ONE TEAM | UNITED ON ACCESS

Frequently Asked Questions

February 2024

The One Team | United on Access project team has heard many concerns and frustrations from physicians (you) regarding the roll out and implementation of this important initiative. As a result, we, with input from the UVA School of Medicine Faculty Senators, have developed this Frequently Asked Questions (FAQ) document to address many of the most commonly asked questions regarding the project.

This document discusses what One Team | United on Access (United on Access) is and why UVA Health is implementing this initiative. These FAQs also answer specific questions that have been raised by faculty and team members and reports the changes that have been made in response to your feedback.

There is quite a bit of information here; just scroll down to the question of interest on the next page and click on that question to learn more.

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GOALS & OBJECTIVES

1. What are the primary goals of One Team | United on Access?

UVA Health's guiding principles in the 10-year Strategic Plan are clear:

1) Patients are first in everything we do, *and*
2) We care for, empower, and support our fellow team members in everything we do.

As such, the goals of the One Team | United on Access (referred throughout as United on Access) initiative are equally clear:

- To increase patient access to our physicians and to improve the patient experience.
- To efficiently utilize our valuable staff and nurses.
- To create efficiencies that make it easier for our schedulers to schedule appointments and provide first-class patient care.
- To create an environment where it is easy and efficient for our physicians to care for patients in the ambulatory setting.

2. What data supports implementing United on Access?

Many, if not most, academic health systems have done this work before us. The data shows that by implementing United on Access, at a minimum, we will increase patient access, improve the patient experience, increase staff satisfaction, and reduce staff turnover. UVA Health has disseminated the data that supports "why" United on Access is being rolled out. Please see Q.36 below for the different venues and channels these data have been disseminated since 2022.

The following is a sampling of outcomes at other academic health systems:

- New patient access
  - University of Wisconsin increased new patient volume by 15%
- Patient experience related to access.
  - Northwestern improved from the 25th to the 75th percentile.
- Call abandonment rate.
  - University of Washington reduced from 21% to 6%
- No shows and late cancellations
  - UNC reduced by 2.1% in one year.
- Staff turnover
  - University of Wisconsin reduced access staff turnover by 8%.
- Reduced visit types
  - University of North Carolina reduced visit types by 5X.

3. What have been the results of United on Access at UVA thus far?

Two waves of United on Access have been completed, and the results to date have been overwhelmingly positive.

- We have created, in multiple specialties, up to a **30% increase in available patient appointments** with the same number of staff, the same number of physicians, and without the need for new clinic space.

- Data tells us that our patients are very appreciative: recent patient experience survey data for Wave 2 validates this as we have improved from the 83rd to the 88th percentile.
- We have experienced **1,800 new patient visits every month** and calculate **over 28,000 new visits annually**.
- It has also become easier for our schedulers to schedule patient appointments since there are standard templates (the time allowed for a visit) for our physicians. In surveying our schedulers in Waves 1 and 2 after go-live, over **80%** said they are able to schedule appointments during the first phone call with a patient – a significant change from prior to United on Access.
- As United on Access continues, we will be able to initiate **online scheduling** which is popular amongst patients across the country and available at many healthcare systems in the US. In our current state there is too much variability around appointment scheduling with thousands of different templates or scheduling times, which means creating an online scheduling solution would be nearly impossible. This variability in scheduling has also resulted in significant frustration for our scheduling staff. This leads to high turnover of the schedulers and frustration for our patients because they cannot get an appointment.

4. How far along are we in this process?

We have just finished implementing Wave 3 of seven potential waves. Each wave takes approximately 6 months so we anticipate finishing the implementation of all 7 waves in 2026. We may need to optimize clinic times, scheduling, templates, etc, after the initial implementation of each wave, so this will be occurring at the same time as the new implementations.

5. Are we benchmarking what this initiative is asking our physicians to do against other academic medical centers across the country?

At UVA Health we are significantly behind our academic peers across the country on how patients are accessing our care. Applying the Vizient benchmark for New Patient Access within 14 Calendar Days, UVA is below the 25th%ile. United on Access was designed to allow us to catch up, with our goal to increase patient access.

The following information provides important context around clinical operations:

Within a five-day work week (Monday to Friday), there are ten potential four-hour clinic sessions – five in the morning (usually 8AM-12PM) and five in the afternoon (usually 1PM-5PM). The vast majority of academic health care organizations ask their physicians to be present *for the full four hours* of a clinic session.

We are not asking our physicians to participate in all ten clinic sessions each week. The number of clinic sessions a physician participates can vary depending upon many factors, acknowledging other obligations such as research, teaching, or administration, as well as whether a physician is part-time or full-time. For example, a physician that has many responsibilities outside of clinical care may only have one or two sessions per week. United on Access does not mandate how many sessions a physician will have each week; rather this is determined by the department chair and the physician's other obligations.

