Data Driven Access: Patient Retention and Growth

Shannon Nielson, MHSA, PCMH CCE
CURIS Consulting and CURIS Connect
Owner and Principal Consultant
Objectives

Part 1:

• Understand how to measure access
• Evaluating patient retention and growth in your current HC infrastructure
• Differentiate between patient retention and patient growth
Why Patient Retention

Patient Retention:
The ability of health care providers to keep patients engaged in their care and coming back for future interactions.

- Retaining patients is less costly than finding new patients.
- Retaining patients improves productivity.
- Retaining patients improves health outcomes.
- Retaining patients improves satisfaction.
Patient Growth

Patient Growth:
New patients seen (3 years)
Patients not seen in previous (X) year

- Patient growth enables community impact
- Patient growth aids in compliance
- Patient growth (currently) leads to financial sustainability
DATA DRIVEN ACCESS PROGRAMS

Patient-centered:
Putting the patient experience at the heart of health services design:
- Provider availability
- Hours of operation
- Accommodations
- Patient experience
- Specialty services
- Geography/markets

Capacity management:
Managing resources to maximize availability of services to meet patient needs:
- Standard visit types
- Visit durations
- Utilization reporting
- Workforce management
- Template optimization

Access channels:
Creating access points to connect patients and referring providers to the health system:
- AI (chatbots)
- Online portal
- Personalized agents
- Self-scheduling

Relationship management:
Creating a seamless process for referral sources:
- Referral management and governance
- Referring provider prioritization
- Documentation management
- Network management
- Leakage analytics
**DATA DRIVEN ACCESS PROGRAMS**

- **Patient Retention**
  - Patient centered: When and why do patients want to be seen?
  - Capacity Management: How often do patients want and need to be seen?
  - Relationship Management: Do patients feel part of a network?
  - Access Channels: Is access accommodating, acceptable and available?

- **Patient Growth**
  - Patient centered: Why would patients want to be seen by us?
  - Capacity Management: What is the churn and availability
  - Relationship Management: Can we help improve cost of care by increasing access
  - Access Channels: Can new patients access us?
Five Dimensions of Access

Assessing

I can afford the care I want and need

Accessibility

I can get to the interaction

Availability

I am able to be seen

Accommodation

I am able to be seen when and how I want to be seen

Acceptability

I get access to care that meets my needs

Evaluating

1. SDOH
2. Adherence to fees/SP collections
3. No show/cx rate

Retention: visit utilization
Growth: Capacity

Retention: Continuity
Growth: Timely

Retention: Empanelment
Growth: Schedule utilization

Disparities in access to care
“Whole person care”
Patient Growth and Retention Measures

- YTD Patient Volume
- 3 Year Retention/Attrition
- Schedule Utilization
- Continuity
- Appropriate Schedule Utilization
- Empanelment
- Appointment Lag Time or 3NA
- Patient Experience
YTD Visit and Patient volume

Compare unique patient count YTD to patient count previous year YTD
ex. 2024- Patient Jan 1-Apr 15
2023- Patient Jan 1- Apr 15

If possible add FTE counts
Is there a direct or indirect correlation between:

A. Patients and visits
B. Patients and FTE
C. Visits and FTE

Do you have other access points besides a provider

• Does every patient need a visit?
3 Year Retention/Attrition

What is your average “attrition” timeline

Site specific or provider specific?

Type of patient?

Simplest form of retention:

\[ S = \text{Patients at beg of period (Ex. 2022)} \]

\[ E = \text{Number at end of period (Ex. 2024)} \]

\[ N = \text{Number of new patients during period} \]

Retention rate = \( \frac{(E-N)}{S} \times 100 \)

Ex. \( \frac{(31,234-9,245)}{27,444} \times 100 = 80\% \) retention over 3 years
Schedule Utilization

No show by type? - New patients?
Rescheduled cancellations create x2 access issue
Double booking doesn’t fix the root cause if your actualized visit rate doesn’t change
Do you have “frequent flyers”
Do you have patients that leave due to long wait time?
  • Are your MA and RNs creating efficiencies
High NS, CX rates:
  • Indicate risk of high attrition; lack of desire to be retained
  • Indicate inability to grow
  • Often correlate with high lag times/3NA
Continuity of Care and Appropriate Schedule Utilization

Patient Retention:
• People want to see the same provider each time
• Panels can be managed when there is continuity of care
• Providers can be more productive when they know who they are seeing

Patient Growth:
• Opportunity for growth is predictable if continuity and provider schedule utilization is managed
• Patient growth cannot be measured if schedule utilization is poor regardless of continuity and provider utilization

![Graph showing continuity and appropriate schedule utilization rates from August 2023 to July 2024. The goal line is consistently at 100%.]
But what is the issue?

