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

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

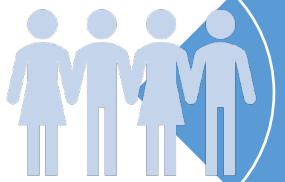
Retaining patients improves health outcomes

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

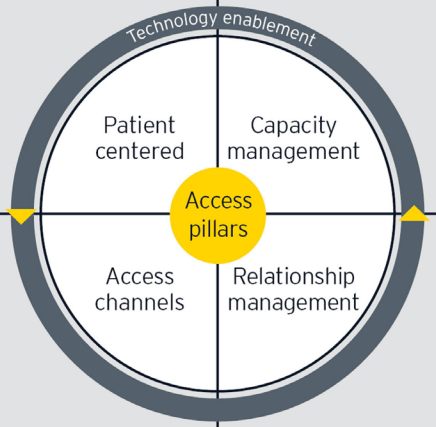
DATA DRIVEN ACCESS PROGRAMS

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



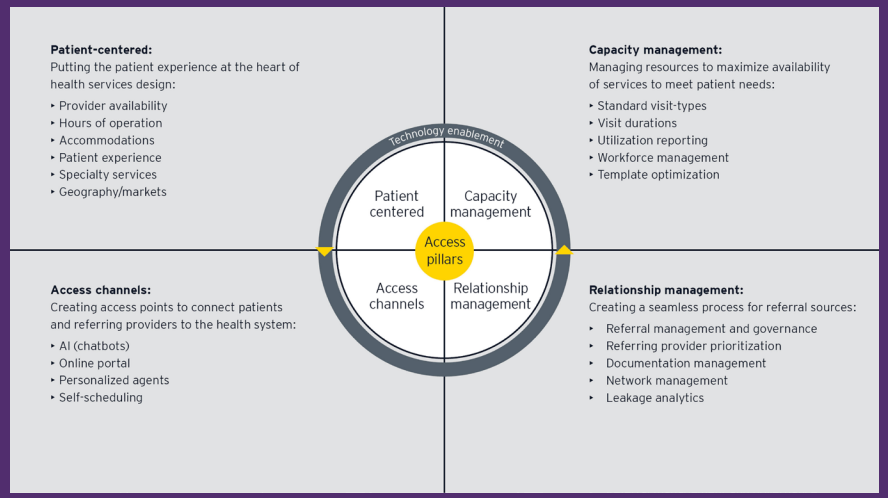
Access channels:
Creating access points to connect patients and referring providers to the health system:

- 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

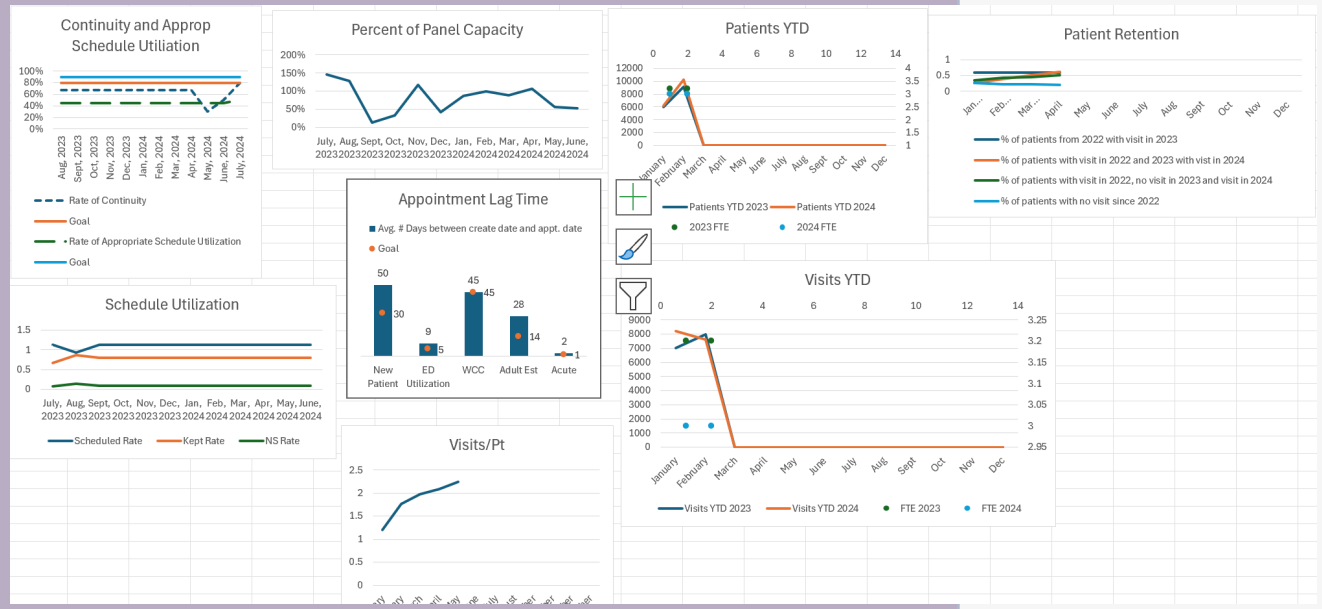
DATA DRIVEN ACCESS PROGRAMS



- **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		Evaluating
I can afford the care I want and need	**Affordability** "Prices of services meet client's income and ability to pay" • Costs: transportation, lost time and income, cost of care, etc. • Perception of worth relative to cost, knowledge of prices, total cost, and credit arrangements	1. SDOH 2. Adherence to fees/SP collections 3. 3. No show/cx rate
I can get to the interaction	**Accessibility** "Location of supply aligns with location of clients or demand" • Accounts for geographical, economic and social distance, transportation resources, etc. • Measured in Distance	Retention: visit utilization Growth: Capacity
I am able to be seen	**Availability** "Size or volume of the supply meets client's needs" • Volume and Type of services VS. Resources to client's volume and Type of needs • Measured in Congestion, Coverage	Retention: Continuity Growth: Timely
I am able to be seen when and how I want to be seen	**Accommodation** "Delivery of healthcare accommodates client's needs" • Appointment systems, hours of operation, walk-in facilities, telephone or web services • Cultural and language barriers	Retention: Empanelment Growth: Schedule utilization
I get access to care that meets my needs	**Acceptability** "Healthcare providers accept all clients regardless of their characteristics" • Client's characteristics: age, sex, social class, ethnicity, type of insurance (e.g. Medicare, Medicaid)	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