What the United on Access team is asking is this – if you are assigned to a four-hour session – that you be in clinic for the full four hours of that session. This ensures that we maximize the use of both our clinical staff (front desk staff, nurses, MAs, etc.) and clinic space, both of which are at a premium. To have a fully staffed four-hour clinic without doctors present and seeing patients is a waste of resources and deprives patients of much-needed access to clinical care.

If you want to work less, the choice should be to work fewer sessions. This is a conversation between you and your department chair. However, when you do work a session, you need to be present for the full four hours of that session to maximally utilize our staff and space – and increase access to care for our patients.

6. I took the StandPoint survey last year. What did the AAMC StandPoint Survey Data show regarding clinical operations?

The 2022 AAMC StandPoint survey showed that faculty views of clinical operations (ability to provide high quality care; how well the clinical practice functions overall) have significantly improved since the previous survey in 2018 – from a 53% to 59% approval rating. The median for UVA Health's cohort in 2022 is 62%. While opportunity for growth is evident, we are moving in the right direction and, with time to fully realize the benefits, United on Access is expected to help build on this progress.

7. How will clinical and access team members benefit from United on Access?

United on Access will bring efficiencies and clarity to team members' roles, as well as consistency. These changes will reduce administrative burden and frustration, enhancing job satisfaction and retention among team members. Some examples of benefits team members will experience include:

- Consistent access and clinical workflows within specialties allow for better cross-coverage on access team and nursing staff:
- Access staff can schedule same-day appointments without going through nurse triage for some common issues.
- Template standards create efficiencies and predictability in scheduling and clinic staffing, lessening the impact of staffing shortages felt by all.
- Template standards help optimize space so clinic leaders can accurately gauge when additional space is needed.

QUESTIONS FOR INDIVIDUAL PRACTITIONERS

8. In academic medicine, I have other responsibilities (teaching, research, administrative) in addition to clinical care. If I have to be in clinic for four hours at a time, when will I have the time to do my other work?

Physicians' work is measured by a time allocation system called the CART. CART stands for Clinical time, Administrative time, Research time, and Teaching time. For each physician the various components of the CART should add up to 100%. However, the individual percentages might differ for each physician.

For example, for an ambulatory care physician who is 100% clinical, the expectation is that the physician would staff eight (not 10) 4-hour clinic sessions, or 32 hours of patient facing care per week. The remaining time in the workweek can be used for non-patient facing administrative work. Another scenario might be a physician who has the following CART effort distribution: 50% clinical, 10% administration, 20% research, and 20% teaching. In this example, the physician would be asked to provide 16 hours of patient facing care and, thus, the clinical assignment would be four half-day sessions each week. United on Access is requesting that when this particular physician is participating in their half-day sessions, they are fully devoted to clinical care for the four hours of each of these clinical sessions. This physician would have, outside of their clinical time, the remainder of the work week to complete their other academic obligations.

Of note, the vast majority of physicians have allocated time for the other missions as evidenced by their CART. The average percentage of clinical time of all our physicians in the School of Medicine is currently 60%. *This means the average physician in the School of Medicine has 40% of their work week protected to accomplish their other duties.* What United on Access is asking is that patient care be the focus during the assigned clinical time.

9. What if I have personal responsibilities that conflict with my four-hour session such as dropping children off at school?

The expectation is that physicians are in clinic for the entire four hours for each one of their four-hour sessions. UVA Health requires our nurses, medical assistants and access team members to be in clinic for the full four-hour session – and outside any urgent problems or absences planned significantly in advance, they are asked to fulfill this expectation as part of their employment. It is difficult to have different standards for our nurses/staff compared to the physicians. In our current state, it is frustrating for our nurses/staff to be in clinic on time, and then to have a clinic full of patients with physicians coming in late or leaving early – perceptions of different employment standards contribute to a negative clinic culture. See also Question #10 below.

10. Is there any flexibility for me? Sometimes issues come up – both personal and work-related – that may keep me from being in clinic for the full four hours.

Yes, it is important that there be flexibility. This is why United on Access sets an expectation that we will meet with the Four-Hour Session Adherence standard **85% of the time**. Therefore, if there is an emergency, personal need, or an academic obligation that occasionally presents itself during clinic, the 85% expectation allows the flexibility to fulfill these obligations but still meet the United on Access standards. It is requested that physicians provide advance notice, at least for elective absences, so clinic staff can notify patients that an appointment may need to be rescheduled.