• Do your patients know who their care team is?
• Does your care team provide access outside of a visit?
• Does your care team practice to peak of scope to allow for efficiency and productivity
• Does your staffing model align with continuity or do your MAs/RNs rotate?
Empanelment (and visit utilization)

What is driving your excess of capacity?
- Growth?
- Over utilization?
- Poor (appropriate) retention?
- Supply?

What is driving your excess availability?
- Attrition?
- Churn/lack of continuity?
- Lack of demand?
- Lack of growth strategy?
- Lack of Supply?
**Panel Size**

Who do you take care of?
When do you take care of them?
How do you take care of them?
What are the needs of your patients?
How many can you take care of? (Eligibility match)
What is your care team?

- You can increase panel size if you have high functioning expanded care teams
- What is the purpose of your expanded care team model? Growth? Retention? - who needs to support that?
Empanelment Process

• Complete RSP Worksheet
• Run list of current provider panels
• Re-distribute using 4-Cut Method:

<table>
<thead>
<tr>
<th>Cut</th>
<th>Description</th>
<th>PCP Assignment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st Cut</td>
<td>Patients who have seen only one provider in the past year</td>
<td>Assigned to that provider</td>
</tr>
<tr>
<td>2nd Cut</td>
<td>Patients who have seen multiple providers but one provider the majority of the time in the past year. Plurality</td>
<td>Assigned to the majority provider</td>
</tr>
<tr>
<td>3rd Cut</td>
<td>Patients who have seen two or more providers equally in the past year (No majority provider can be determined)</td>
<td>Assigned to the provider who performed the last physical exam</td>
</tr>
<tr>
<td>4th Cut</td>
<td>Patients who have seen multiple providers</td>
<td>Assigned to the last provider seen</td>
</tr>
<tr>
<td>(The Zero Cut)</td>
<td>Patients who are empaneled to provider but have not been seen in 3 years</td>
<td>(No assignment)</td>
</tr>
<tr>
<td></td>
<td>Patients who are empaneled to a provider no longer in the system</td>
<td>(4 Cut methodology or based on capacity)</td>
</tr>
</tbody>
</table>
Risk is Dynamic

Monitor your panels by size...

Also monitor your panels by risk

Payer data isn’t real time...

But a patient’s clinical indicators are

Social Determinants of Health are critical to understand...

As patients’ physical, environmental and social situations change

A provider’s panel capacity is set...

And can change as risk of their panel changes

Your staffing should be appropriate to manage panels...

And should change as your patient needs change
Appointment Availability: Lag Time vs. 3NA

Lag Time = Appt Date – Create date

Indirect correlation with growth opportunity

Patient Retention: High lag time:

- Is it because we have retained all of our patients without increasing supply?
- Is it because we have taken on too many patients and not able to appropriately see retained patients which will lead to attrition?
<table>
<thead>
<tr>
<th>Date of Request</th>
<th>Time of Request</th>
<th>Reason for Visit (pt. demo)</th>
<th>Provider requested</th>
<th>App. type should be scheduled</th>
<th>Date of 3rd NA Actual Scheduled App.</th>
<th>App. Date Sched.</th>
<th>Scheduled Provider</th>
<th>Walk-In</th>
</tr>
</thead>
<tbody>
<tr>
<td>3/12/2023</td>
<td>6:30 AM</td>
<td>walk physical</td>
<td>Dr. X</td>
<td>Established</td>
<td>1/5 Same Day</td>
<td>3/11/2023</td>
<td>Dr. Y</td>
<td></td>
</tr>
</tbody>
</table>
# 3NA vs. Lag Time