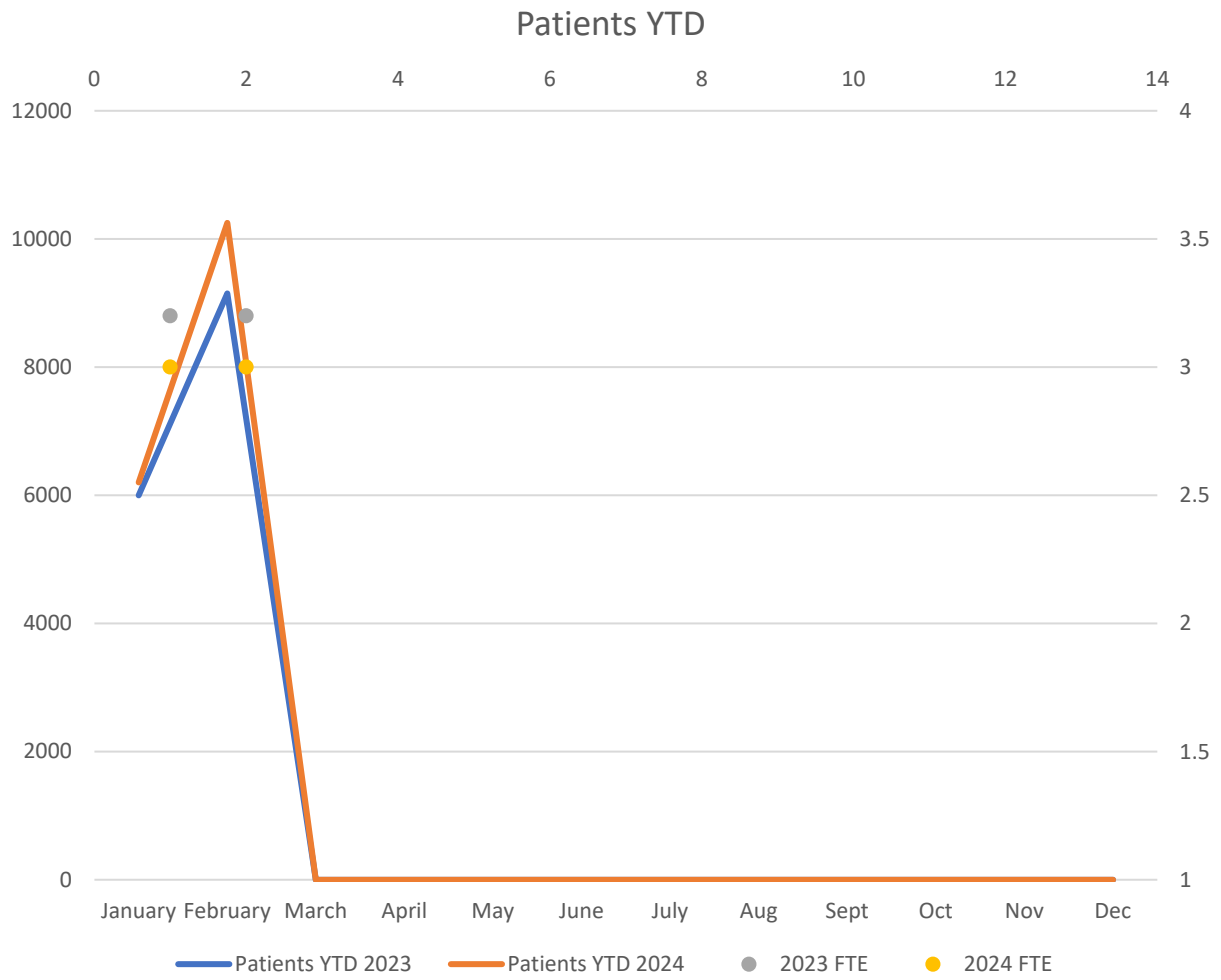
YTD Visit and Patient volume

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



Patient and Visit YTD: Self Assess

Is there a direct or indirect correlation between:

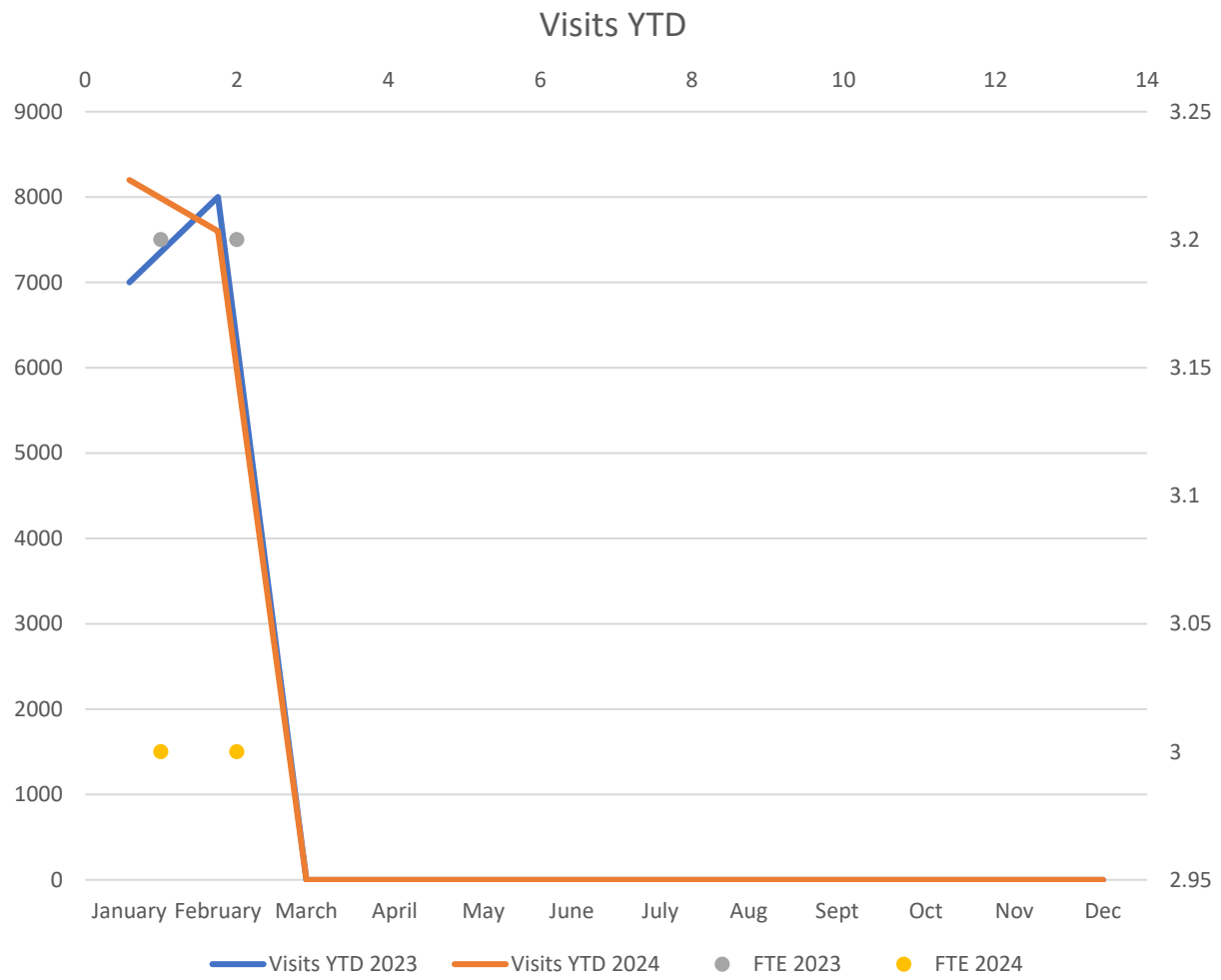
A. Patients and visits

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 for of retention:

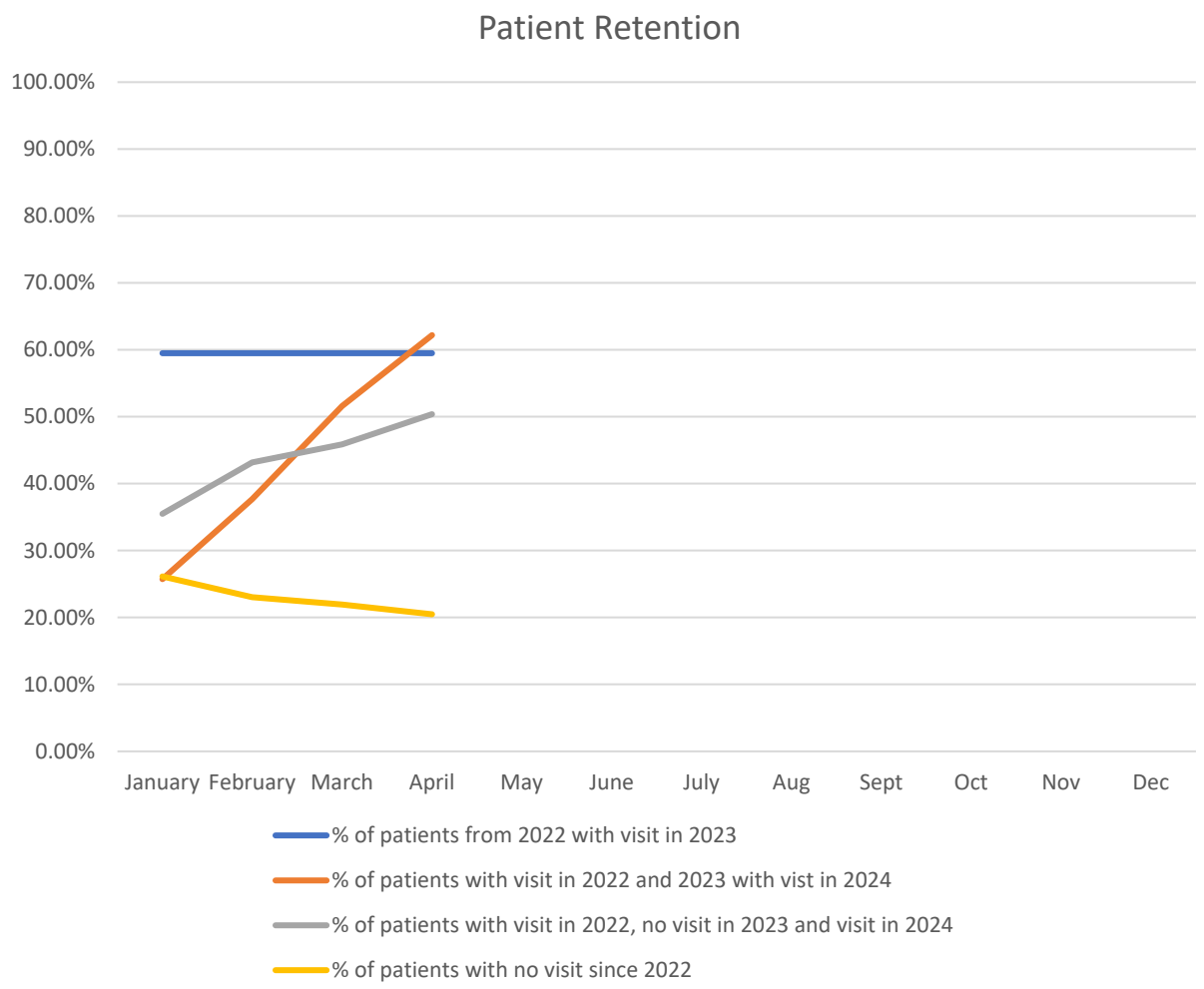
S= Patients at beg of period (Ex. 2022)