Based on feedback from faculty, changes have been made to the metrics as well. The 4 Hour Session Adherence metric is still in place. Physicians still need to create four-hour sessions in their templates. Another metric has been added – Scheduled Slot Adherence – this complements the 4 Hour Session Adherence metric and offers greater flexibility in how to utilize the four-hour sessions. The intent of this new metric is to allow physicians to pursue the other

academic missions (teaching, research, etc.). It is not intended to allow physicians to start clinic late or to end clinic early on a recurring basis.

Here is an example that will illustrate how this new metric – Scheduled Slot Adherence – will work:

- Provider A has 12 slots in their four-hour session on a particular day of the month. This physician blocks 2 of those slots to attend a School of Medicine Committee meeting.
    - Using the 4 Hour Session Adherence calculation, Provider A would receive 0% credit for working 10/12 appointment slots.
    - Using the Scheduled Slot Adherence calculation, Provider A will receive 83% credit for working 10/12 appointment slots.

The expectation for 85% adherence to Scheduled Slot Adherence will be at the department level, just like the 4 Hour Session Adherence. However, the data portal will report data on the individual level, division level, and department level. Most physicians are currently meeting the 85% goal for Scheduled Slot Adherence.

11. How do I resolve recurring conflicts during my scheduled clinic times?

Clinical and ambulatory leadership will help you solve the conflict. For example, if you have an obligation in the School of Medicine that conflicts with your scheduled clinic time, you will need to work with both the School of Medicine and your clinic leadership (access leader, clinic manager and medical director) to either reschedule the School of Medicine obligation or the clinical obligation. If the conflict is occasional, then you may use the flexibility associated with the 85% expectation described above to solve the conflict. If the conflict is more frequent, you will need to find a way to not have obligations in two places at once. For any conflicts, you can work with your department and clinic leadership. If you are unsuccessful, you can reach out to John Bennett, and he will put together the correct individuals to address this issue.

12. Can I work outside the usual 8AM-12PM and 1PM-5PM templates?

Yes, but this requires coordination with the access and clinical teams. For example, if you want to begin clinic at 8:30AM and go to 12:30PM, this would be possible. You need to work with the clinic manager and access leader to ensure that the necessary staff is available. As you might anticipate, a change in schedule that accommodates you might be an imposition for the staff and, thus, coordination is required. If you want to make a change, you need to work with the clinic leadership. If you are unsuccessful, you can reach out to John Bennett, and he will put together the correct individuals to address this issue.

13. Will United on Access make my clinical life better?

There are several ways that United on Access may make your clinical life better. New scheduling workflows will enable the following benefits:

- Fewer unfilled slots in your schedule
- Patients are scheduled with the right physician
- Decrease in the amount of review time needed before scheduling an appointment, thereby decreasing the time it takes to schedule a patient.

- Streamlined records collection process ensuring that the patient's medical records are available before their visit.
- Implementation of an enhanced referral process to ensure our care team receives all the necessary information to schedule an appointment for the patient avoiding the back and forth between the referring office and the receiving office

14. Can I add on patients/sessions in my clinic on my non-clinic days and not be penalized?

Yes, there are a few ways in which you can add on patients/sessions. These sessions are meant to be ***non-recurring sessions*** that are added beyond your existing four-hour sessions for the purposes of either making up a clinic session or improving patient access by having additional sessions to work down the backlog.

- Less than 90 Minutes – Sessions under 90 minutes in length can be added by the local access team. The main requirements are that both space and support staff can accommodate the added session. These sessions do NOT negatively impact the metrics.

- More than 90 minutes but less than four-hours – Sessions that are more than 90 minutes but less than four-hours can also be added. These sessions need to be added by the Central Template Team and can be requested through your local access supervisor. The main requirements are that both space and staff can accommodate the added session and that the request has been made several days in advance of the session occurring. These sessions do NOT negatively impact the metrics/compliance.

15. Can I add extra telehealth sessions?

Yes, there is a way to add on exclusively telehealth sessions. These sessions can be either a one-time addition or a recurring addition. These sessions need to be added by the Central Template Team and can be requested through your local access supervisor. The main requirements are that support staff are not needed for the session and that the request has been made several days in advance of the session occurring. Exclusively telehealth sessions do not negatively impact the metrics.

16. Are my residents and fellows held to the United on Access standards?

No. Also refer to Q.27 below.

United on Access follows ACGME guidelines for training resident and fellow physicians. Templates and patient volumes for residents and fellows are at the discretion of program directors. All residents and fellows are excluded from the United on Access metrics and template/compliance standards.

17. Can I start early and end my clinic early?

Yes, but this requires coordination with the access and clinical teams. For example, if you want to begin clinic at 7:30AM and go to 11:30AM, this would be possible. You can also start at 8:30am and end at 12:30pm.