<table>
<thead>
<tr>
<th>Row Labels</th>
<th>Average of Lag Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>[1173000002]</td>
<td>8.46</td>
</tr>
<tr>
<td>AMB ECG 12-LEAD [ECG7]</td>
<td>8.24</td>
</tr>
<tr>
<td>Case Manager [1173000009]</td>
<td>6.94</td>
</tr>
<tr>
<td>COMPLETE PULMONARY FUNCTION TEST [PFT13]</td>
<td>20.33</td>
</tr>
<tr>
<td>COVID PFIZER 1ST DOSE [1170002015]</td>
<td>12.86</td>
</tr>
<tr>
<td>Dental 60 [11730000077]</td>
<td>1.00</td>
</tr>
<tr>
<td>ERAP [1170002030]</td>
<td>4.66</td>
</tr>
<tr>
<td>Group [1170000013]</td>
<td>8.03</td>
</tr>
<tr>
<td>Intake [1173000006]</td>
<td>0.30</td>
</tr>
<tr>
<td>MCVN ANNUAL WELLNESS [1170002038]</td>
<td>40.50</td>
</tr>
<tr>
<td>MED WEL FU [117001020]</td>
<td>11.79</td>
</tr>
<tr>
<td>New Pat [1170000022]</td>
<td>7.65</td>
</tr>
<tr>
<td>NEW PSYCH [1170000301]</td>
<td>34.29</td>
</tr>
<tr>
<td>New Ther [1170000070]</td>
<td>8.18</td>
</tr>
<tr>
<td>Nurse Visit [1170000008]</td>
<td>5.88</td>
</tr>
<tr>
<td>Office Visit [1170000112]</td>
<td>10.46</td>
</tr>
<tr>
<td>PFIZER BOOSTER [1170002004]</td>
<td>13.58</td>
</tr>
<tr>
<td>Pro [1170000010]</td>
<td>8.76</td>
</tr>
<tr>
<td>PSYCH FU [1170000302]</td>
<td>42.51</td>
</tr>
<tr>
<td>PULMONARY FUNCTION TEST-SPIROMETRY [PFT14]</td>
<td>5.25</td>
</tr>
<tr>
<td>Resource Screening [1556]</td>
<td>0.68</td>
</tr>
<tr>
<td>Sports Phys [1170000051]</td>
<td>4.42</td>
</tr>
<tr>
<td>Tele [1170000006]</td>
<td>9.94</td>
</tr>
<tr>
<td>TELEPHONE W [1170031500]</td>
<td>8.66</td>
</tr>
<tr>
<td>TELEPSYCH FU [1170031516]</td>
<td>41.38</td>
</tr>
<tr>
<td>TELEPSYCH NP [1170031515]</td>
<td>43.10</td>
</tr>
<tr>
<td>TELERTHERAPY [117000179]</td>
<td>6.75</td>
</tr>
<tr>
<td>Ther [1170000069]</td>
<td>38.08</td>
</tr>
<tr>
<td>Wel to Med [1170000096]</td>
<td>7.90</td>
</tr>
<tr>
<td>Grand Total</td>
<td>16.13</td>
</tr>
</tbody>
</table>
Patient Experience

- Net Promoter Score: Gauge customer loyalty, satisfaction and enthusiasm

- Critical in understanding Patient Retention:
  - Patient passives: Can be swayed by competitors or by you

- Critical in understanding Patient Detractors:
  - Will impede patient growth

- Other questions to consider:
  - How many times have you visited us in the past year?
  - How likely are you to visit us again?
  - Do you consider us your primary care provider?
  - If telling people about us, what would you say?
    - Positive/negative

**Net Promoter Score®**

\[
\text{Net Promoter Score} = \frac{\% \text{ Promoters} - \% \text{ Detractors}}{100}
\]
Access-Patient Experience or Engagement?

• I was able to get an appointment in a timely manner?
• My definition of getting an appointment in a timely manner is:

• Answer vs. Reason
Additional Current HC KPIs To Consider:

- Productivity
- Care Management Engagement
- Order Completion
- Outreach Engagement
- Care Plan Adherence
- Patients with well visits in last 18 months
- Abandonment Rates
Patient Retention

Proactive Management of quality, cost, access and supply

Planned Growth
Questions and Answers
Data Driven Access: Patient Retention and Growth

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Objectives

Part 1:
• Understand how to measure access
• Evaluating patient retention and growth in your current HC infrastructure
• Differentiate between patient retention and patient growth

Part 2:
• Developing the key drivers for patient retention and growth
• Best practices for patient retention and growth
Drivers of Patient Retention