E= Number at end of period (Ex. 2024)

N= Number of new patients during period

Retention rate= ((E-N)/S)*100

Ex. (31,234-9,245)/27,444)*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

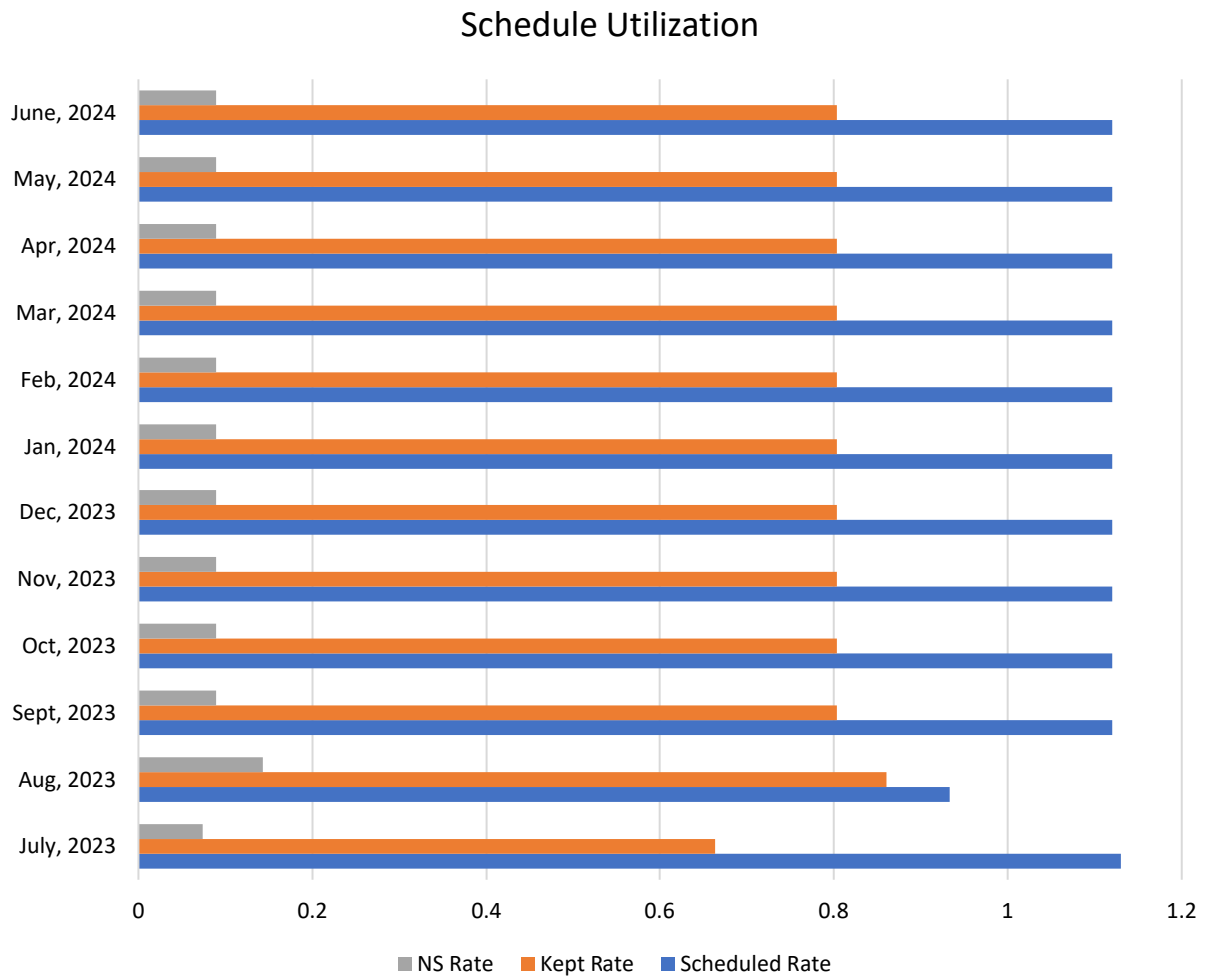
Do you have "frequent flyers"

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



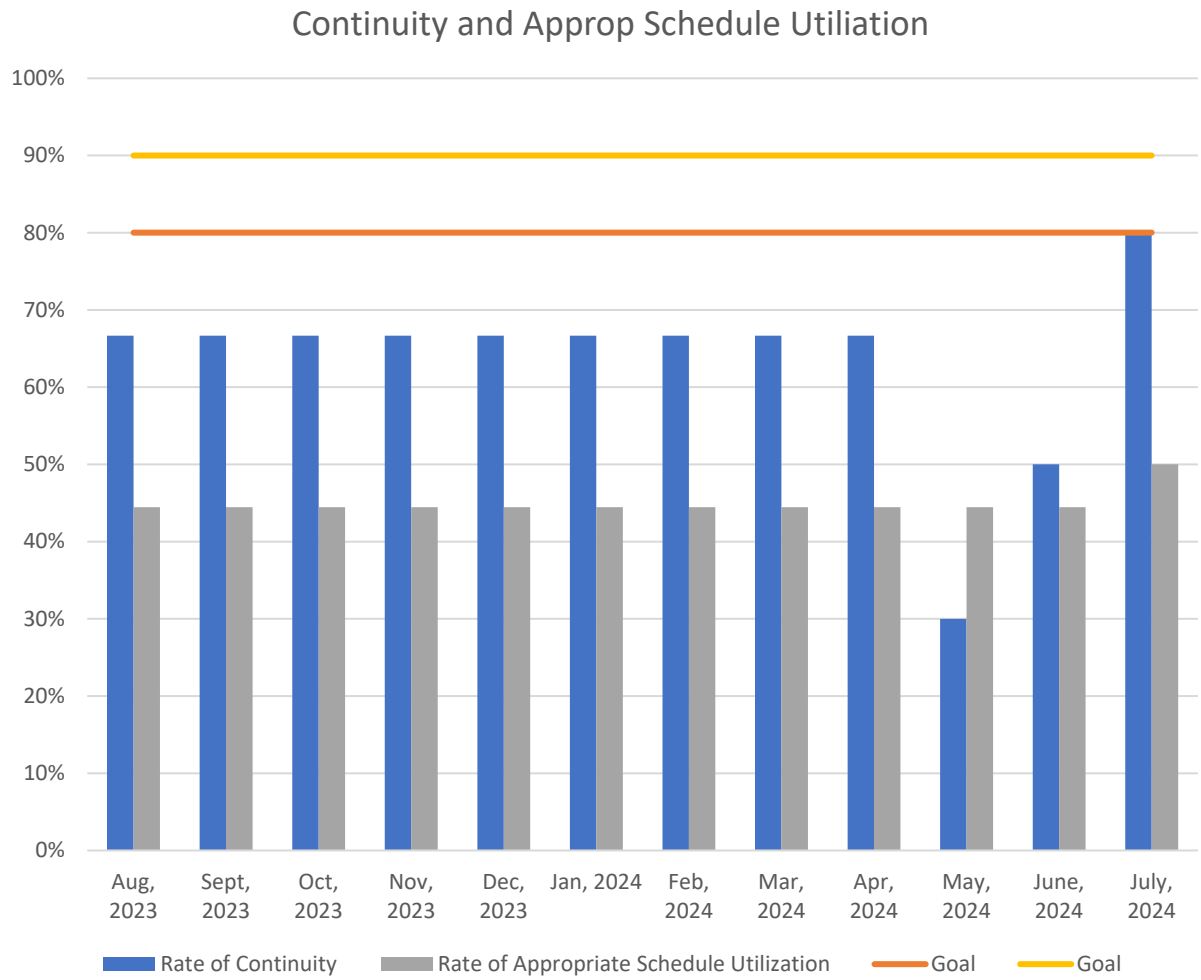
Continuity of Care and Appropriate Schedule Utilization

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



Count of Pt. Number	Visit Provider										% Continuity	% Appropriate Schedule Utilization
PCP Provider	Provider A	Provider B	Provider C	Provider D	Provider F	Provider G	Provider H	Provider R	Provider T	TOTAL PCP ASSIGNMENT		
Provider A	228	20	35	5	0	0	2	31	4	325	70%	52%
Provider B	5	125	95	46	38	0	12	0	0	321	39%	30%
Provider C	22	46	225	20	36	2	40	52	18	461	49%	55%
Provider D	18	52	0	200	15	22	110	50	5	472	42%	56%
Provider E	25	40	36	2	90	18	20	46	6	283	0%	45%
Provider F	59	56	2	15	186	20	69	20	4	431	43%	76%
Provider G	8	6	0	2	0	252	8	9	11	296	85%	76%
Provider R	15	2	12	6	9	2	0	165	2	213	77%	39%
Provider T	62	72	2	64	36	14	102	48	385	785	49%	89%
TOTAL VISIT BY PROVIDER	442	419	407	360	410	330	363	421	435			

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?