You need to work with the clinic and access leadership to ensure the staff necessary to support the session are available. As you might anticipate, a change in schedule that accommodates you might be an imposition for the staff and, thus, coordination is required. If you want to make a change, please work with your clinic leaders. If you are unsuccessful, you can reach out to John Bennett who will put together the correct individuals to address this issue.

18. Will I be penalized for late cancellations and/or no shows?

No. Late cancellations and no shows have no impact on the 4 Hour Session Adherence or Scheduled Slot Adherence metrics. Those two metrics are based only on how your template is built, not on how visits are scheduled or completed. Late cancellations will impact the Appointment Slot Utilization metric, but this metric is now considered an operational measure on how well our operations teams are able to fill your schedule.

19. Can I start clinic late or end clinic early to attend a grand rounds, a conference or tumor board?

Yes. With the addition of the Scheduled Slot Adherence metric, you now have the flexibility to block certain appointment slots on your schedule to allow you to attend these other academic and patient care activities. You still need to give at least 30 days' notice so patients can be rescheduled, if needed. Grand rounds and most tumor boards (if before 9:00AM, from 12-1:00PM, after 4:00PM) are approved meetings and the metrics are not negatively impacted for your attendance.

In addition, you may be granted an exemption to the 4-Hour Session Adherence rule for some conferences. There is a process, with an online application, for conference leaders to apply for this exemption. A meeting is held quarterly to review these requests and approve or deny the request for exemption. These reviews are performed by the Ambulatory ACMOs. The online exemption application can be found here.

See also Q.17 regarding starting later (or earlier) and ending later (or earlier).

20. Can I have time in the middle of my clinic to catch my breath, maybe catch up on doing some charts?

With the introduction of the asynchronous slot, this will be possible. To begin with, the roll-out of the asynchronous slot will be with the primary care physicians. Once implemented, an assessment will occur on how it is working and further roll-outs will continue with E/M physicians as the next group.

21. I have been told my clinic is not in compliance? What does this mean?

An individual physician's clinic session can be in or out of compliance with the template standards and metrics – not a clinic generically. When a physician's clinic session is in compliance, it means it meets the metric targets. For example, 85% or above for 4 Hour Session Adherence, Scheduled Slot Adherence and Appointment Slot Utilization means a clinic session is in compliance.

22. What are the compliance goals?

85% and above; See Q.21 above.

23. How are the clinic compliance numbers tracked and what are the repercussions of not being in compliance?

See Q.21 above. Once again, an entire clinic is not considered to be in or out of compliance. It is an individual physician's clinic session that is tracked for compliance to the template standards and metrics.

24. What is an asynchronous slot?

It is the lowest visit duration slot (usually 15 or 20 minutes) on a physician's template to perform non-patient facing clinical work that is required to care for patients. This could include, but is not limited to:

- MyChart message handling
- Prescription renewals
- Home health certifications
- Patient phone calls
- Prior authorization appeals
- E-visits
- Documentation

The implementation of this slot will begin with primary care physicians and will be evaluated on how effective it is. Once this evaluation occurs, there will be continued implementation beginning with other E/M physicians across the School of Medicine. Here are some of the specifics:

- Physicians will get one asynchronous slot (or the PACLAC slot) in 1 four-hour session, not both.
- Physicians will need to opt-in to receive this slot
- Criteria to qualify for this slot include:
    - Minimum of 4 four-hour ambulatory/clinic sessions per week
    - Minimum of 184 four-hour ambulatory/clinic sessions per year (based upon 46 weeks per year); adjusted for inpatient service weeks
    - Need to maintain Scheduled Slot Adherence ≥85% for prior 6 months
    - Need to achieve 90% of individual wRVU target in prior year

QUESTIONS ABOUT CLINICS

25. What local control do individual clinics have to manage operations, staffing and other matters?

In partnership with the School of Medicine Departments, the Medical Center has primary responsibility for managing operations, staffing, etc. Optimizing the clinic sessions is part of this responsibility. As a physician, and in partnership with your department, you determine how many clinic sessions you will have. The number of sessions you work is not determined by the United on Access team. Operationally, the goal is to optimize the time you are in the clinic for the full benefit of the patients who seek your care.

26. How do template standards accommodate my multidisciplinary clinic (with multiple specialties providing care in the same encounter) or my complex patients who require longer visits?

For any situation that needs consideration outside of the template standards, there is a process to request an exemption. For example, there have been six multidisciplinary clinic exemption requests and five have been granted. These exemption requests are discussed and decided upon by physicians, including 3 faculty. The online exemption application can be found here.

We recognize that not all patients fit neatly into a 15- or 20-minute slot. Complex patients may see more than one doctor in a multidisciplinary clinic and may need more time during their visit. Visual markers and/or modifiers may be added to Epic to help facilitate allocating the extra time needed. You need to work with your clinic leaders to help this work in your clinic. Specific slots for more complex patients who need extra time may be added.