Patient Experience, Patient Satisfaction and Patient Engagement
Relationship Management
Technology
Training
Culture of Equity
Workforce
Patient Experience, Satisfaction and Engagement

Patient Experience: Interactions intended to meet the patients’ expectations

Patient Satisfaction: Meeting patient expectations

Patient Engagement: Patients who are willing and able to participate in their care
# Patient Experience Creates Value

## THE PATIENT EXPERIENCE DEFINED

<table>
<thead>
<tr>
<th>Interactions</th>
<th>Culture</th>
<th>Perceptions</th>
<th>Continuum of Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>The orchestrated touchpoints of people, processes, policies, communications, actions and environment.</td>
<td>The vision, values, people (at all levels and in all parts of the organization) and community.</td>
<td>What is recognized, understood, and remembered by patients and support people. Perceptions vary based on individual experiences such as beliefs, values, cultural background, etc.</td>
<td>Before, during and after the delivery of care.</td>
</tr>
</tbody>
</table>

- **Increased Patient Loyalty**
- **Improved Patient Retention**
- **Decreased Staff Turnover**
- **Consistent Financial Viability**

## Strategies to Improve Experience, Satisfaction and Engagement for Retention

<table>
<thead>
<tr>
<th>Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Value Add Interaction Mapping</td>
</tr>
<tr>
<td>Patient experience and satisfaction surveys</td>
</tr>
<tr>
<td>Setting expectations</td>
</tr>
<tr>
<td>Creating the “HC” way</td>
</tr>
<tr>
<td>Customer focus groups</td>
</tr>
<tr>
<td>Patient exit interviews</td>
</tr>
</tbody>
</table>
Relationship Management

- Personalization
- Communication
- Goal Oriented
Relationship Management

Personalization
- Un-necessary but personal follow up
- Do you know the person or the health of the person?
- Celebrate even when not in the office

Communication
- Communication preferences
- Patients need to understand
- Opportunity for engagement

Goal Oriented
- Follow up
- Aligned patient goals
- In-between visits
Access via Technology

• **Availability**: Can patients communicate or access to meet their needs?

• **Accessibility**: Is the technology available to the patient when/how they need it?

• **Accommodation**: Does technology offer patients an alternative way of getting what they need?

• **Affordability**: Can the health center afford to offer the access?

• **Acceptability**: Does the patient get what they need via technology?
Will Technology help you retain or grow?

Does the technology increase access (offer more opportunities for visits)?

Does the technology make it easier for a patient to be heard or seen?

Does the technology reduce the overall cost of care?

Does the technology improve the chances of a patient getting the care they need?

Does the technology reduce the need for non-revenue generating or value add human interaction?
Practical Applications of Technology for Impacting Access

Electronic scheduling (portal, texting, triage, urgent care)
Patient outreach (Technology, Topic, Timeliness)
Care Coordination (External access)
Reducing phone call volume
Reducing no show rate
Wait list utilization

Closing the Care Gaps
Training

Soft Skills
- Communication
- Cultural competence
- Empathy
- Collaboration
- Adaptability
- Physical presence

Hard Skills
- Competencies
- Technology
- Continuous quality improvement
- Certifications
Opportunity for Patient Training?

How can I communicate and access?

Who can I and who should I communicate with and access?

What do I expect and what do you expect?

Why is this happening?
Culture of Equity

Equitable care means providing care that does not vary in quality because of personal characteristics such as gender, race, socioeconomic status and geographic location.

Stigma can lead to a perceived lack of support, lack of empathy, feelings of embarrassment, feeling misunderstood and marginalized.

Stigma can cause more than hurt feelings.

It can result in lack of trust/lack of engagement in care, feelings of isolation, risk factors being overlooked, symptoms being ignored, lead to poor health outcomes.
Putting Aside Bias

Bias is defined as the negative evaluation of one group and its members relative to another.

- **Explicit bias** means that a person is aware of his/her evaluation of a group and believes that evaluation is accurate.
- **Implicit (unconscious) bias** means an individual may be unaware of their evaluations of a certain group and operates in an unintentionally

Patients should never expect to receive a lower standard of care when walking into a provider’s office because of bias (explicit or implicit) based on race, age, gender or any other characteristic.