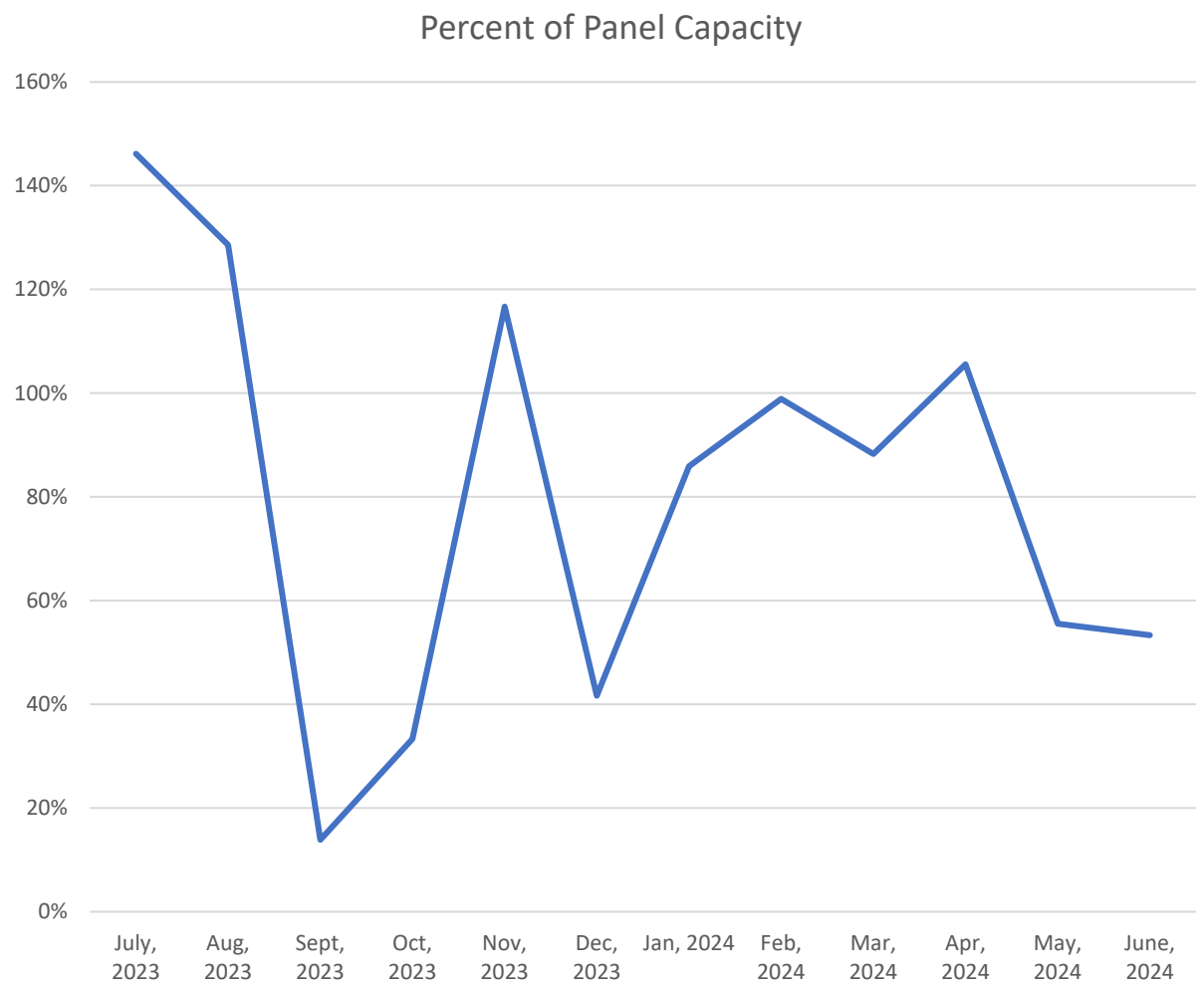
Empanelment (and visit utilization)

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?

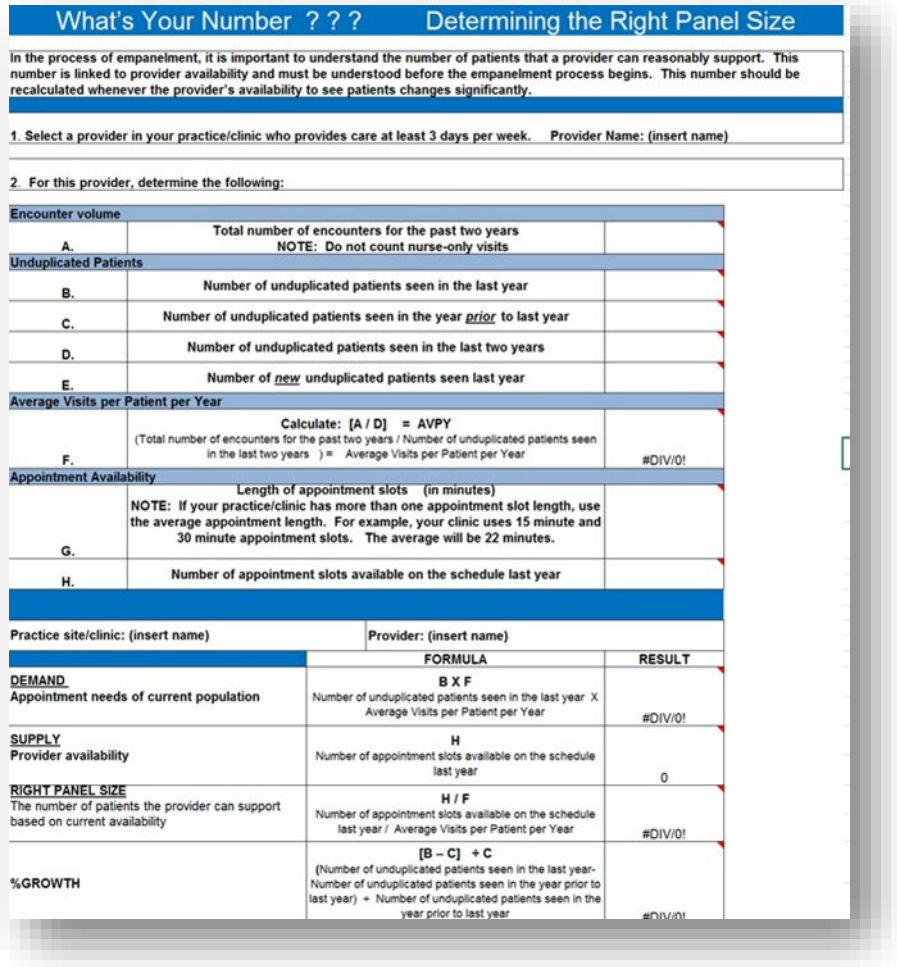
How do you take care of them?

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?



What's Your Number ? ? ? Determining the Right Panel Size

In the process of empanelment, it is important to understand the number of patients that a provider can reasonably support. This number is linked to provider availability and must be understood before the empanelment process begins. This number should be recalculated whenever the provider's availability to see patients changes significantly.