27. How does United on Access impact the way I work with my residents and/or students in clinic?

United on Access supports you and learners in the following ways:

- Following ACGME guidelines for training and preparing resident and fellow physicians.
- Exempting learners (i.e., all trainees) from the template standards. Templates and patient volumes for residents and fellows are at the discretion of program directors.
- Excluding learners from the United on Access metrics.
- When precepting, I am given time and allowance to meet the educational needs of the learner(s).

28. Will United on Access negatively impact patient continuity?

Continuity of patient care – meaning a patient can always be seen by their primary care physician (PCP) – is a priority shared by physicians and UVA Health leadership alike. Unfortunately, continuity of patient care is not always possible, especially for acute needs (respiratory virus, UTI, etc.) when patients need same or next day care.

When this happens, the following pathway has been established to help patients receive care within UVA Health when their PCP is not available. This work has been performed by the

United on Access team with support by the three primary care department chairs. Patients are seen in order of escalation by:

1. The patient's own PCP
2. Another provider in the PCP's clinic
3. Same-Day Care, Urgent Care, or Virtual Care
4. Another UVA Health PCP in the same specialty
5. Another PCP within the UVA Health network

Having the patient receive care within the UVA Health network of providers ensures access to the patient's medical record. Unless medically necessary, keeping the patient from going to the emergency department (ED) is also an organization goal to ensure the ED has better access for the most seriously injured or sick patients.

29. What are the panel size expectations for primary care faculty and how were they determined?

Prior to United on Access, UVA Health has never had a panel management process for primary care physicians (PCPs). It is important to have this process in place, *so we know when to open or close our PCP panels to new patients.* This is a common practice across the country throughout primary care.

In determining the PCP panel size, UVA Health used the American Medical Group Association (AMGA) 2023 National Panel Size Academic Benchmark and methodology to determine the targets for PCPs. The AMGA panel size data are risk adjusted. The goal is for our PCPs to eventually reach the median benchmark in their respective risk adjusted primary care specialties for panel size. Currently, the risk adjusted panel sizes for many of our PCPs are significantly smaller than the AMGA national specialty specific benchmarks. Given all the change related to the four-hour sessions, templates, etc., UVA Health leadership is currently ***not*** asking physicians to increase their risk adjusted panel sizes to the national benchmarks. Working with the chairs of internal medicine, pediatrics, and family medicine, panel size targets were developed that remain much smaller than the AMGA national benchmarks. This will be an intermediate goal. As this is a new process for UVA Health, PCP panels will be assessed consistently every 3-6 months to determine what if any changes need to be considered. In the future, after United on Access has been fully implemented, risk adjusted panel sizes will be re-evaluated and we will set as our goal achieving panel sizes for our physicians that are on par with the national benchmarks.

30. United on Access is focused on access – what is being done to address other operational challenges?

It's important to note that United on Access is just part of a larger effort to make UVA Health the best place to give and receive care. Other work is happening in parallel to reduce the administrative burden on team members and support everyone working at the top of their licenses. Examples include:

- Reducing Epic In Basket volume
- Implementing MyChart enhancements (e.g., E-Visits, Fast Pass).
- Implementing new protocols (e.g., point-of-care testing protocol, prescription refill protocol, etc.).
- Making asynchronous slots available to qualifying physicians.

- Empowering APP's to independently see and manage patients where clinically appropriate.
- Staffing and hiring investments such as Earn While You Learn, Central Intake Team, and strategic use of nurse float pools (enabled by consistent physician templates).
- Assessing staffing ratios to determine if they are adequate and in line with peer organizations.
- Implementing Role Delineation to ensure our staff is working at the top of their scope/license.
- Optimizing use of clinic space.
- Restructuring of the Primary Care Optimization Group to vet and implement ways to enhance clinic operations and support physicians and team members.

31. Are primary care panel sizes risk adjusted?

Yes. See Q.29 above.

COMMUNICATION

32. How do I provide input into this process?

There have been over 100 different sessions including presentations at CSEC, the School of Medicine General Faculty Meetings, Department faculty meetings, SOM Faculty Communications Council meetings, and dozens of other venues, where United on Access has been discussed and reviewed with the goal of seeking input. Further, a full FAQ was disseminated in 2022 to all physicians about United on Access. Over the past two years, dozens of listening sessions have been conducted and a tremendous amount of input has been received. This has resulted in revisions to United on Access in numerous ways, directly responding to physician input. For examples, please see Q.34 below.