- Working to eliminate healthcare disparities is one of our primary goals as Health Centers.
Workforce

Retention drives continuity

Trained drives peak of scope

Supply drives

Supply and Demand drive:
• Staffing ratios
• Roles and responsibilities

Capacity drives recruitment plans

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Figure 3. Proposed PCMH Staffing Ratio Estimates (FTEs) and Incremental Costs per FTE Primary Care Physician (Patel, 2013)

<table>
<thead>
<tr>
<th>Staffing Variable</th>
<th>Interview Rangea</th>
<th>MGMAb</th>
<th>Proposedc</th>
<th>Difference from MGMA</th>
<th>Estimated Incremental Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical</td>
<td>0.18-1.85</td>
<td>1.12</td>
<td>1.42</td>
<td>0.30</td>
<td>$ 11,661</td>
</tr>
<tr>
<td>MA, Technician, LPN</td>
<td>0-1.66</td>
<td>1.33</td>
<td>1.33</td>
<td>0.00</td>
<td>-</td>
</tr>
<tr>
<td>RN</td>
<td>0.21-1.78</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>-</td>
</tr>
<tr>
<td>RN Care Manager</td>
<td>0.1-0</td>
<td>0.00</td>
<td>0.40</td>
<td>0.40</td>
<td>$ 38,116</td>
</tr>
<tr>
<td>NP/PA</td>
<td>0-1.36</td>
<td>0.23</td>
<td>0.25</td>
<td>0.02</td>
<td>$ 2,584</td>
</tr>
<tr>
<td>Health Coaches ($ for MA)</td>
<td>0-0.25</td>
<td>0.25</td>
<td>0.25</td>
<td>0.00</td>
<td>$ 9,864</td>
</tr>
<tr>
<td>Pharmacist</td>
<td>0-0.53</td>
<td>0.75</td>
<td>0.50</td>
<td>0.25</td>
<td>$ 59,790</td>
</tr>
<tr>
<td>Mental Health ($ for SW)</td>
<td>0-0.83</td>
<td>0.25</td>
<td>0.25</td>
<td>0.00</td>
<td>$ 18,330</td>
</tr>
<tr>
<td>Nutritionist</td>
<td>0-0.20</td>
<td>0.10</td>
<td>0.10</td>
<td>0.00</td>
<td>$ 6,890</td>
</tr>
<tr>
<td>Clinical Data Analyst</td>
<td>NA</td>
<td>0.05</td>
<td>0.05</td>
<td>0.00</td>
<td>$ 3,653</td>
</tr>
<tr>
<td>Total</td>
<td>2.68</td>
<td>4.25</td>
<td>1.57</td>
<td>0.50</td>
<td>$ 120,652</td>
</tr>
</tbody>
</table>

FTE indicates full-time equivalent; LPN, licensed practical nurse; MA, medical assistant; MGMA, Medical Group Management Association; NA, not applicable; NP, nurse practitioner; PA, physician assistant; PCMH, patient-centered medical home; RN, registered nurse; SW, social worker.

aBased on telephone interviews.
bMedian integrated delivery system owned, all internal medicine.
cMost were unaudited; several used risk stratification techniques.
dMGMA 2010 Cost Survey Report.
eBased on proprietary risk adjustment software from Economic Research Institute, Geographical, Anesthesia.

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Figure 4. Mean Number of FTE Staff per FTE Physician—Among CPC Initiative Practices With Staff Type—By Practice Size

