

UTSouthwestern
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Office of Institutional Compliance
and Audit Services

Patient Access Audit

Internal Audit Report 24:11

July 18, 2024



Executive Summary

Patient access refers to the ease with which patients can obtain medical appointments and receive care, which can ultimately lead to timely care delivery, improved patient outcomes and satisfaction. By promoting equitable appointment scheduling and reducing wait times, healthcare providers can enhance the overall patient experience and build a more responsive and patient-centered healthcare system. A robust governance of patient access processes and controls are essential to mitigate risk and maximize patient access and safety, financial performance, and operational efficiency. This requires clearly defined accountabilities and monitoring patient access to ensure alignment with UT Southwestern's business goals, strategies, and mission.

Currently, UTSW leverages both a centralized and decentralized approach to patient access with patient appointments being scheduled by the Centralized Patient Access Services (CPAS) team, directly with the clinics, or by the patient through MyChart. Once the appointment is scheduled, Patient Financial Services (PFS) manages patient registration and benefit verification. Canceled and rescheduled appointments are then managed by both CPAS and the clinics.

CPAS is required to utilize decision trees, scheduling templates, and tools maintained in Epic, which assist schedulers in identifying appropriate providers for patients based on visit type (e.g., new patient, established patient) and available appointment slots based on provider availability. Additionally, CPAS partners with some Clinical departments to manage decision trees and scheduling templates. In parallel, business units are responsible for monitoring contracted clinical effort in comparison to both assigned scheduling templated hours and actual clinical effort for their respective clinics and associated providers.

Audit Results

The Office of Institutional Compliance & Audit Services (OICAS) conducted a patient access audit with a focus on clinics that follow the centralized scheduling process. Overall, multiple strengths were identified in the process, including but not limited to the following: (i) use of ambulatory scheduling and clinical effort dashboards to highlight key performance metrics; (ii) cross-functional review of CPAS scheduling metrics; and (iii) release of additional appointment slots shortly before an appointment date to increase patient access for new patients. However, several control gaps were identified related to the management of scheduling templates and decision trees, as well as accountability to oversee provider contractual clinical effort.

A summary of observations is outlined on the following page:

AREA	OPPORTUNITIES	RISK RATING
<i>Scheduling template and decision tree management</i>	<ul style="list-style-type: none"> Standards for scheduling templates and decision trees Oversight for overruled warnings / errors / bypasses Slot utilization and third-next available 	HIGH
<i>Clinical effort accountability</i>	<ul style="list-style-type: none"> Provider clinical effort oversight Provider utilization 	MEDIUM

Further details are outlined in the Detailed Observations section. Less significant issues were communicated to management.

Management Summary Response:

Management agrees with the observations and recommendations and has developed action plans to be implemented on or before 2/28/25.

Appendix A outlines the objective(s), scope, methodology, stakeholder list, and audit team for the engagement.

Appendix B outlines the Risk Rating Classifications and Definitions.

Appendix C outlines Patient Access leading practices.

Appendix D outlines data analytical outcomes related to Observation #4.

Appendix E outlines Patient Access benchmarking.

The courtesy and cooperation extended by the personnel in Ambulatory Services, Patient Financial Services, and in-scope clinical departments are appreciated.

Natalie Ramello

Natalie A. Ramello, JD, CHC, CHPC, CHRC, CHIAP
Vice President, Chief Institutional Compliance Officer & Interim Chief Audit Executive
Office of Institutional Compliance & Audit Services
July 18, 2024

DETAILED OBSERVATIONS

Scheduling template and decision tree management

Scheduling template and decision tree standards do not exist for clinics supported by the Centralized Patient Access Services (CPAS) team, including oversight processes to verify scheduling tools are current and overruled warnings/errors/bypasses are monitored and addressed. Without proper template and decision tree governance and controls, there may be an increased risk of patient safety and quality of care incidents, incorrect scheduling, and operational inefficiency.

HIGH

1. Standards for scheduling templates and decision trees	Recommendation	Management Action Plan
<p>The decision trees and provider scheduling templates are tools that are maintained in Epic to assist schedulers in booking patient appointments and are expected to be current and up to date. It is a common practice to have changes to these tools, along with a process to monitor appropriateness of certain changes, as needed.</p> <p>Our review indicated the following gaps and improvement opportunities:</p> <ul style="list-style-type: none"> • A process to monitor and track changes to scheduling templates and decision trees needs to be formalized. This could otherwise lead to incorrect scheduling, operational inefficiencies, and impact patient access. These risks are further escalated due to the absence of clearly defined standards and controls to guide the use of scheduling templates and decision trees, including associated change management processes. • Typically, if an optimized decision tree is in place, supplemental documentation (e.g., protocols, guidelines, tip sheets) to assist with 	<ol style="list-style-type: none"> 1. Management should establish a template management and decision tree governance (refer to Appendix C) to define and enforce consistent standards across the system, including the following: <ol style="list-style-type: none"> a. Framework that outlines the responsibilities to maintain accurate scheduling templates and decision trees, adherence to scheduling templates and decision trees, and compliance expectations and outcomes. b. Centralized template management team to manage template changes, analyze the impact of requests to provider effort and to patient access, including monitoring. c. Centralized decision tree management team to manage decision tree implementation and changes, including restrictions for clinic schedulers to bypass decision trees. 	<p>Action Plan Owners: Toni Eby Hicham Ibrahim, MD</p> <p>Action Plan Executives: Toni Eby Hicham Ibrahim, MD</p> <p>Due Date: 1/31/2025</p> <ol style="list-style-type: none"> 1. Ambulatory Operations will establish decision tree governance team per service line which will include AVP CPAS, Director of Operations, and Clinic Medical Director to be responsible for: <ol style="list-style-type: none"> a. Review of current decision trees and clinical interests for accuracy and a bi-annual maintenance review