You can also reach out to one of the physicians on the project leadership team or John Bennett to provide feedback. The faculty/physicians who are on the project leadership team include:

- Alan Dalkin, MD – representing Medicine
- Gina Engel, MD – representing Primary Care
- Andrea Garrod, MD – representing Pediatrics
- Shayna Showalter, MD – representing Surgery

United on Access will be an ongoing, iterative process for years to come. We appreciate that faculty are able to provide input and thoughts about how to make the program better while serving the needs of patients who are increasingly choosing UVA Health for their care.

33. Have physicians been part of the decision-making for United on Access?

From the very beginning of United on Access, physicians have been involved in designing the model now being implemented. In addition, the project governance is robust and designed for faculty involvement and participation in making decisions. The governance structure consists of the following groups:

- Executive Escalation: Composed of 2 physicians (1 faculty and 1 non-faculty physician) and 2 senior administrators.

John Bennett	Chief Ambulatory Operations Officer
Scott Just, MD (Emergency Medicine)	Chief Executive Officer UVA UPG
Melina Kibbe, MD (Vascular Surgery)	Dean, School of Medicine
Erik Shannon	CEO, UVA Community Health

- Steering Committee: Composed of 11 physicians (9 faculty and 2 non-faculty physicians) and 11 senior administrators.

Lisa Badeau	Chief Marketing and Coms. Officer
John Bennett	Chief Ambulatory Operations Officer
Alan Dalkin, MD (Endocrinology)	Ambulatory ACMO - Primary Care
Gina Engel, MD (Family Medicine)	Ambulatory ACMO - Medical Specialties
Katie Fellows	Adminstrator, UVA Health Access
Karmen Fittes	Chief of UVA Health Human Resoruces
Karen Forsman	Administrator, Heart and Vascular Center
Andrea Garrod, MD (Pediatric Pulmonary & Critical Care)	Ambulatory Medical Director - Pediatrics
Howard Goodkin, MD (Pediatric Neurology)	Chair Dept. Neurology
Tracey Hoke, MD (Pediatric Cardiology)	Chief Quality Officer
Wendy Horton	Chief Executive Officer
Stephen Keiser	Chief Operations & Growth Officer (UVACHMG)
Jim Larner, MD (Radiation Oncology)	President (UPG)
Jason Lineen	Chief Strategy Officer
Brent McGhee	Chief Revenue Officer
Jim Min, MD (Family Medicine)	Bull Run Family Medicine, Haymarket
Rachel Nauman, DNP	Nursing Adminstrator, Ambulatory
Robin Parkin	Chief Information & Technology Officer
Billy Petersen, MD (Pediatric Hem/Onc)	Ambulatory ACMO - Childrens
Karen Rheuban, MD (Pediatric Cardiology)	Pediatric Cardiology; Medical Director, Telemedicine
Kari Ring, MD (GynOnc)	Obstetrics and Gynecology
Shayna Showalter, MD (Breast Surgery)	Ambulatory ACMO - Surgery

- One Team Leadership Group: Composed of 5 physicians (4 faculty, 1 non-faculty physician) and 4 senior administrators.

John Bennett	Chief Ambulatory Operations Officer
Alan Dalkin, MD (Endocrinology)	Ambulatory ACMO - Primary Care
Gina Engel, MD (Family Medicine)	Ambulatory ACMO - Medical Specialties
Katie Fellows	Adminstrator, Patient Acces
Andrea Garrod, MD (Pediatric Pulmonary & Critical Care)	Ambulatory Medical Director - Pediatrics
Brent McGhee	UVA Health Revenue Officer
Rachel Nauman, DNP	Nursing Adminstrator, Ambulatory
Billy Petersen, MD (Pediatric Hem/Onc)	Ambulatory ACMO - Childrens
Shayna Showalter, MD (Breast Surgery)	Ambulatory ACMO - Surgery

Due to the unique nature of primary care, in addition to the above, an enhanced governance structure was also adopted for Wave 3:

- Primary Care Executive Escalation: Composed of 5 physicians (4 faculty and 1 non-faculty physician) and 2 senior administrators.

John Bennett	Chief Ambulatory Operations Officer
Scott Just, MD (Emergency Medicine)	Chief Executive Officer, UPG
Melina Kibbe, MD (Vascular Surgery)	Dean, School of Medicine
Li Li, MD (Family Medicine)	Chair, Department of Family Medicine
Madhusmita Misra, MD (Pediatrics)	Chair, Department of Pediatrics
Mitch Rosner, MD (Medicine – Nephrology)	Chair, Department of Medicine
Erik Shannon	CEO, UVA Community Health

- Primary Care Executive Team: Composed of 11 providers (8 faculty, 2 non-faculty physicians and 1 APP) and 4 senior administrators.