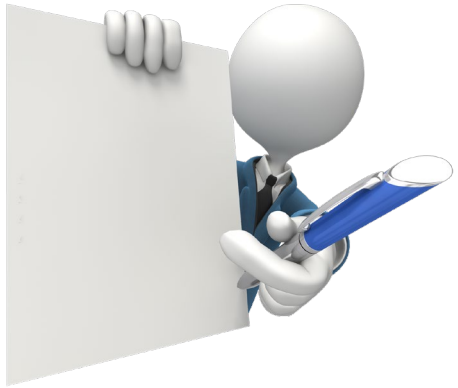
1. Select a provider in your practice/clinic who provides care at least 3 days per week. Provider Name: (insert name)

2. For this provider, determine the following:

Encounter volume		
A.	Total number of encounters for the past two years NOTE: Do not count nurse-only visits	
Unduplicated Patients		
B.	Number of unduplicated patients seen in the last year	
C.	Number of unduplicated patients seen in the year *prior* to last year	
D.	Number of unduplicated patients seen in the last two years	
E.	Number of *new* unduplicated patients seen last year	
Average Visits per Patient per Year		
F.	Calculate: [A / D] = AVPY (Total number of encounters for the past two years / Number of unduplicated patients seen in the last two years) = Average Visits per Patient per Year	#DIV/0!
Appointment Availability		
G.	Length of appointment slots (in minutes) NOTE: If your practice/clinic has more than one appointment slot length, use the average appointment length. For example, your clinic uses 15 minute and 30 minute appointment slots. The average will be 22 minutes.	
H.	Number of appointment slots available on the schedule last year	

Practice site/clinic: (insert name)	Provider: (insert name)	
	FORMULA	**RESULT**
DEMAND **Appointment needs of current population**	**B X F** Number of unduplicated patients seen in the last year X Average Visits per Patient per Year	#DIV/0!
SUPPLY **Provider availability**	**H** Number of appointment slots available on the schedule last year	0
RIGHT PANEL SIZE The number of patients the provider can support based on current availability	**H / F** Number of appointment slots available on the schedule last year / Average Visits per Patient per Year	#DIV/0!
%GROWTH	**[B – C] + C** (Number of unduplicated patients seen in the last year- Number of unduplicated patients seen in the year prior to last year) + Number of unduplicated patients seen in the year prior to last year	#DIV/0!

Empanelment Process



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

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

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

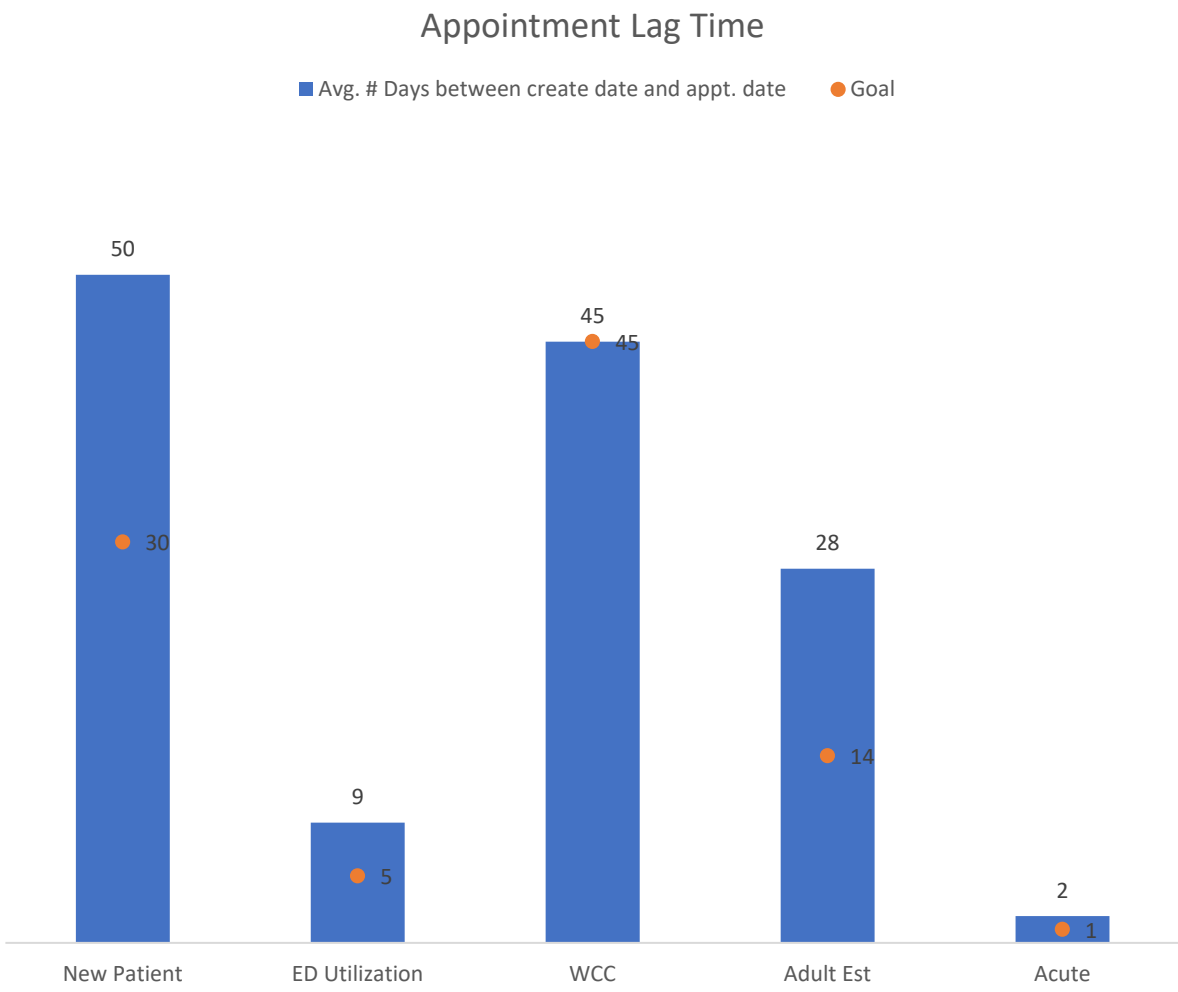
Lag Time=

Appt Date – Create date

Indirect correlation with growth opportunity

Patient Retention: High lag time:

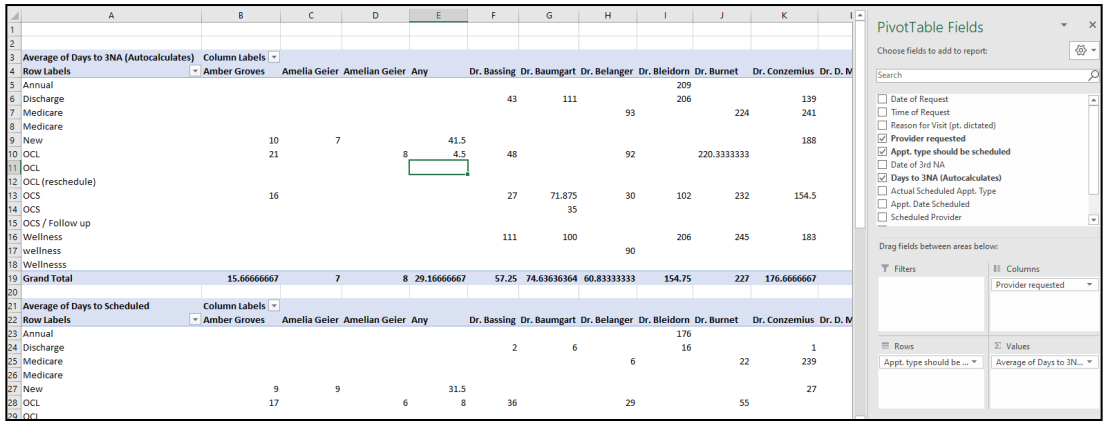
- Is it because we have retained al of our patients without increasing supply?
- Is it because we have taken on too many patients and not able to appropriately see retained patients which will lead to attrition?



3NA

Date of Request	Time of Request	Reason for Visit (pt. dictat	Provider requested	Appt. type should be scheduled	Date of 3rd NA	Actual Scheduled Appt. T	Appt. Date Sched	Scheduled Provider	Walk In
9/11/2018	10:30AM	work physical	Dr.X	Established	15	Same Day	9/11/2018	Dr.Z	

3NA vs. Lag Time



Average of Days to 3NA (Autocalculates)	Column Labels										
Row Labels	Amber Groves	Amelia Geier	Amelian Geier	Any	Dr. Bassing	Dr. Baumgart	Dr. Belanger	Dr. Bleidorn	Dr. Burnet	Dr. Conzemius	Dr. D. M
Annual								209			
Discharge					43	111		206		139	
Medicare							93		224	241	
Medicare											
New	10	7		41.5						188	
OCL	21		8	4.5	48		92		220.3333333		
OCL											
OCL (reschedule)											
OCS	16				27	71.875	30	102	232	154.5	
OCS						35					
OCS / Follow up											
Wellness					111	100		206	245	183	
wellness							90				
Wellnesss											
Grand Total	15.66666667	7	8	29.16666667	57.25	74.63636364	60.83333333	154.75	227	176.6666667	

Average of Days to Scheduled	Column Labels										
Row Labels	Amber Groves	Amelia Geier	Amelian Geier	Any	Dr. Bassing	Dr. Baumgart	Dr. Belanger	Dr. Bleidorn	Dr. Burnet	Dr. Conzemius	Dr. D. M
Annual								176			
Discharge					2	6		16		1	
Medicare							6		22	239	
Medicare											
New	9	9		31.5						27	
OCL	17		6	8	36		29		55		
OCL											

PivotTable Fields

Choose fields to add to report:

Search

- Date of Request
- Time of Request
- Reason for Visit (pt. dictated)
- Provider requested
- Appt. type should be scheduled
- Date of 3rd NA
- Days to 3NA (Autocalculates)
- Actual Scheduled Appt. Type
- Appt. Date Scheduled
- Scheduled Provider

Drag fields between areas below:

Filters | Columns: Provider requested

Rows: Appt. type should be ... | Values: Average of Days to 3N...