<p>scheduling is not required. However, management indicated they are often required to maintain supplemental documentation due to complexity or absence of a decision tree in certain cases, resulting in operational inefficiencies.</p> <p>Furthermore, we noted the following from the virtual collaboration sessions held with schedulers across in-scope clinics:</p> <ul style="list-style-type: none"> • 26 out of 28 respondents experienced mis-schedules due to issues with decision trees, e.g., incorrect subgroups (group of providers tagged to specific visit type); complexity of decision trees. • 25 of 27 respondents (note: one individual refrained from responding) stated that they override templates when scheduling patients, e.g., provider approves booking new patient into an established patient template slot; provider approves overbooking two patients into one appointment slot. 	<ul style="list-style-type: none"> d. Centralized oversight committee, including physician leadership, tasked to enforce compliance to scheduling template processes and decision tree protocols and approve all changes. e. Designated clinic managers (“local team”) performing allowable changes to scheduling templates, as defined by management, such as template holds and changes in provider availability if the change is less than 48 hours. <ol style="list-style-type: none"> 2. Following optimization of scheduling template governance, management should consider limiting the number of individuals that can override scheduling template warnings (e.g., booking appointments outside the templated hours) and restricting the number of individuals who have access to make urgent changes to scheduling templates. 3. Management should evaluate existing decision trees utilized by CPAS for complexity and coordinate with the clinics to simplify overly complex decision trees accordingly. The review should include verifying subgroups tie to scheduling templates and evaluation of the decision tree logic. 	<ul style="list-style-type: none"> b. Final approving body for any/all changes c. Review for escalations for decision tree modifications d. Review of use and accuracy of Template details of ‘Time on Hold’ and ‘Provider Unavailable’ <ol style="list-style-type: none"> 2. Clinic Managers/CSA Supervisor may make single day edits with approval from Medical Director. In addition, centralized template management team to manage all major template changes. 3. Decentralized clinics will be encouraged to apply the same process as HSA areas and will be provided the following tools with monitoring: Clinic Leader Program: Intro & Advanced <ul style="list-style-type: none"> a. Medical Director Program b. Ambulatory Managers Forum c. Suite of PowerBI reports with Template Matrix of use/goals d. Staffing calculators e. Epic Training documents
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2. Oversight for overruled warnings / errors / bypasses	Recommendation	Management Action Plan
<p>Schedulers are expected to book patient appointments within Epic, leverage scheduling tools (scheduling template and decision tree) and obtain patient insurance information. Epic will issue warnings and errors when scheduling templates and registration steps are overridden, or when decision trees are bypassed (i.e., not used).</p> <p>Considering sector-nuances, it is not un-common to have templates overruled and insurance information not available while scheduling appointments. However, it is imperative to have a streamlined approach to monitor the appropriateness of overruled warnings, errors, and bypasses, and to take corrective actions to minimize rescheduling or cancellation of appointments and impacts on patient care.</p> <p>We noted the following gaps and improvement opportunities based on our review:</p> <ul style="list-style-type: none"> • For the appointments scheduled by CPAS, there is a process to monitor and evaluate overruled warnings and bypasses, however a process to take corrective actions needs to be formalized. • The overruled warning metrics reviewed by CPAS do not include all warning types (e.g., guarantor warnings) that could further impact the completeness of the monitoring process. • For appointments scheduled by teams other than CPAS, a process to monitor, evaluate, and take corrective action for overruled warnings and bypasses needs to be formalized. • Discussions with Patient Financial Services (PFS) indicated that the team performs a benefit verification review within 14-days from a patient's 	<ol style="list-style-type: none"> 1. Management should establish an oversight process for overruled warnings /errors / bypasses received at the time of scheduling, including to monitor, evaluate appropriateness and timely address (e.g., update scheduling template or decision tree, scheduler training). <ol style="list-style-type: none"> a. Verify the existing Ambulatory User Scorecard incorporates all scheduling, template, and registration warnings and errors into the metrics, and that overruled warning and bypass data is included for all schedulers. b. Assess the existing CPAS review process to ensure the following are considered: (i) appropriate stakeholders are included (e.g., CPAS, PFS, clinics, physician leadership); (ii) agenda and metrics reviewed; (iii) overruled warning and bypass evaluation procedures; (iv) documentation of actions, owners, and timeline; (v) escalation procedures; and (vi) compliance expectations and outcomes. 2. Management should define if/when a decision tree can be bypassed and consider restricting clinic schedulers' ability to bypass decision trees. 3. Management should establish a defined timeline to complete benefit 	<p>Action Plan Owners: Toni Eby Hicham Ibrahim, MD</p> <p>Action Plan Executives: Toni Eby Hicham Ibrahim, MD</p> <p>Due Date: 1/31/2025</p> <p>Management will:</p> <ol style="list-style-type: none"> 1. Establish and oversight process for scheduling accuracy including overrule warnings/errors/bypasses to monitor the process for enhancements, technical corrections, and staff training. 2. Assess and define when a decision tree can be bypassed, if ever, to draft proposed business rules for future Governance Committee. 3. Ambulatory Ops Mgmt, in partnership with Revenue Cycle Mgmt, will establish a defined timeline to complete benefit verification to be included in written SOPs describing verification requirements and pre-payment review of network status. 4. Ambulatory Ops Mgmt, in partnership with Revenue Cycle Mgmt, will establish a process to identify upcoming encounters without complete pre-verification

