressures across tightening margins and resources. But this push toward operational efficiency can come with perceived tradeoffs: Often the area that gets squeezed the most in challenging environments is access—worsening an already major problem for health care executives. As leaders address access impacts, they're often making an expensive error by looking outward rather than in.

This comes down to the build-versus-buy argument: On one hand, organizations can buy more capacity by adding staff, clinic space, and other expansions. But buying capacity is costly and less sustainable, especially given the many financial unknowns in this current reimbursement and economic climate.

On the other hand, leaders can make better use of previously bought capacity by being more strategic about their existing internal infrastructure. This is the more sustainable option, especially when it's done in a way that prioritizes worker wellbeing.

In this playbook, we'll explore six practical ways that health care leaders can think about their resource allocations so that they can more effectively and efficiently build instead of buy their way to better access.



Breaking Down the Build-vs-Buy Debate: Factors to Consider

While buying capacity to address access may seem easier, it's much more challenging in the long run—and rarely, if ever, is it successful compared to building capacity by optimizing current investments.

One reason is **cost**, according to Aaron Adams, Managing Director, Performance Excellence at Moss Adams. Buying and leasing new space, recruiting more physicians, and other capacity-adding changes involve capital-intensive decisions—and the benefits of those investments are often not fully realized.

> "It's hard to get physicians, it's hard to get space, it's hard to get resources. It creates a lot of lead time and complexity in your business at a time when everybody in health care for the last decade has been looking to find a way to dramatically reduce cost structures, not add to them."
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> **AARON ADAMS,** Managing Director, Performance Excellence, Moss Adams

That's assuming, of course, that buying capacity is a realistic option at all. It may not be, at least not anymore, adds Marnee Iseman, MHA, Principal, Performance Excellence at Moss Adams. It comes down to the **sustainability** of ongoing hiring, onboarding, and other forms of resource-gathering, she adds.

"If you look at the projections for health care in the next 10 to 20 years, experts are saying that we are going to be hundreds of thousands if not millions of people short to fill positions," she said. "So even if people can afford it and they want to take the 'easy' route, that route might not be open much longer."

Beyond costs and sustainability, a third factor that should persuade leaders to build instead of buy is **worker wellbeing**. The notion that you can have one or the other but not both—happy workers or better access—is simply false, Iseman adds.

What is true is that access and morale aren't at odds with each other; improve one and you actually improve the other. Case in point: patient frustration. Frontline clinicians have sounded the alarms for years about combative, hostile, and even violently active patients. If better access addresses those issues even in small ways, morale could dramatically improve.

> "You can actually do more without making people feel exhausted and burned out. People's perception of 'it's easier to buy' really stems from a fear: 'If I try to improve my system, it's going to require my doctors to work harder and we're going to have to do more and that'll be a really bad thing.' That doesn't have to be true."
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> **MARNEE ISEMAN, MHA,** Principal, Performance Excellence, Moss Adams

6 Best Practices to Address Access

Access improvements come gradually, but some fixes do involve lower-hanging fruit. A strong strategy can target a mix of both outcomes—long-term, hard-fought gains coupled with easy, morale-boosting wins. Consider these six best practices, according to our experts:

01 **Define success**

02 **Strengthen the change management plea**

03 **Be honest about progress**

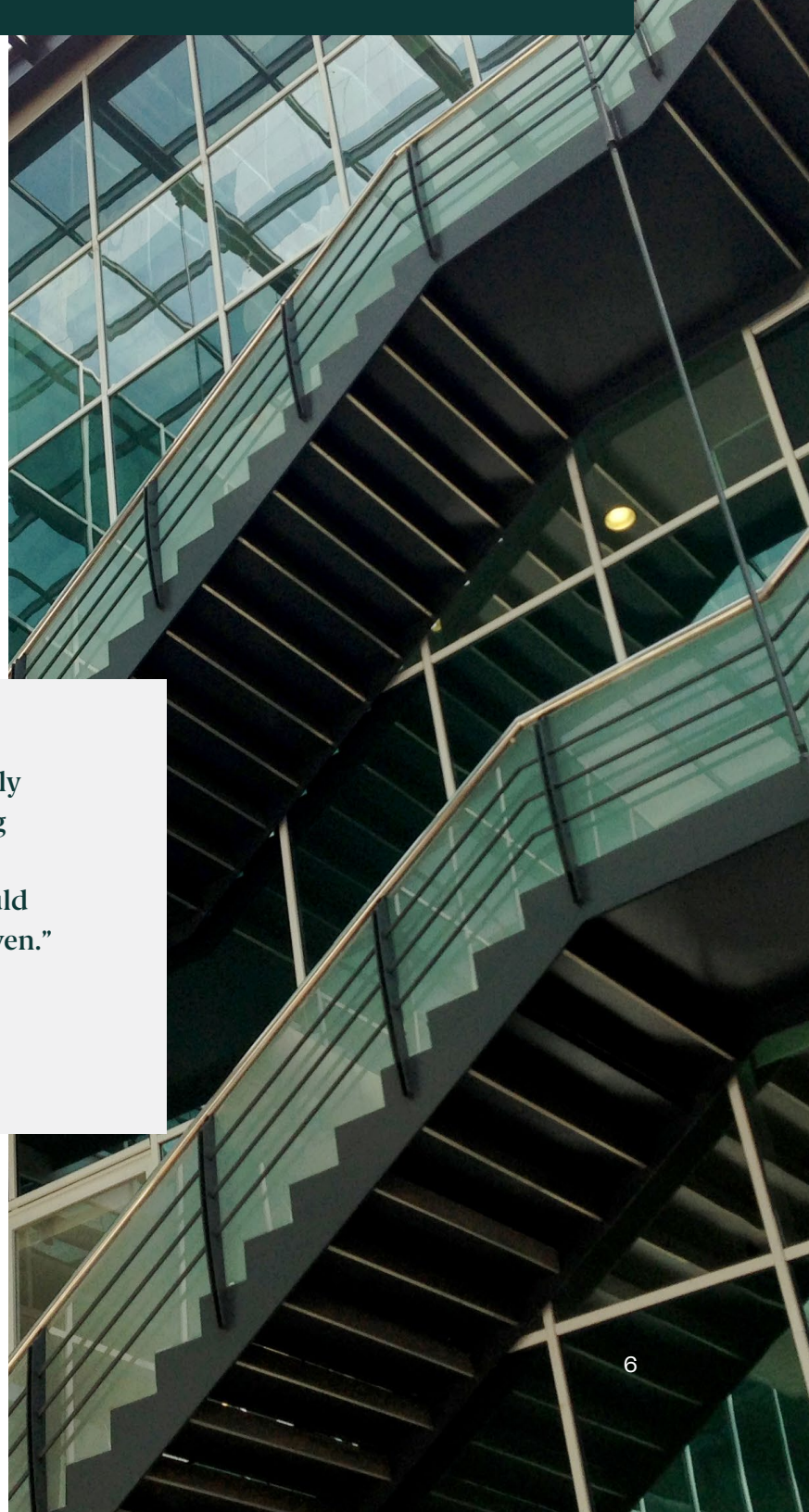
04 **Create evidence-based capacity plans**