Average of Lag Time	Column Labels				
Row Labels	Can	Comp	Left	No Show	Grand Total
' [1173000002]	9.06	8.11	5.00	8.66	8.46
AMB ECG 12-LEAD [ECG7]	18.00	7.01			8.26
Case Managem [1173000009]	11.53	5.74		6.57	6.94
COMPLETE PULMONARY FUNCTION TEST [PFT13]		20.33			20.33
COVID PFIZER 1ST DOSE [1170002015]	17.00	9.00		15.00	12.86
COVID-19 (21 DAY) Pfizer [1170002001]	26.75	21.67		21.50	24.37
Dental 60 [1173000007]				1.00	1.00
ERAP [117000023078]	7.39	3.73		5.13	4.46
Group [1170000115]	7.75	7.69		16.00	8.06
Intake [1173000005]	3.17	0.10		5.25	0.30
MCVV ANNUAL WELLNESS [1170002038]	74.00	7.00			40.50
MED WEL FU [1170010020]	13.00	11.59			11.79
New Pat [1170000220]	10.10	6.84	5.25	7.96	7.65
NEW PSYCH [1170000301]	45.95	28.42		39.31	34.29
New Ther [1170000070]	11.22	6.81		7.35	8.18
Nurse Visit [1170000008]	9.91	4.93	6.00	8.08	5.94
Office Visit [1170000112]	16.08	8.40	4.40	11.77	10.46
PFIZER BOOSTER [1170002004]	18.64	9.43		14.13	13.58
Pro [1170000100]	11.60	7.36	8.00	9.19	8.76
PSYCH FU [1170000302]	46.79	41.95	42.00	40.72	42.51
PULMONARY FUNCTION TEST-SPIROMETRY [PFT14]		5.25			5.25
Resource Screening [1566]		0.52		3.00	0.68
Sports Phys [1170000051]	22.50	2.95		1.67	4.42
Tele [1170000006]	24.50	5.08			9.94
TELEPHONE VI [1170033500]	9.20	8.85		1.00	8.66
TELEPSYCH FU [1170033156]	51.00	41.34		38.27	41.36
TELEPSYCH NP [1170033155]	65.00	36.08		52.00	43.10
TELETHERAPY [1171000179]	6.67	7.00			6.75
Ther [1170000069]	48.40	35.72	39.00	22.03	38.08
Wel to Med [1170000096]	9.00	5.00			7.00
Grand Total	**23.65**	**13.95**	**7.80**	**15.06**	**16.12**

Row Labels	Average of Lag Time
' [1173000002]	8.46
AMB ECG 12-LEAD [ECG7]	8.26
Case Managem [1173000009]	6.94
COMPLETE PULMONARY FUNCTION TEST [PFT13]	20.33
COVID PFIZER 1ST DOSE [1170002015]	12.86
COVID-19 (21 DAY) Pfizer [1170002001]	24.37
Dental 60 [1173000007]	1.00
ERAP [117000023078]	4.46
Group [1170000115]	8.06
Intake [1173000005]	0.30
MCVV ANNUAL WELLNESS [1170002038]	40.50
MED WEL FU [1170010020]	11.79
New Pat [1170000220]	7.65
NEW PSYCH [1170000301]	34.29
New Ther [1170000070]	8.18
Nurse Visit [1170000008]	5.94
Office Visit [1170000112]	10.46
PFIZER BOOSTER [1170002004]	13.58
Pro [1170000100]	8.76
PSYCH FU [1170000302]	42.51
PULMONARY FUNCTION TEST-SPIROMETRY [PFT14]	5.25
Resource Screening [1566]	0.68
Sports Phys [1170000051]	4.42
Tele [1170000006]	9.94
TELEPHONE VI [1170033500]	8.66
TELEPSYCH FU [1170033156]	41.36
TELEPSYCH NP [1170033155]	43.10
TELETHERAPY [1171000179]	6.75
Ther [1170000069]	38.08
Wel to Med [1170000096]	7.00
Grand Total	**16.12**

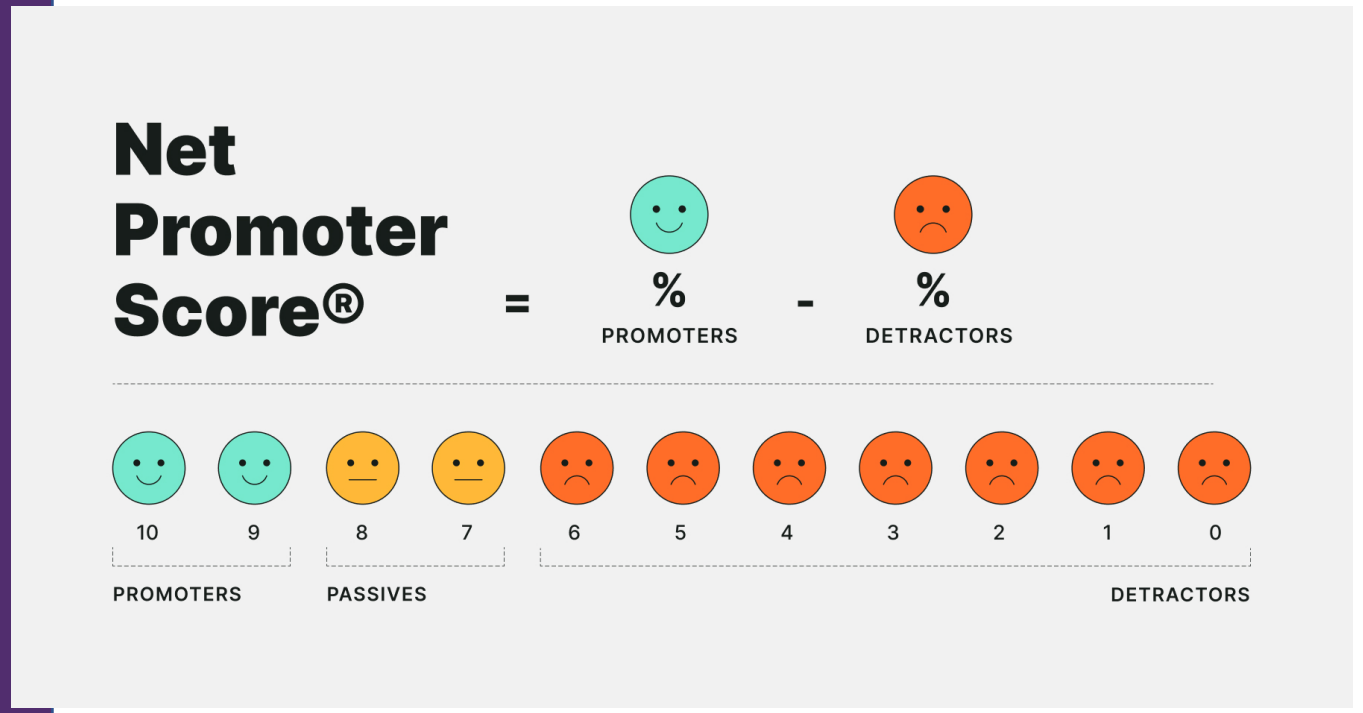
Patient Experience

- Net Promoter Score: Guage 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 you would you say?
    - Positive/negative