<p>scheduled appointment to clear registration and insurance-related issues. However, PFS does not have visibility into overruled warnings and appointments which require higher prioritization and may lead to inefficiencies and patient dissatisfaction.</p> <p>Furthermore, sample testing was performed for cancelled appointments and for overruled warnings / errors / bypasses for scheduled appointments. Refer to Appendix D for the list of exceptions and trends that were noted as part of the review.</p>	<p>verification processes (e.g., 5 days prior to an appointment) and adjust the start of its current benefit verification review, accordingly.</p> <p>4. Management should establish a process to identify insurance-related and real-time eligibility errors (e.g., Epic workqueue or flag for patient appointments where the individual does not have eligible insurance and/or insurance is not verified) to enable prioritization during the benefit verification process by date of service.</p>	<p>by date of service to enable prioritization.</p>
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3. Slot utilization and third-next available	Recommendation	Management Action Plan
<p>Benchmarking was performed for third-next available and compared to slot utilization for both new and established patient appointments across 28 specialties from 9/1/23 - 2/29/24 (refer to Appendix E). The benchmarking identified certain gaps and improvement opportunities that could impact patient access and health outcomes.</p> <ul style="list-style-type: none"> • Slot utilization for established patient appointments was marginally lower than new patient appointments. <ul style="list-style-type: none"> ○ Non-surgical and surgical specialties had 14-15% higher slot utilization for new patient appointments in comparison to established patients (i.e., providers are using a lower proportion of appointment slots allocated for established patients) that could be opened to new patients. • For all 28 specialties, the third-next available appointment was benchmarked above the 50th percentile (ranges from 11 to 96 average days), indicating limited/constrained patient access. <ul style="list-style-type: none"> ○ 19 of 28 specialties are at or above the 65th percentile for third-next available in their respective specialties (ranges from 13 to 96 average days). ○ New patients looking for non-surgical services and primary care face a 2- to 3-month third-next available time on average, longer than 75% and 82% of other health systems, respectively. 	<ol style="list-style-type: none"> 1. Management should consider reallocating established and new patient appointment slots based on demand, specialty, and care urgency and/or removing visit type restrictions. 2. Management should enhance its process to periodically review how appointment slots are distributed across different specialties and clinics and ensure that following each review, appropriate actions are taken within a defined timeframe. 3. Management should leverage advanced scheduling algorithms to predict no-shows and appointment cancellations to limit predictable negative impact on access to care and clinic operations. 	<p>Action Plan Owners: Hicham Ibrahim, MD Kory Termine</p> <p>Action Plan Executives: Hicham Ibrahim, MD Kory Termine</p> <p>Due Date: 1/31/2025</p> <ol style="list-style-type: none"> 1. Health System will continue to educate clinic leadership on the existing ambulatory reports that detail slot utilization by appointment grouper (e.g., new versus established visits) as well as metrics that may impact slot utilization such as no show and cancelation rates. <p>Clinics with slot utilizations that are lower than expected target (currently set at 80%) for new or established patient slot will be expected to develop a remediation plan that may include reallocating new and established slots to better meet demands, removing template restrictions, or implementing measures to mitigate no shows and cancelations (such as limiting how far in the future an appointment can be scheduled).</p> 2. The Health System will conduct quarterly review of all clinics slot utilizations and guide clinic management in developing appropriate solutions when needed. 3. To improve access, clinics will also be educated on leveraging predictive no

		shows and cancelation analytics report to identify patients at high risk for no shows/cancelations and develop appropriate action plans for them that may include more robust appointment reminders and use existing overbook capacity to schedule them.
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Clinical effort accountability

Providers are not consistently meeting their contractual clinical effort across the clinical departments, and there is no formalized process to monitor and address variances in expected, assigned, and actual clinical effort. Without a standardized monitoring process with clear expectations and enforcement to oversee clinical effort, UTSW may be at risk for reduced patient access and provider contractual total effort misalignment.

MEDIUM

4. Provider clinical effort oversight

Recommendation

Management Action Plan

The business units (departments) are responsible to monitor expected (contracted) clinical effort in comparison to both assigned (scheduling templated hours) and actual clinical effort for respective ambulatory clinics and associated providers.

It was noted that actual ambulatory clinical effort for fiscal year 2024 was 15% below the expected scheduling templated hours in Epic. As of 4/30/2024, the total actual clinical hours (469,870.7 hours) did not meet the expected minimum patient facing hours (552,512.7 hours). This could potentially lead to inefficient resource allocation and impact patient access.

Discussions with select stakeholders indicated that while there is a policy which defines the minimum effort required for a clinical full time equivalent (cFTE), it does not outline guidance around its monitoring and enforcement. Some providers' overall effort is reviewed through the incentive program; however, a process to address variances between expected, assigned and actual clinical effort needs to be formalized.

1. Management should develop written guidance to support and enforce the existing *Ambulatory Effort Expectations* policy and educate stakeholders on their accountabilities, accordingly. This may include the following: (i) expectation to review the Ambulatory cFTE tracking dashboard; (ii) frequency of review over ambulatory cFTE; (iii) remediation expectations and timelines to address existing or potential variances; (iv) roles and responsibilities for departments and the clinics they operate; (v) department-specific nuances affecting implementation relative to the policy; and (vi) policy compliance expectations and outcomes.
2. Management should define a compliance process to validate ambulatory cFTE within the Total Professional Effort (TPE) report is accurate, including accountabilities and expectations that all changes to

Action Plan Owner[s]:
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Action Plan Executive[s]:
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Due Date: 2/28/2025

1. To enforce implementation of existing Ambulatory Effort Expectations policy, healthcare system leadership will develop guidelines that reiterate roles and responsibilities of operating business units in ensuring implementation of and compliance with policy, and outline expectation that clinic management reviews and communicates with providers periodically (e.g. monthly or quarterly) (1) ambulatory cFTE allocation, and (2) ambulatory effort performance relative to expected numbers of yearly clinic hours and sessions as detailed in policy. Guidelines will also stipulate development of remediation plans for providers who are not meeting expectations that include, but