05 **Go from batch work to work-in-flow**

06 **Explore unused EHR functions**

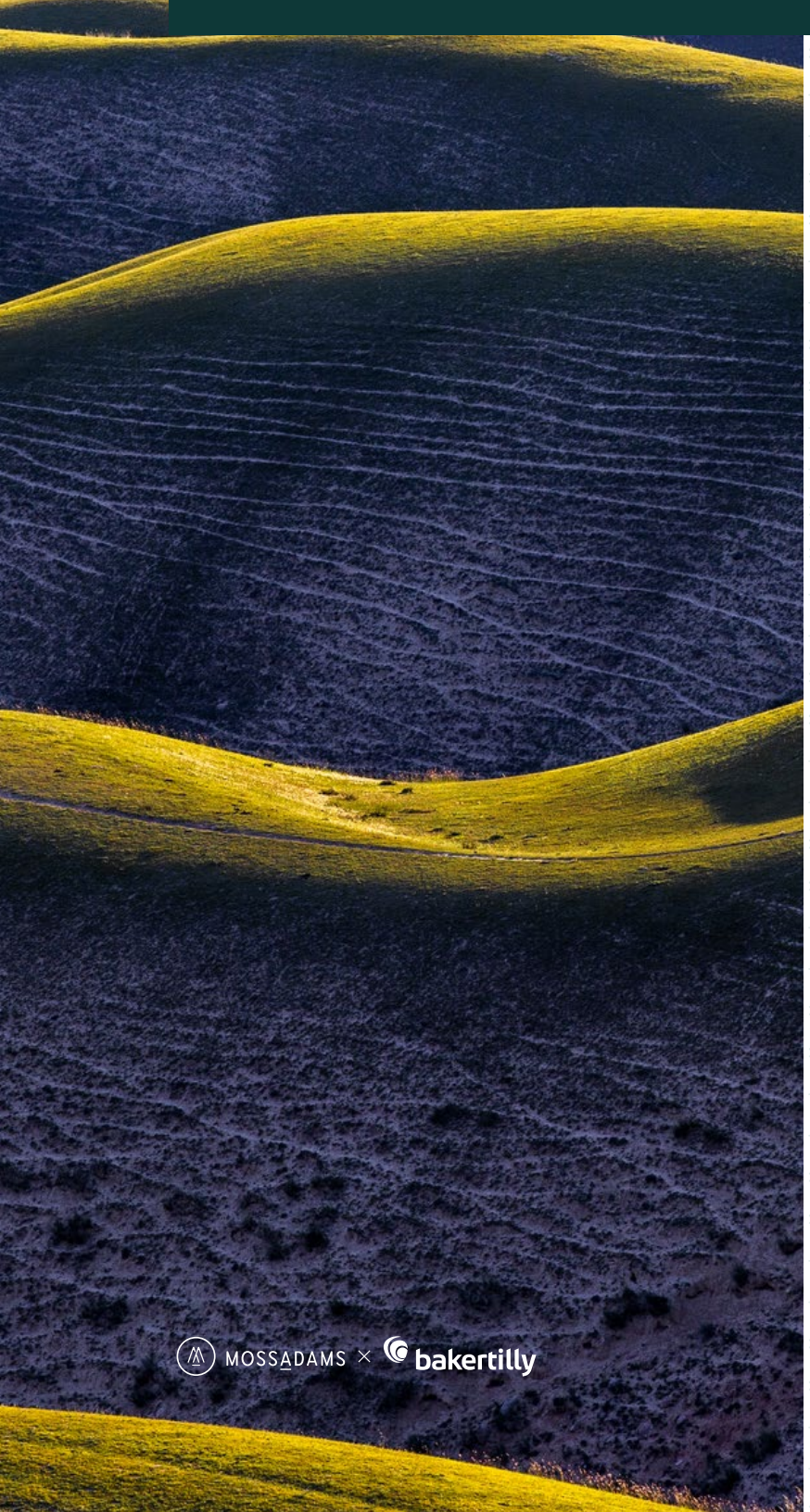
01. Define success

What does success look like in the context of financial growth, population health, patient experience, and other outcomes? Organizations already do this assessment, of course. But Adams challenges leaders to think about success with much more humility and candor—and, where possible, a more aggressive stance on goals that are just "good enough."



> "People are fighting to get back to the mean, but can your business really succeed if your target is average, where 50% of organizations are doing better than you are? You have to be honest about what your business really needs from a success standpoint, and part of that equation should involve greater expectations—striving for the top quartile or decile, even."

AARON ADAMS, Managing Director, Performance Excellence, Moss Adams



02. Strengthen the change management plea

Any kind of workflow change—whether a new process or new technology—is going to cause chaos if stakeholder input isn't considered. But often, that's the very move health care organizations make when hurried: They shortcut change management, glossing it over for seemingly bigger priorities.

Instead, leaders should build a more complete and logical case when campaigning for a change. Part of that plea will certainly involve cost. But it will also cover other things, like patient impact—fewer combative patients, maybe, or fewer late-stage disease progressions. All of these components can help create a stronger rationale for workflow transitions.

"Half the battle should be in getting buy-in and confidence that we can make the work better and more efficient with less burnout, better productivity, and improved patient outcomes," Adams said. "But you have to have great communication in defining that why."

This approach could have positive effects in other ways too, Iseman adds. It could help restore trust, especially between clinicians and administrators.

"Letting other people in to help you do work you've always done yourself requires trust, and there's a real gap there these days," she said. "Don't skimp on the why in that change management plea, because it could be supporting that trust in a time when there's very little of it systemwide."

03. Be honest about progress

Many health care organizations have improvement teams who've been focused on access for years—and yet, they still struggle to show meaningful progress. Adams stresses that some of those challenges come from tough questions going unasked—like simply, 'Is what we're doing really working?'

"Organizations need to be honest with themselves about how effective their improvement efforts have been to date and whether or not they're on the trajectory they need to be to reach the success they've already defined for themselves," he said. "If you've only seen marginal improvements, there may be some shuffling that needs to happen to get on the right track."