<table>
<thead>
<tr>
<th>Staff Type</th>
<th>≤2 FTE Physicians (n=516)</th>
<th>&gt;2-4 FTE Physicians (n=138)</th>
<th>&gt;4-7 FTE Physicians (n=92)</th>
<th>&gt;7 FTE Physicians (n=49)</th>
<th>All Practices (n=496)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrative staff</td>
<td>2.42</td>
<td>2.16</td>
<td>1.70</td>
<td>1.98</td>
<td>2.65</td>
</tr>
<tr>
<td>Medical assistants</td>
<td>1.76</td>
<td>1.31</td>
<td>1.23</td>
<td>1.11</td>
<td>1.45</td>
</tr>
<tr>
<td>NPs, PAs</td>
<td>0.97</td>
<td>0.49</td>
<td>0.38</td>
<td>0.20</td>
<td>0.65</td>
</tr>
<tr>
<td>LPNs, LVNs</td>
<td>1.38</td>
<td>0.78</td>
<td>0.66</td>
<td>0.53</td>
<td>0.95</td>
</tr>
<tr>
<td>RNs</td>
<td>1.04</td>
<td>0.54</td>
<td>0.38</td>
<td>0.31</td>
<td>0.64</td>
</tr>
<tr>
<td>Care managers/coordinators</td>
<td>0.77</td>
<td>0.46</td>
<td>0.24</td>
<td>0.23</td>
<td>0.47</td>
</tr>
<tr>
<td>Pharmacists</td>
<td>0.73</td>
<td>0.42</td>
<td>0.15</td>
<td>0.29</td>
<td>0.32</td>
</tr>
<tr>
<td>Social workers</td>
<td>0.73</td>
<td>0.22</td>
<td>0.13</td>
<td>0.12</td>
<td>0.20</td>
</tr>
<tr>
<td>Community service coordinators</td>
<td>0.86</td>
<td>0.26</td>
<td>0.17</td>
<td>0.20</td>
<td>0.48</td>
</tr>
<tr>
<td>Health educators</td>
<td>1.00</td>
<td>0.37</td>
<td>0.19</td>
<td>0.10</td>
<td>0.42</td>
</tr>
<tr>
<td>Nutritionists</td>
<td>0.54</td>
<td>0.38</td>
<td>0.08</td>
<td>0.07</td>
<td>0.27</td>
</tr>
</tbody>
</table>

CPC = Comprehensive Primary Care; FTE = full-time equivalent; LPN = licensed practical nurse; LVN = licensed vocational nurse; NP = nurse practitioner; PA = physician assistant; RN = registered nurse.
Source: The CPC practice survey, fielded October through December 2012.
Note: Practice size is defined by the number of FTE physicians.
Administrative staff include those managing reception, medical records, appointments, finance, etc.
Key Drivers of Patient Retention - Exercise

Retain >75% of patients YOY

What do we need to do to improve on each of the primary drivers?

Patient Experience
Patient Engagement
Relationship Management
Technology
Training
Culture of Equity
Workforce
Drivers of Patient Growth

- Patient Retention
- Supply
- Demand
Patient Retention

- Retaining patients:
  - Leads to growth to create impact
  - Is the quickest strategy to achieving goal
  - Is directly correlated to growth from patient referrals
  - Is directly correlated to HC ability to add vs. replace providers
Supply
Supply is directly correlated to growth

Provider retention
Calculated growth opportunity
Data driven increase in supply
Demand

- Demand is driven by:
  - Clinical need- do we grow in people, services or through partnerships?
  - Social need- do we grow by meeting unmet social needs?
  - Patient behaviors- do we need to grow to meet (change in) patient behaviors?

- What is the purpose of our growth?
Key Drivers of Patient Growth - Exercise

- Exercise: 5% increase in patients YOY
- Patient Retention
- Supply
- Demand

What do we need to do to improve on each of the primary drivers?
BEST PRACTICES TO RETAIN AND GROW

- Outreach: Follow the 3 Ts
  - Topic: Narrow your topic and focus area to be purposeful
  - Timely: Conduct outreach in a timely (proactive), consistent, manner
  - Technology: Utilize technology to actualize a greater ROI

- Manage Access from the Patient Perspective:
  - What do patients need to be seen for? Do we provide availability to meet those needs?
  - Why are patients not being seen? How are we using technology, people or processes to impact that?
  - How, when and where would patients prefer to have access? What is the utilization of those access preferences?

- Understand Capacity to Drive your Growth Plan
  - How much demand can your health center managed within current supply? What is your potential demand and how much supply is needed to meet that?
  - How do we utilize non provider access to manage demand?
  - Risk based panels to balance financial productivity targets
# Best Practices to Retain and Grow

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<th>Incentive plans</th>
<th>Staff and patient referral programs</th>
<th>Patient engagement strategies</th>
<th>Marketing</th>
<th>Immediate access</th>
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<td>Staff and providers</td>
<td>If patients bring other patients, they tend to stay!</td>
<td>Cancellation and No-shows</td>
<td>Use the patient voice</td>
<td>Appointments</td>
<td>AI/BOT</td>
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<td>Retention and growth</td>
<td>If staff bring patients they are more likely to stay!</td>
<td>Patient driven utilization of technology</td>
<td>ID disparities in community</td>
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<td>Where do you have capacity</td>
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Questions and Answers