	<p>ambulatory cFTE are approved and monitored.</p>	<p>are not limited to, corrective actions such as make up sessions to meet yearly expectations or financial disincentives to address recurrent non-compliance.</p> <p>Executive leadership will meet with department/clinic leadership at least once a year to review clinic compliance with Provider Effort Expectations policy.</p> <p>2. The health system and academic affairs will develop a process by which ambulatory clinical effort in the Total Professional Effort (TPE) system is evaluated against the templated time in Epic looking at retrospective templates and prospective templates quarterly. Variances between ambulatory cFTE and templated time in EPIC above a certain threshold (e.g. >5%, exact percentages TBD) will be referred to the department leadership for review and remediation. Variances at a higher threshold (e.g. >10%, exact percentages TBD) will be referred to the same group in addition to health system leadership for review and remediation. This will satisfy the monitoring recommendation.</p> <p>For the approval process, a process will be built for ambulatory cFTE changes where academic affairs in partnership with the health system will approve/reject ambulatory cFTE changes using the similar criteria as the quarterly review process. In order to account for clinical effort outside of visits scheduled in Epic (i.e. service coverage and image/test interpretation work), Qgenda will be used to populate workdays (using half-day equivalents) for</p>
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		<p>areas where Epic templates are non-viable, and a methodology used to equate half-day equivalents with cFTE. Populating Qgenda with usable data across departments is likely to require centralized resources to facilitate this transition and ongoing accuracy for all academic departments.</p>
5. Provider utilization	Recommendation	Management Action Plan
<p>Benchmarking was performed for provider productivity (physician and APP) and third-next available and compared to slot utilization across 28 specialties from 9/1/23 - 2/29/24. The benchmarking identified certain gaps and improvement opportunities that could otherwise result in suboptimal provider productivity and constrained patient access levels.</p> <ul style="list-style-type: none"> Physician productivity for surgical specialties was benchmarked at the 58th percentile while third-next available and slot utilization were at the 73rd percentile and 88% respectively, indicating an opportunity to increase utilization of resources despite high utilization of template slots. APP productivity benchmarks for primary care, surgical, and non-surgical specialties ranged from 39th to 53rd percentile, indicating an opportunity to increase provider capacity to see more patients. Primary care patient access levels (third-next available at the 76th percentile and slot utilization had an 87% average) were more constrained than expected based on lower productivity at 57th percentile, 	<ol style="list-style-type: none"> Management should optimize scheduling templates and evaluate the duration of appointment slots (e.g., 20 min., 40 min.) by both visit type (new and establish/return patients) and specialty, and standardize where applicable, to increase provider slot capacity and increase provider productivity. Management should assess APP utilization by department, including the following: (i) verify APPs have dedicated scheduling templates and are included in decision trees; (ii) evaluate the use of APPs for new patients; and (iii) define guidelines to transfer and share patients with APPs from physicians. Management should assess the provider care team model to identify opportunities to best utilize provider capacity across physicians and APPs. 	<p>Action Plan Owner[s]: Hicham Ibrahim, MD Christopher McLarty, DNP</p> <p>Action Plan Executive[s]: Hicham Ibrahim, MD Christopher McLarty, DNP</p> <p>Due Date: 2/28/2025</p> <ol style="list-style-type: none"> To help optimize access and appointment slot capacity, Health System will work with departments and clinics to develop standardized expectations for (1) appointment duration by visit type and specialty that will be implemented across UTSW ambulatory clinics (both health system- and department-operated clinics) and (2) relative allocations of new and established patient visits. UTSW Office of Advance Practice Provider, in collaboration with departments and clinic leadership, will continue to oversee optimization of APP utilization including consistent representation of APPs in scheduling decision trees related to access; refinement of APP templates;

<p>indicating an opportunity to review appointment slot durations and visit types to shift and create additional availability, increasing patient access.</p> <p>Refer to Appendix E for the benchmarking results and targets.</p>		<p>evolution of APP panels; and developing best practices for integration of APPs for new patients, further enhancing collaborative care team model between physicians and APPs.</p> <p>3. Further, a document outlining expected best practices will be developed and deployed, including institutional positions related to “incident to” and “split-shared” billing.</p>
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Appendix A

Objective, Scope, and Methodology:

The objective of the review was to assess patient access and scheduling processes and controls to identify gaps and improvement opportunities related to scheduling effectiveness and utilization of providers.

The audit scope period (09/01/2023 to 02/29/2024) included activities for clinical departments whose appointments are scheduled by the Centralized Patient Access Services (CPAS) team. The review included patient scheduling and registration, provider productivity, provider slot utilization, and provider availability. The review did not include referral processes and provider compensation and excluded clinical departments that did not follow the centralized scheduling process.

Our procedures included but were not limited to the following:

- Interviewed key personnel and reviewed relevant organizational policies.
- Conducted virtual collaborations sessions with select stakeholders from CPAS, in-scope clinical departments, ambulatory services, and revenue cycle to better understand current processes and controls related to patient access, scheduling, and registration.
- Performed benchmarking analysis and leading practice trends for provider productivity, third next available, and provider slot utilization.
- Evaluated key scheduling activities, including provider template governance, scheduling decision trees and management oversight.
- Analyzed data for scheduled and cancelled appointments, provider clinical effort, decision tree and scheduling template warnings/errors/bypasses.
- Conducted sample testing for select scheduled appointments to evaluate the use of decision trees and validate provider scheduling templates were in line with contractual clinical effort.
- Conducted sample testing for select cancelled appointments to evaluate patient eligibility and coverage selection processes.

We conducted our examination according to guidelines set forth by the Institute of Internal Auditors' International Standards for the Professional Practice of Internal Auditing.