John Bennett	Chief Ambulatory Operations Officer
Becky Compton, DNP (Family Medicine)	CPG Clinical Operations; Nurse Practitioner in Dept. of Family Medicine
Alan Dalkin, MD (Endocrinology)	Ambulatory ACMO - Primary Care
Gina Engel, MD (Family Medicine)	Ambulatory ACMO - Medical Specialties
Katie Fellows	Director, Ambulatory Patient Access
Andrea Garrod, MD (Pediatric Pulmonary & Critical Care)	Ambulatory Medical Director - Pediatrics
Brian Halstater, MD (Family Medicine)	Vice Chair, Family Medicine
Ann Kellams, MD (Pediatrics)	Interim Division Chief, General Pediatrics
Li Li, MD (Family Medicine)	Chair, Family Medicine
Jim Min, MD (Family Medicine)	Chief Physician Executive, UVACHMG
Mo Nadkarni, MD (Internal Medicine)	Division Chief, General Internal Medicine
Rachel Nauman, DNP	Administrator, Ambulatory Nursing
Billy Petersen, MD (Pediatric Hem/Onc)	Ambulatory ACMO - Childrens
Shayna Showalter, MD (Breast Surgery)	Ambulatory ACMO - Surgery
Karin Skeen, RN	Associate Chief Nursing Officer - Childrens

- Leadership Accountability Groups: Composed of
  - Adult Primary Care: 9 providers (4 faculty and 5 non-faculty physicians), 4 administrators, and 5 managers

Kimberly Bednar, DNP	Clinical Instrutor of Nursing/Advanced Practice Provider
Brigitte Binard	Associate Division Adminstrator, Medicine
Sarah Creef Baugher	Chief Operations Officer, Family Medicine
Alan Dalkin, MD (Internal Medicine, Endocrinology)	Ambulatory ACMO - Primary Care
Benjamin Dolewski	Director, Ambulatory – Primary Care & Psychiatry
Kimberly Dowdell, MD (Internal Medicine)	Vice Chair Ambulatory - Primary Care & Telemedicine
Gina Engel, MD (Primary Care)	Ambulatory ACMO - Primary Care
Andrew Lockman, MD (Family Medicine)	Medical Director of Crossroads Family Practice
Brian Halstater, MD (Family Medicine)	Vice Chair, Family Medicine
Jennifer Joseph	Director, Ambulatory Access
Joseph Long	Director, Support Services, UVACHMG
Elaine Mahieu, RN	Clinic Manager
James Min, MD (Family Medicine)	Chief Physician Executive, UVACHMG
Kelli Payne	Regional Operations Manager
Victoria Sims	Senior Manager, Access Operations
Cynthia Smith	Division Administrator, Department of Medicine
Steven Tang, MD (Family Medicine)	Physician
Wendy Westfield, MD (General Internal Medicine)	Clinical Assistant Professor of Internal Medicine

- Pediatric Primary Care: 8 providers (5 faculty and 3 non-faculty physicians), 3 administrators, and 4 managers

Sarah Boggs, MD (Pediatric Infectious Diseases)	Pediatrics
Gina Engel, MD (Primary Care)	Ambulatory ACMO - Primary Care
Keith Foster	Access Manager, Childrens
Andrea Garrod, MD (Pediatric Pulmonary & Critical Care)	Ambulatory Medical Director - Pediatrics
Teresa Green	Ambulatory Director, Women's and Children's Services
Brian Halstater, MD (Family Medicine)	Vice Chair, Family Medicine
Jennifer Joseph	Director, Ambulatory Access
Virginia Kockler, MD (Pediatrics)	Pediatrician
Joseph Long	Director, Support Services, UVACHMG
James Min, MD (Family Medicine)	Chief Physician Executive, UVACHMG
Nanci Miranda	
Anne Ranney, MD (General Pediatrics)	Physician
Lisa Rudy	Clinic Manager
Elizabeth Schinstock, MD (Pediatrics)	Physician
Victoria Sims	Senior Manager, Access Operations

34. What have been the United on Access issues raised by my faculty peers and how have they been addressed?

Feedback from faculty has primarily focused on template standards and flexibility within those standards, staffing, and other operational concerns. UVA Health Leadership have listened and worked to be responsive to physician concerns while staying true to the project's fundamental goals of patient-centered care. Examples of this responsiveness include the following:

- Allowing flexible start/end times for clinic sessions as long as this is coordinated with staff
- Adding 90 minute or less sessions that are not included as part of the metrics

- Implementing MyChart changes to patient messages to encourage more appropriate patient use of MyChart
- Decreasing primary care physician panel target sizes below the expected national median resulting in a decrease in the number of required new initial visits
- Adding asynchronous slots so that physicians have the ability to catch up on charting and other patient related work
- Adding the new metric, Scheduled Slot Adherence, to provide flexibility to pursue other non-clinical academic missions
- Decreasing the number of new initial visit slots
- Granting exemptions from the metrics for grand rounds, tumor boards, many multi-disciplinary clinics, and out of town conferences.
- Enabling physicians to bill for MyChart message responses as appropriate/eligible (in process)
- Implementing operational improvements such as new protocols (e.g., point of care testing) and MyChart/Epic enhancements to help reduce provider In Basket Work.
- Increasing investment in recruiting and staffing efforts to support clinic operations (ongoing).