That "shuffling" could involve many things, from including the right partners to reprioritizing access initiatives. But it starts with that honesty, he adds. "Without it, you'd have no way of knowing what's working and what's not."

04. Create evidence-based capacity plans

Much of the demand for health care services is predictable—right down to the emergency department, even. And yet, capacity doesn't often reflect predictable metrics, creating misalignment between supply and demand. This presents an opportunity for health care leaders to rethink their approach with evidence-based capacity planning, Iseman said.

> "Most organizations understand the universe of who it is they're trying to serve, so it would make sense that they can also build a schedule relative to the very predictable demand of that population. When you focus on demand, then you can turn your sights to supply."
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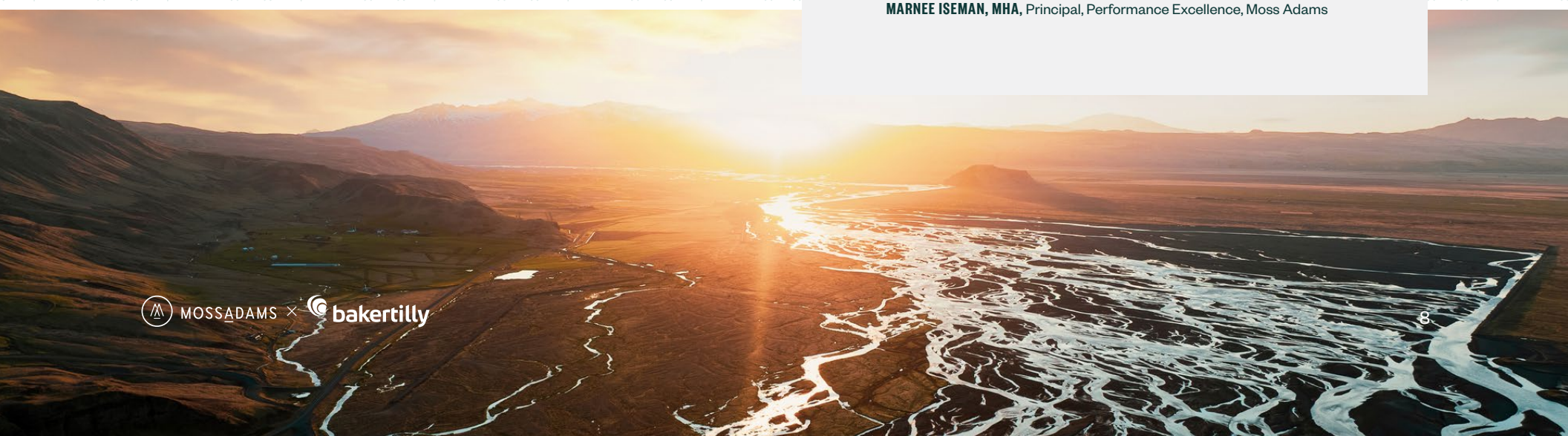