Executive Sponsors:

Toni Eby, Associate Vice President, Chief Operating Officer, Ambulatory Services

Dr. Hicham Ibrahim, Associate Vice President, Chief Medical Officer, Ambulatory Services

Key Stakeholder List:

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Ruxandra Brashear, Manager, Patient Financial Services
Karen Copeland, Manager, Ambulatory Services
Amy Curtis, Director, Patient Financial Services
Kelly Kloeckler, Associate Vice President, Revenue Cycle
Alan Kramer, Associate Vice President, Health System Strategy and Business Development
Christopher Madden, Vice President, Chief Operating Officer, Health System
Dr. Christopher McLarty, Associate Vice President, Chief Nursing Officer, Ambulatory Nursing Operations
Mark Meyer, Chief Financial Officer, Hospital Administration
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Martin Hauck, Senior Consultant, EY
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Appendix B

Risk Classifications and Definitions

Each observation has been assigned a risk rating according to the perceived degree of risk that exists based upon the identified deficiency combined with the subsequent priority of action to be undertaken by management. The following chart is intended to provide information with respect to the applicable definitions, color-coded depictions, and terms utilized as part of our risk ranking process:

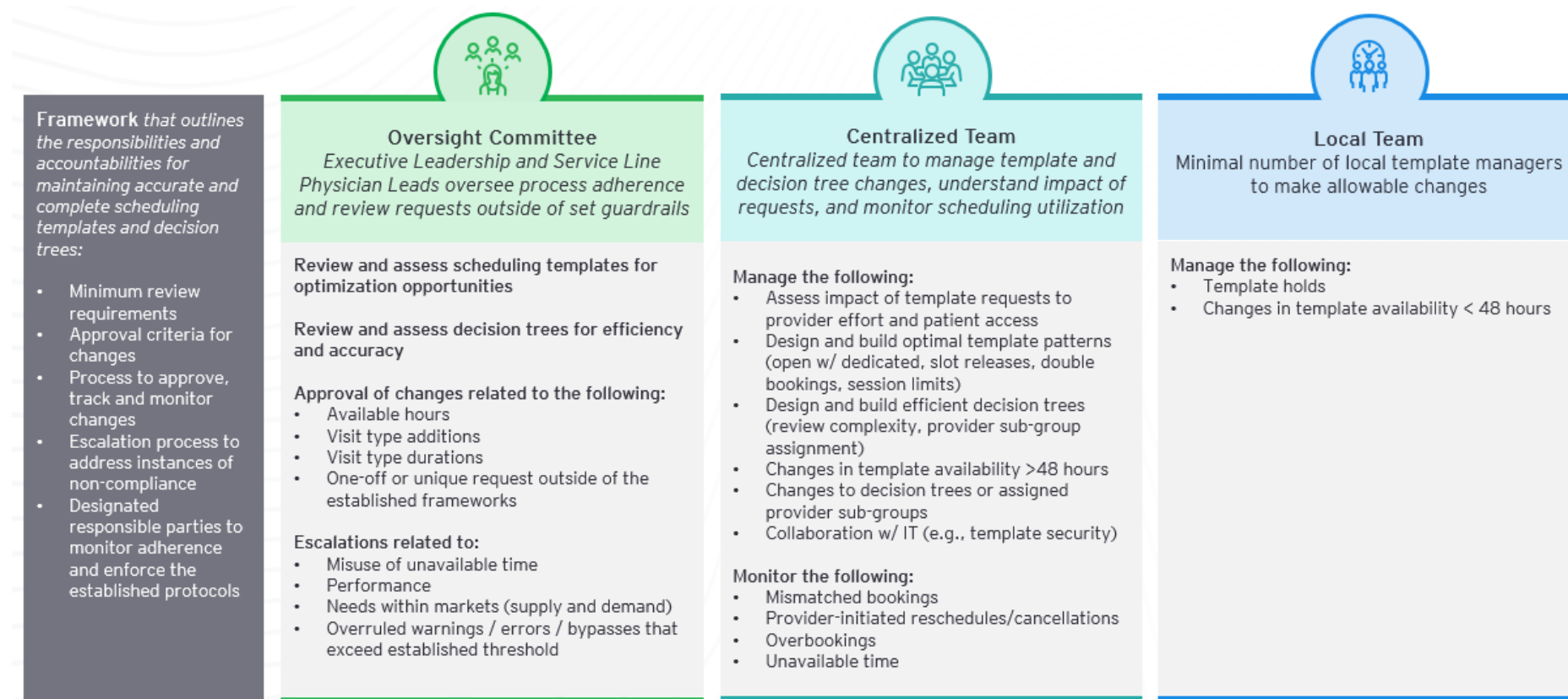
Degree of Risk and Priority of Action	
Priority	An issue identified by Internal Audit that, if not addressed immediately, has a high probability to directly impact achievement of a strategic or important operational objective of a UT institution or the UT System as a whole.
High	A finding identified by Internal Audit that is considered to have a high probability of adverse effects to the UT institution either as a whole or to a significant college / school / unit level. As such, immediate action is required by management in order to address the noted concern and reduce risks to the organization.
Medium	A finding identified by Internal Audit that is considered to have a medium probability of adverse effects to the UT institution either as a whole or to a college / school / unit level. As such, action is needed by management in order to address the noted concern and reduce the risk to a more desirable level.
Low	A finding identified by Internal Audit that is considered to have minimal probability of adverse effects to the UT institution either as a whole or to a college / school / unit level. As such, action should be taken by management to address the noted concern and reduce risks to the organization.

It is important to note that considerable professional judgment is required in determining the overall ratings. Accordingly, others could evaluate the results differently and draw different conclusions. It is also important to note that this report provides management with information about the condition of risks and internal controls at one point in time. Future changes in environmental factors and actions by personnel may significantly and adversely impact these risks and controls in ways that this report did not and cannot anticipate.

Appendix C

Scheduling template and decision tree management governance and structure leading practices

Shifting to a centralized approach for scheduling template and decision tree management requires a well-defined governance structure for successful implementation of strategic and operational improvements.