35. Am I able to voice my concerns without fear of retaliation?

Absolutely. There have been – and continue to be – forums and channels for open dialogue and feedback related to United on Access. These channels remain open to all physicians, at any time. Constructive dialogue is welcome, and you are encouraged to raise concerns regarding any issue related to this initiative.

The incredible amount of dialog that has already occurred regarding this initiative is evidence that you are welcome to express any views. It is important to note that if leaders do not agree on an issue, this is simply disagreement and does not equate to an inability to voice concerns or shutting down discussion.

We have also worked with the School of Medicine Faculty Senators on this project. Feel free to reach out to one of the School of Medicine senators to voice concerns. Future General Faculty meetings will be another avenue to voice concerns.

36. How has the United on Access project been communicated to the broader UVA Health community and the SOM/UPG faculty, specifically? How will it be communicated on a go forward?

Noted below are numerous communication channels that have been used to communicate United on Access progress. In addition, there are several forums in which United on Access has been discussed, including throughout each Specialty Wave of the implementation.

- **Monthly Ambulatory Operations Progress Report** – emailed to all faculty.
- **Newsletters**: UVA Health Update and Inside UVA Community Health newsletters
- **Wave 3:** Learnings from earlier waves indicated that more regular communication to team members *as they were going through the wave process* would be beneficial. As such, Wave 3 piloted these additional communication channels:
  - Workgroup Weekly Updates

- Wave 3 Weekly Wisdom for Managers
- Kick Off Lunch and Learns
- Take 30 for United on Access Webinar Series (recordings posted and shared)
- Virtual Office Hours

Specifically, UVA Health leadership have routinely provided updates to the department chairs, CSEC, general faculty meetings, individual clinical department faculty meetings, division meetings, and other provider audiences. Below is a partial timeline of key meetings and forums since March 2022:

3/30/22	Faculty Communications Council
4/25/22	Dept. of Medicine Town Hall
5/12/22	School of Medicine Administrator's Meeting
6/25/22	Dept. of Gynecology
8/3/22	Dept. of Otolaryngology
8/11/22	Dept. of Digestive Health
8/23/22	Dept. of Urology
10/3/22	Dept. of Urology
10/4/22	Ambulatory Nursing Committee
10/20/22	APP Leaders
10/27/22	Dept. of Digestive Health
12/12/22	Detailed project overview and FAQs emailed to all clinical faculty ahead of Clinical Faculty Roundtable
12/14/22	Clinical Faculty Roundtable (requested by the Faculty Communications Council)
1/10/23	Clinical Faculty Roundtable recording, project overview, and updated FAQ emailed to all clinical faculty in follow up to 12/14/22 forum
2/23/23	APP Council Meeting
5/9/23	Clinical Faculty Meeting
7/20/23	General Faculty Meeting
8/9/23	Dept. of Surgery
9/15/23	Dept. of Neurology
10/31/23	Dept. of Family Medicine
1/8/24	Clinical Faculty Meeting
1/9/24	Dept. of Family Medicine
1/16/24	CSEC
1/29/24	SOM Faculty Senate
2/1/24	Dept. of Pediatrics

Going forward, other communication channels will be explored, as well as continuing to use many of the channels mentioned above. If you have recommendations on other communication channels that can be used to share the United on Access information, please email them to ROFFICEOFTHECAOO@uvahealth.org.

37. How will United Access progress/results *continue* to be shared as the initiative moves forward?

Through the same channels and forums outlined in Q.36 above. If you have recommendations on other communication channels that can be used to share the United on Access information, please email them to ROFFICEOFTHECAOO@uvahealth.org.

United on Access metrics are also accessible via the UVA Health data portal that faculty can access at any time. Key metrics such as Appointment Slot Utilization, 4-Hour Session Adherence, Scheduled Slot Adherence and No-Show rates may be viewed on the Ambulatory Operations Scorecard. Other One Team United on Access metrics for specialties that have completed the wave process are available via the One Team Metrics on the Ambulatory Dashboard, which can be accessed via this link to the data portal.

38. What are next steps?

We will continue to seek input and feedback as the implementation of future waves continues. We will also communicate through different channels and in more succinct ways highlighting one FAQ at a time. If there are other forums and/or communications channels we should consider, please let a Faculty Senator know or email them to ROFFICEOFTHECAOO@uvahealth.org.