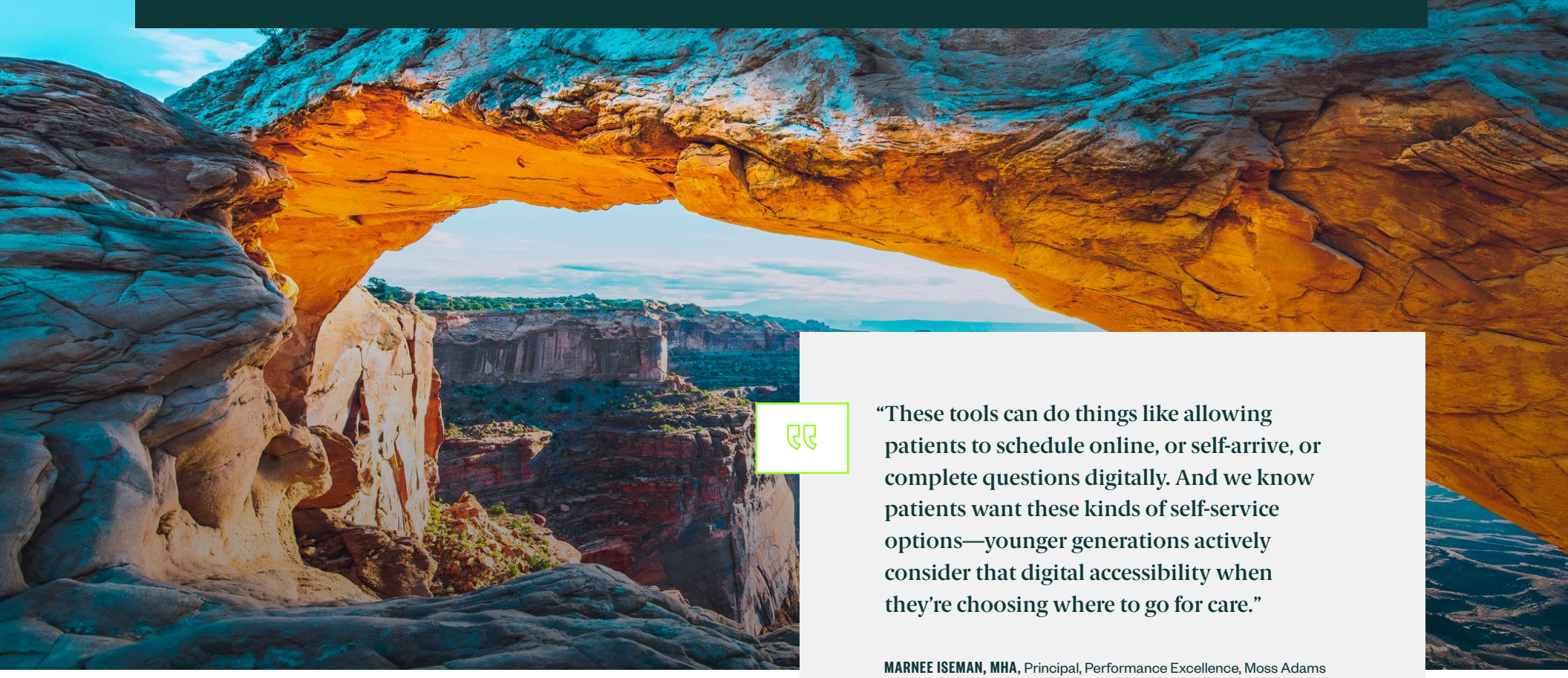
05. Go from batch work to work-in-flow

Many clinical workflows operate from a batched-work model, where clinicians do their administrative work in chunks—often set for a single "admin day" of the week. This work can include everything from in-basket messaging and test result reporting to orders, requests, documentation, etc.

But this model hurts more than it helps, Iseman says. It's hard for clinicians to remember details when tasks like chart notes aren't done during or immediately after visits. There are also patient impacts—people get understandably upset when their messages go unanswered, and outcomes could be affected if critical tasks like refill requests aren't fulfilled promptly.

"If you're a provider with a four-day clinical schedule and you take a day for administrative care, you've just lost 25% of your capacity right out of the gate by doing that," she said. "But if you instead reorganize the work with some basic process engineering and do a little bit of administrative work between every patient visit, the clinician can end their day without a pile of charts to close or an in-basket full of messages, or a truckload of test results and orders."

"And you haven't lost any capacity in the process, and they won't have worked more hours either," she added. "It turns out that doing work in flow tends to take less time."



> "These tools can do things like allowing patients to schedule online, or self-arrive, or complete questions digitally. And we know patients want these kinds of self-service options—younger generations actively consider that digital accessibility when they're choosing where to go for care."
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> **MARNEE ISEMAN, MHA,** Principal, Performance Excellence, Moss Adams

06. Explore unused EHR functions

EHRs have multiple functions built into their platforms that could help health care facilities operationalize workflows in more automated ways. The problem, Iseman says, is that many users of those platforms don't turn them on—if they even know those functions exist at all.

Iseman points to the fact that because these tools already exist in these systems, the costs of implementation may be low for relatively high benefit potential. "Automation is underutilized in health care right now, and this really is an opportunity to get somewhere meaningful with it, right away."

Build Your Way to Better Access

As health care organizations struggle under the weight of financial and resource pressures, access is often the first thing compromised—not because anyone wants that, but because it's an understood tradeoff in the current environment. But ultimately, it doesn't have to be that way.

Organizations can address their pain points without squeezing access, but they need to look inward to do it. Building capacity by optimizing existing infrastructure rather than buying labor and leases is the cost-effective, sustainable, and morale-improving choice.

If you're looking for support as you implement these best practices, learn how Moss Adams can help.

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