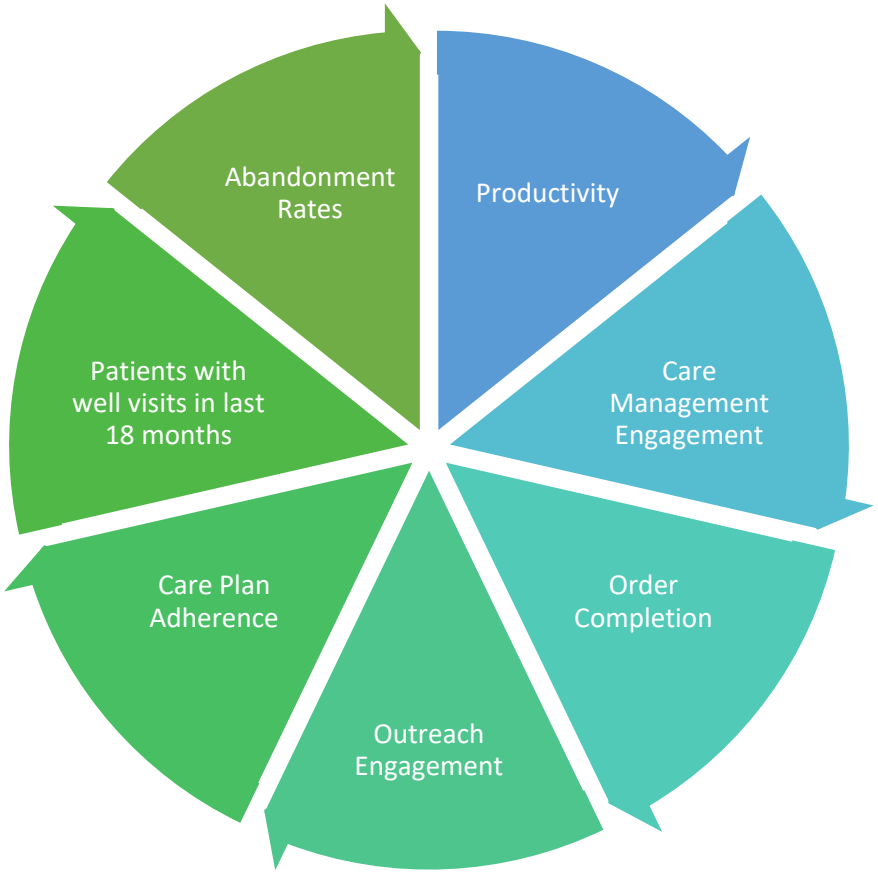


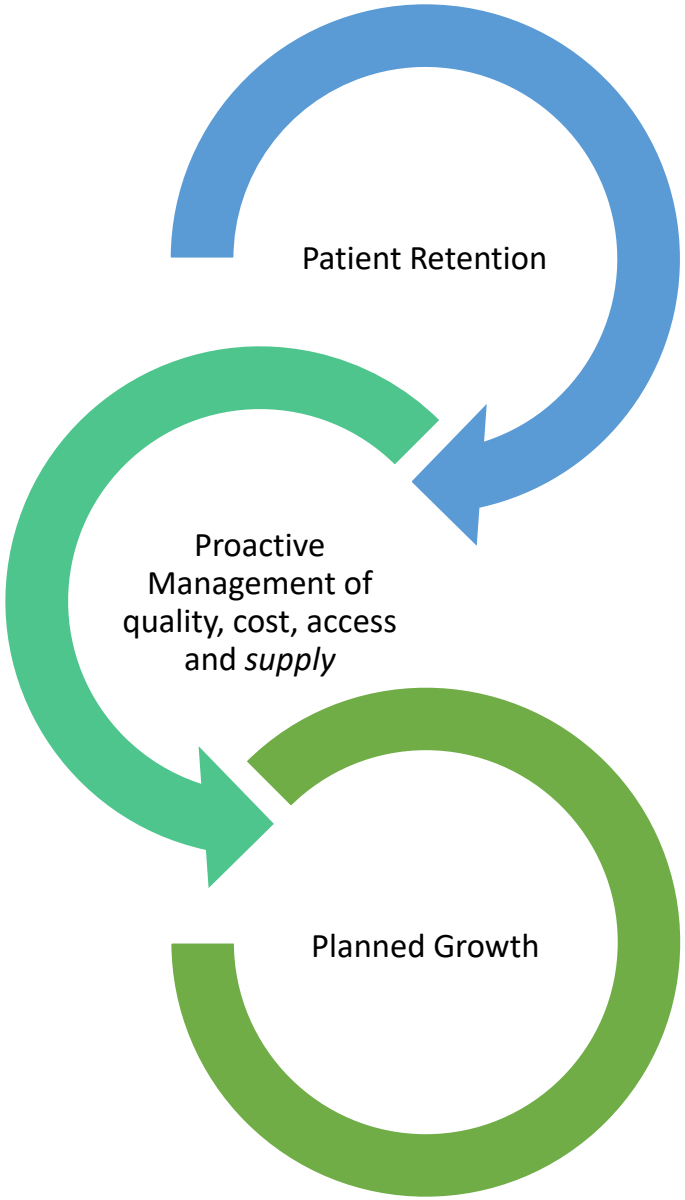
Access-Patient Experience or Engagement?

- 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:




Patient Retention
Proactive Management of quality, cost, access and *supply*
Planned Growth

Questions and Answers

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- Understand how to measure access
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- **Part 2**:
- Developing the key drivers for patient retention and growth
- Best practices for patient retention and growth

Drivers of Patient Retention

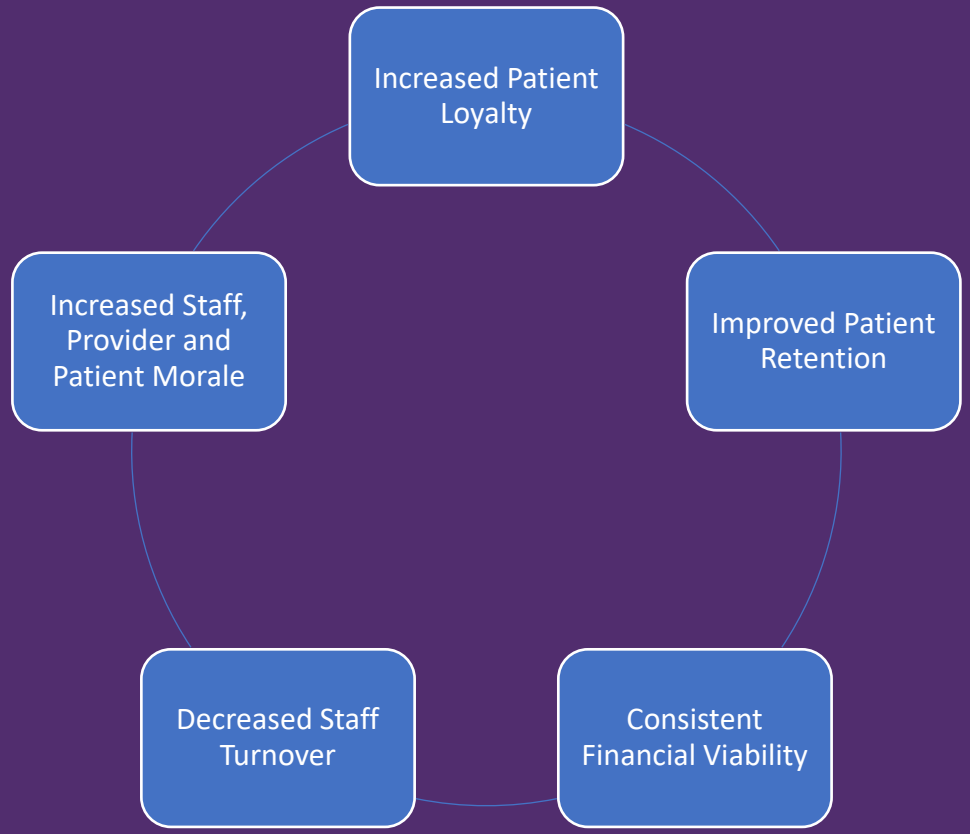
- Patient Experience, Patient Satisfaction and Patient Engagement
- Relationship Management
- Technology
- Training
- Culture of Equity
- Workforce

Patient Experience, Satisfaction and Engagement

Patient Experience Creates Value

THE PATIENT EXPERIENCE DEFINED

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

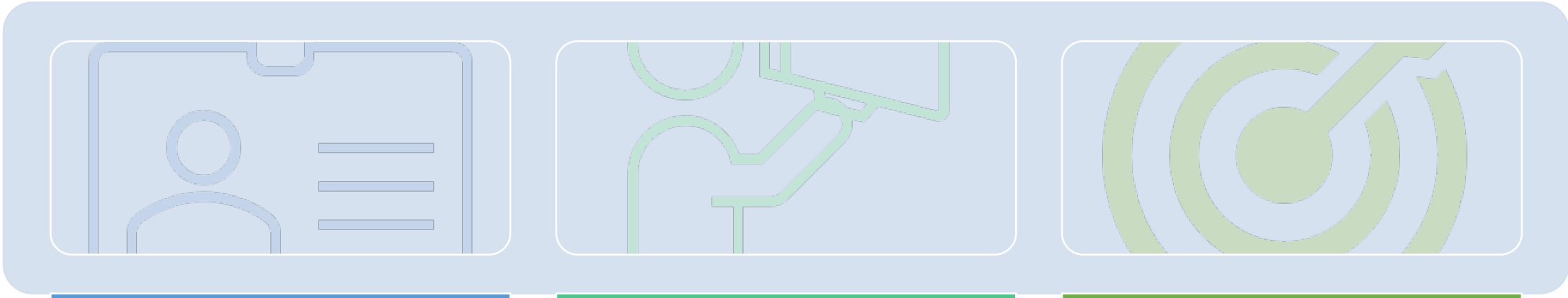


https://www.miramedgs.com/ealerts/583-improving-the-patient-experience-drives-superior-patient-satisfaction.html

Strategies to Improve Experience, Satisfaction and Engagement for Retention

- Value Add Interaction Mapping
- Patient experience and satisfaction surveys
- Setting expectations
- Creating the “HC” way
- Customer focus groups
- Patient exit interviews

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?
- Accessbility: Is the technology available to the patient when/how they need it?
- Accomodation: 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?