Template management leading practices

1. Optimize template structures to match cFTE and with optimized patterns

- Templates to reflect provider cFTE to increase provider productivity and system growth
- Templates are released up to 18 months at a system level
- Provider templates should balance open schedules with dedicated new slots to allow better access, more flexibility, and less overbooking by practice
- Implement slot releases 48-72 hours prior to an unfilled visit type
- Build session limits/quotas to set maximums on types of patients per day (as needed)

2. Standardize visit types and durations for new and established patients

- Reduce the variation in visit types available to eliminate arbitrary access barriers
- Develop standard definitions for each visit type
- Determine mode of visit type times for each specialty and implement a standard duration

3. Implement template governance and security

- Implement security templates for all users to restrict access to adding blocks to templates, overriding visit types, and manually changing times
- Develop a committee to oversee template changes to confirm alignment with standards
- Centralize template management by establishing a team to monitor template utilization (e.g., mismatches)

Appendix D

Observation #4 - Based on analytics of overruled warnings, errors, and bypasses, and sample testing of cancelled patient appointments, the following was identified:

For approximately 171,000 patient appointments scheduled for a sample of 9 clinics from 9/1/23-2/29/24, the following was noted:

- There were 63 types of overruled warnings and errors that were overruled by a scheduler, such as “No more openings”, “Outside template”, and “Group number missing”.
- 17% (29,323) of appointments had a scheduler overrule a template warning, and for 2 of the 9 clinics more than 20% of appointments had overruled warnings.
 - In 53% (15,694) of appointments, the overruled template warnings attributed to “Time on Hold” and “Outside Template”, indicating appointments were scheduled outside the provider’s designated clinical hours.
- 13% (21,660) of appointments had a scheduler overrule a scheduling warning.
 - In 7% (1,668) of the appointments, the overruled scheduling warnings were attributed to “Provider Out of Network” or “Service Not Covered”, indicating incomplete benefit verification.
- 2% (3,424) of appointments had a scheduler bypassing a registration errors.
 - In 5% (188) of appointments, the bypassed registration errors were attributed to “Group Number is Missing” or were missing guarantor data, indicating incomplete insurance verification.

For approximately 3,350 patient appointments cancelled due to financial, insurance, or billing reasons for a sample of 9 clinics with date of service from 9/1/23-2/29/24, the following was noted:

- 5 of 6 sampled appointments (83%) did not have insurance issues cleared prior to the patient’s scheduled appointment and were canceled within 1 to 3 days before the scheduled appointment. Additionally, the following was noted for the 5 appointments:
 - 4 appointments were scheduled more than 90 days in advance of the appointment date.
 - 4 appointments had an insurance-related warning (e.g., plan mismatch).
 - 1 appointment did not have insurance benefits verified.

For approximately 650,000 patient appointments scheduled for in-scope clinics from 12/1/23-3/24/24, the following was noted:

- 21% of appointments (~93,000) scheduled with a decision tree had a scheduler bypass the decision tree.
 - 9 clinics had over 50% of their appointments scheduled outside of the decision tree with 1 clinic bypassing the decision tree for 98% of its appointments.
- 32% of patient appointments (~210,000) were manually scheduled without the use of decision tree.

Appendix E

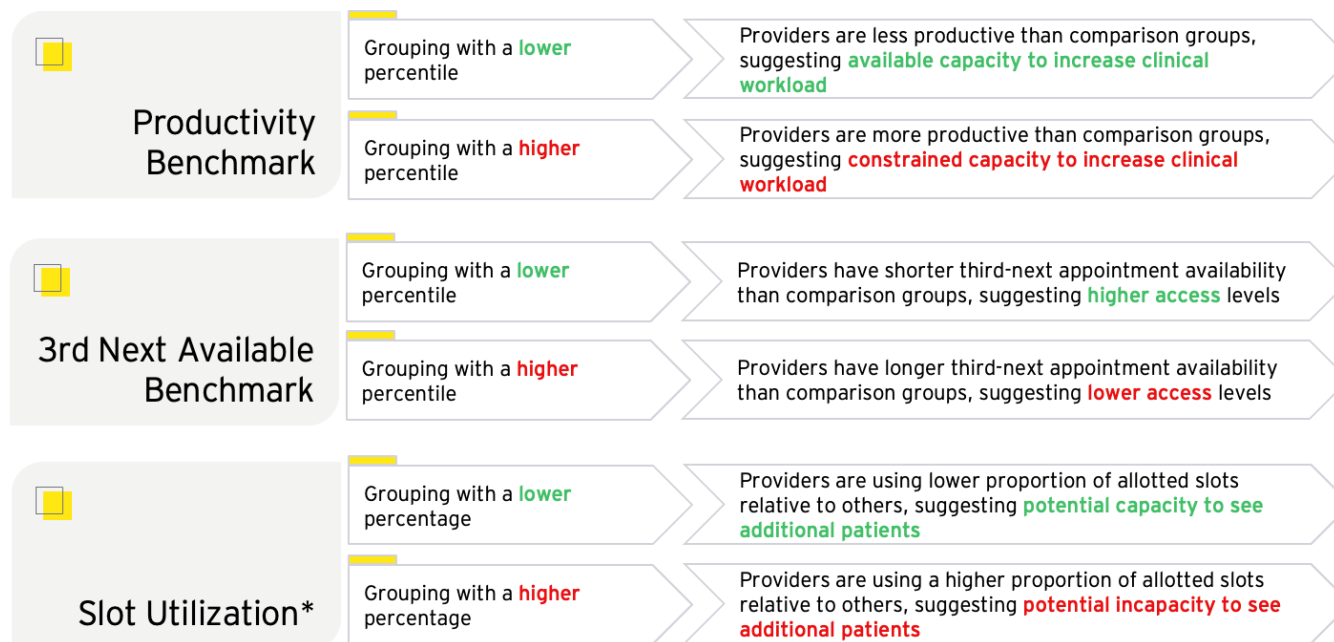
Patient access benchmarking | overview

The Patient Access internal audit included performing benchmarking of provider productivity and third-next available in comparison to other health systems for clinical departments scheduled by the Centralized Patient Access Services team. Slot utilization was compared to the benchmarks to further evaluate where there is opportunity to optimize patient access and scheduling.