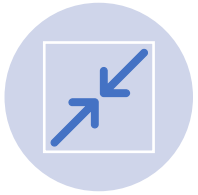
Will Technology help you retain or grow?

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

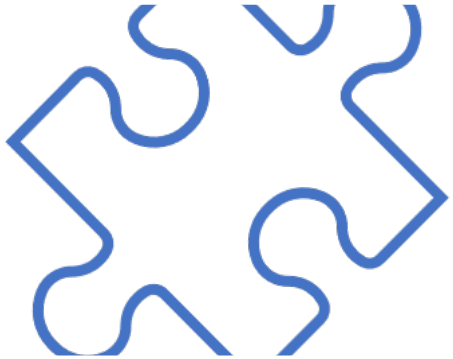
Competencies

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

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

Staffing Variable	Interview Range[a1]	MGMA[b2]	Proposed[3]	Difference from MGMA	Estimated Incremental Cost
Clerical	0.18-1.85	1.12	1.42	0.30	$ 11,661
MA, Technician, LPN	0-1.66	1.33	1.33	0.00	-
RN	0.21-1.78	0.00	0.00	0.00	-
RN Care Manager	0-1.0	0.00	0.40	0.40	$ 38,116
NP/PA	0-1.36	0.23	0.25	0.02	$ 2,384
Health Coaches ($ for MA)	0-0.25	0	0.25	0.25	$ 9,848
Pharmacist	0-0.53	0	0.2	0.20	$ 29,770
Mental Health ($ for SW)	0-0.83	0	0.25	0.25	$ 18,330
Nutritionist	0-0.20	0	0.1	0.10	$ 6,890
Clinical Data Analyst	NA	0	0.05	0.05	$ 3,653
Total		**2.68**	**4.25**	**1.57**	**$ 120,652**

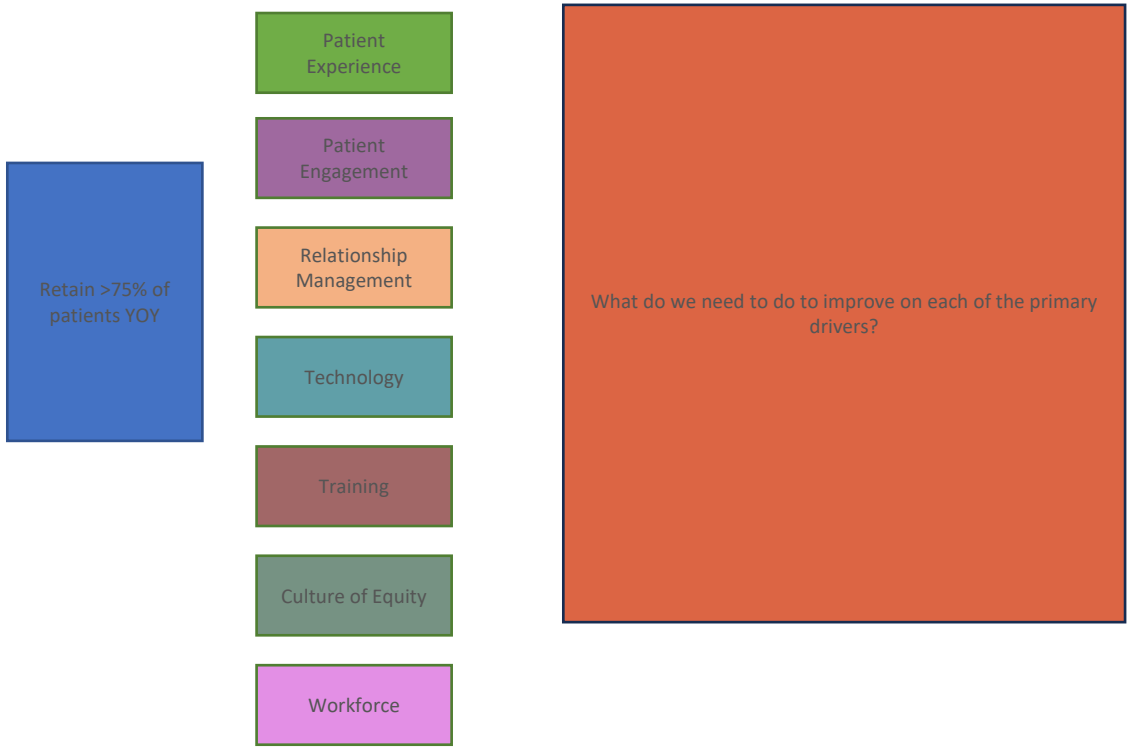
FTE indicates full-time equivalent; LPN, licensed practical nurse; MA, medical assistant; MGMA, Medical Group Management Association; NA, not applicable; NP, nurse practitioner; PA, physician assistant; PCMH, patient-centered medical home; RN, registered nurse; SW, social worker.
[a]Based on telephone interviews.
[b]Median integrated delivery system owned, all internal medicine.
[1]Most were unadjusted; several used risk stratification techniques
[2]MGMA 2010 Cost Survey Report
[3]Based on proprietary risk adjustment software from Economic Research Institute. Geographic AssessorR-Professional (North America). Data as of April 1, 2011. http://www.erieri.com/GeographicAssessor. Accessed August 31, 2011.
Adapted with revisions from Patel, 2013.

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

Staff Type	≤2 FTE Physicians (n=216)	>2-4 FTE Physicians (n = 148)	>4-7 FTE Physicians (n = 92)	>7 FTE Physicians (n = 40)	All Practices (n = 496)
Administrative staff[a]	2.42	1.76	1.70	1.98	2.05
Medical assistants	1.76	1.31	1.23	1.11	1.45
NPs, PAs	0.97	0.49	0.38	0.20	0.65
LPNs, LVNs	1.38	0.78	0.66	0.53	0.95
RNs	1.04	0.54	0.38	0.31	0.64
Care managers/coordinators	0.77	0.46	0.24	0.23	0.47
Pharmacists	0.75	0.42	0.15	0.29	0.32
Social workers	0.75	0.22	0.13	0.12	0.20
Community service coordinators	0.86	0.26	0.17	0.20	0.48
Health educators	1.00	0.37	0.19	0.10	0.42
Nutritionists	0.58	0.38	0.08	0.07	0.27

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.
[a] Administrative staff include those managing reception, medical records, appointments, finance, etc.

Key Drivers of Patient Retention- Exercise



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

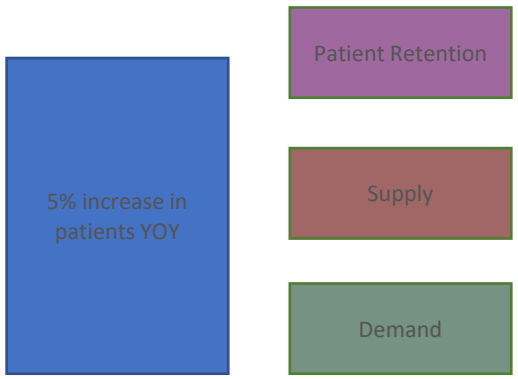
Supply is directly correlated to growth

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



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

Incentive plans

Staff and providers

Retention and growth

Staff and patient referral programs

If patients bring other patients, they tend to stay!

If staff bring patients they are more likely to stay!

Patient engagement strategies

Cancellation and No-shows

Patient driven utilization of technology

Marketing

Use the patient voice

ID disparities in community

Where do you have capacity

Search engine optimization

Community partners

Immediate access

Appointments

Phone

Team members

Technology

AI/BOT
Portal
Immediate-Telehealth
RPA Text/Voice
Targeted engagement

Questions and Answers