Observations

- ▶ All UTSW specialties are above the 50th percentile for third-next available, indicating limited/constrained access relative to benchmarks
- ▶ Primary Care patient access levels (third-next available and slot utilization) are more constrained than expected based on lower productivity levels
- ▶ APPs may have capacity to see more patients in primary care and specialties with productivity benchmarks ranging from 39th to 53rd percentile
- ▶ New patients looking for primary care and non-surgical services face a 2- to 3-month third-next available time on average, longer than ~75% of other health systems

Below is an orientation for the benchmark percentiles used in the next three slides and how they translate to patient access levels.

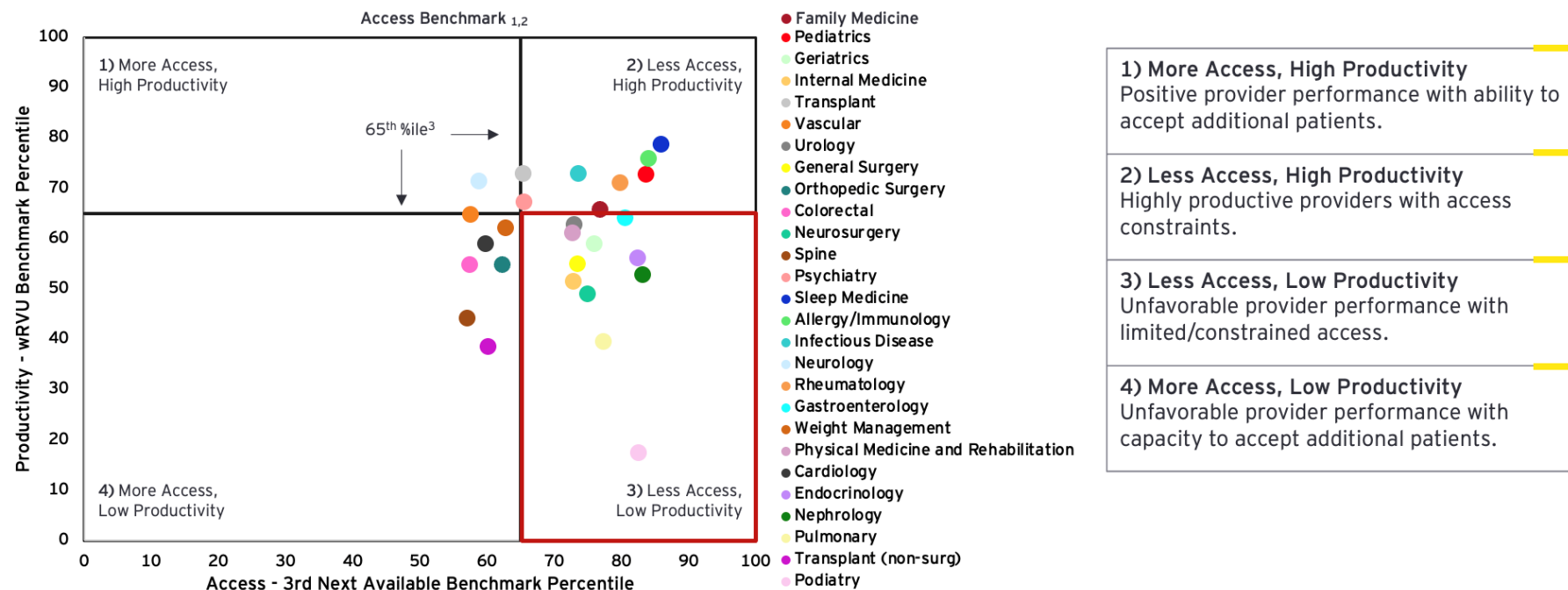


* Not a percentile compared to benchmark; true slot utilization as reported by UTSW Ambulatory Analytics Dashboard reports

Patient access benchmarking | executive summary

Provider productivity and third-next available benchmarking for centralized scheduling departments

All UTSW specialties are above the 50th percentile for third-next available, indicating limited/constrained access relative to benchmarks. When viewed in comparison to provider productivity, opportunities exist to enhance appointment availability where provider productivity is low and third-next available is high (i.e., patient access is low), refer to bottom right quadrant.



1. Source: Ambulatory Analytics Dashboard 9/2/2023-3/25/2024. Includes centralized scheduling Epic departments based on information from CPAS and ambulatory analytics leadership. Excludes nutrition, research, toxicology, and culinary departments as benchmarking data was not available; 2023 Practice Operations MGMA 3rd Next Available Appointment report
2. Source: TPE i07 provider productivity report February YTD FY24; 2023 Academic Compensation MGMA Work RVUs report – adjusted relative to reported FYTD cFTE
3. 65thile is a leading practice target for provider production; the third-next axis is a balancing measure to determine if there is a disconnect between productivity and access. Greater than 50th percentile third-next indicates some access constraints, greater than 65th percentile indicates significant access constraints.

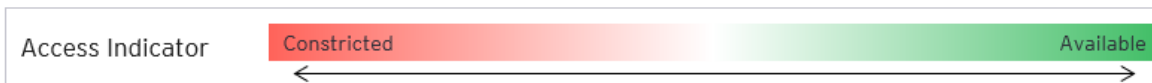
Patient access benchmarking | Physician vs. APP for centralized scheduling departments

Deeper analysis identified the following:

- ▶ Primary Care patient access levels (third-next available and slot utilization) are more constrained than expected based on lower productivity levels;
- ▶ Surgical specialty productivity and access levels more closely align, signaling opportunity to increase utilization of resources despite high utilization of template slots;
- ▶ APP resources may have capacity to see more patients.

Further optimization of APP deployment models may unlock additional capacity in hard-to-schedule specialties.

Specialty Grouping	Provider Type ¹	Productivity Benchmark Percentile (avg.) ²	3rd Next Average (days) ³	3rd Next Available Benchmark Percentile (avg.) ⁴	Slot Utilization Average ⁵ (Target: 80%) ⁵
Primary Care	Physician	65%	38	80%	89%
	APP	39%	9	54%	82%
Non-Surgical Specialties	Physician	65%	72	77%	85%
	APP	49%	27	57%	76%
Surgical Specialties	Physician	58%	30	73%	88%
	APP	53%	24	65%	76%
Behavioral Health	Physician	64%	27	74%	84%
	APP	80%	15	63%	78%

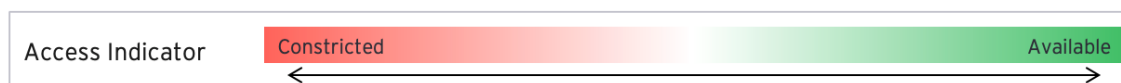


1. Weighted average across new and established patient populations
2. Source: TPE i07 provider productivity report February FYTD24; 2023 Academic Compensation MGMA Work RVUs report – adjusted relative to reported FYTD cFTE
3. Source: Ambulatory Analytics Dashboard 9/2/2023-3/25/2024. Includes centralized scheduling Epic departments based on information from CPAS and ambulatory analytics leadership. Excludes nutrition, research, toxicology, and culinary departments as benchmarking data was not available
4. 2023 Practice Operations MGMA 3rd Next Available Appointment report
5. 80% slot utilization target applied based on industry leading practice

Patient access benchmarking | New vs. established patients for centralized scheduling departments

New patients looking for primary care and non-surgical services face a 2- to 3-month third-next available time on average, longer than ~75% of other health systems. Slot utilization for established patient appointments is slightly lower than new patient appointments, suggesting opportunity to optimize availability by increasing open scheduling slots.

Patient Type	Specialty Grouping ¹	3rd Next Average (days) ² (Physicians & APPs)	3rd Next Available Benchmark Percentile (avg.) ³	Slot Utilization Average ² (Target: 80%) ⁴
New	Primary Care	59	82%	93%
	Non-Surgical Specialties	73	75%	90%
	Surgical Specialties	27	66%	91%
	Behavioral Health	24	65%	79%
		55	72%	90%
Established	Primary Care	23	73%	87%
	Non-Surgical Specialties	54	69%	75%
	Surgical Specialties	24	69%	77%
	Behavioral Health	17	66%	78%
		42	69%	79%



1. Weighted average across provider types and new vs. established patients
2. Source: Ambulatory Analytics Dashboard 9/2/2023-3/25/2024. Includes centralized scheduling Epic departments based on information from CPAS and ambulatory analytics leadership. Excludes nutrition, research, toxicology, and culinary departments as benchmarking data was not available
3. 2023 Practice Operations MGMA 3rd Next Available Appointment report - Academic Medical Centers
4. 80% slot utilization target applied (80% or less slot utilization provides additional slot availability for patients) based on industry leading practice

Patient access benchmarking | Service line breakdown for centralized scheduling departments

Service lines are performing slightly above median productivity benchmarks for their respective service line but are averaging near the 70th percentile for third-next available appointments with high rates of slot utilization, suggesting opportunity to increase provider capacity through template optimization and/or increase of clinical provider support.

Service Line – Specialty Roll Up ¹	Productivity Benchmark Percentile (avg.) ²	3rd Next Available (avg. days) ³	3rd Next Available Benchmark Percentile (avg.) ⁴	Slot Utilization (avg.) ³ (Target: 80%)
Primary Care	57%	34	76%	87%
Pediatrics*	73%	47	84%	73%
Family Medicine	66%	29	77%	87%
Geriatrics	59%	29	76%	86%
Internal Medicine	52%	42	73%	89%
Surgical Specialties	56%	28	67%	83%
Transplant	73%	13	65%	36%
Vascular	65%	11	58%	76%
Urology	63%	39	73%	81%
General Surgery	55%	15	73%	69%
Orthopedic Surgery	55%	21	62%	91%
Colorectal	55%	20	57%	68%
Neurosurgery	49%	23	75%	78%
Spine	44%	17	57%	85%
Behavioral Health	67%	20	65%	78%
Psychiatry	67%	20	65%	78%

Service Line – Specialty Roll Up ¹	Productivity Benchmark Percentile (avg.) ²	3rd Next Available (avg. days) ³	3rd Next Available Benchmark Percentile (avg.) ⁴	Slot Utilization (avg.) ³ (Target: 80%)
Non-Surgical Specialties	61%	63	72%	79%
Sleep Medicine	79%	54	86%	88%
Allergy/Immunology	76%	61	84%	75%
Infectious Disease	73%	40	74%	92%
Neurology	71%	81	59%	82%
Rheumatology	71%	74	80%	86%
Gastroenterology: Hepatology	68%	66	78%	87%
Gastroenterology	63%	96	79%	83%
Weight Management	62%	41	63%	69%
PM&R	61%	37	73%	83%
Cardiology	59%	42	60%	68%
Endocrinology	56%	76	82%	83%
Nephrology	53%	66	83%	87%
Pulmonary	40%	66	77%	68%
Transplant (medical)**	39%	26	60%	66%
Podiatry	18%	29	83%	59%

1. Weighted average across physician and APP provider types; new and established patient types
 2. Source: TPE i07 provider productivity report February FYTD24; 2023 Academic Compensation MGMA Work RVUs report – adjusted relative to reported FYTD cFTE
 3. Source: Ambulatory Analytics Dashboard 9/2/2023-3/25/2024.
 4. 2023 Practice Operations MGMA 3rd Next Available Appointment report
- * Meds Peds only
** Accounts for physicians identified in various transplant clinics that were not associated with surgical specialties in the TPE report

