

**UT Southwestern**  
Medical Center

**Patient Access Scheduling Audit**

**Internal Audit Report 22:10**

**June 30, 2022**

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# Executive Summary

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## **Background**

A key concern for healthcare organizations is maximizing the utilization of services by optimizing the scheduling processes for appointments and services and meeting patient demands for healthcare services. With strong controls in place, as well as a constant pulse on these processes, an organization can maximize efficiency and ensure patient satisfaction. Patient scheduling activities (e.g., transcribing orders, order entry, scheduling procedures, verifying patient coverage, etc.) are primarily performed within the Epic electronic health records (EHR) system.

Patient Access Scheduling is the process in which a patient is able to get an appointment to see a provider. The two centralized scheduling teams (i.e., Access Center and Referral Management) report to ambulatory services leadership.

- The Access Center call center team receives calls to schedule both new and established patient appointments.
- The Referral Management team transitioned from Southwestern Health Resources (SWHR) to UT Southwestern in January 2022. This team enters provider orders into Epic based on the appointment type and specialty (e.g., Cardiology, Neurology, etc.).

Once the order is entered, the referral routes to either Referral Management or to a specialty clinic to contact the patient to schedule the visit. Scheduling appointments are made through the use of scheduling templates, decision trees, and provider preferences. Additionally, patients may request and/or schedule appointments online through Epic MyChart or directly from the clinic's website for some specialties. See Appendix A for a high-level visual representation of this multi-faceted and complex process.

## **Scope and Objectives**

The Office of Internal Audit Services, with the assistance of Protiviti (an Internal Audit co-source partner), performed a Patient Access Scheduling Audit (the "audit"), as part the fiscal year (FY) 2022 Audit Plan. The audit focused on evaluating patient scheduling practices to ensure patients are scheduled timely and accurately and existing controls are in place for monitoring the integrity of the scheduling process and issue resolution protocols.

The key areas of focus for the audit included the following:

- Assessed UT Southwestern centralized Access Center, centralized Referral Management team, select decentralized scheduling departments, and Epic MyChart's policies, procedures, protocols, and guidelines for adequacy, completeness, and adherence to industry leading practice and regulatory requirements. The decentralized scheduling departments selected as part of this audit were: Ophthalmology, Cancer Center, and Pediatrics at Plano.
- Evaluated patient scheduling processes and controls to understand current operations and identified processes not operating as intended or in line with management's expectations.

# Executive Summary

- Analyzed patient scheduling monitoring and denial reporting to stratify the populations across varying data elements, such as referral source, department, specialty, denial type, etc. to isolate a targeted sample of scheduled encounters for testing. See Appendix B for referral metrics for centralized vs. decentralized scheduling functions.
- Tested a sample of encounters to verify the appointment was scheduled in an accurate, complete, and timely manner and identified any variances and deviations from internal policies and industry leading practices.

Audit procedures included: review of policies, procedures, and other supporting documentation, interviews with stakeholders, analysis of monitoring reporting, and detailed testing of scheduled patient appointments by Access Center, Referral Management, decentralized scheduling departments, and Epic MyChart.

## Conclusion

Overall, adequate centralized scheduling reporting controls are in place, however opportunities exist to further coordinate with clinics to assess and update key scheduling tools such as the provider preferences, clinic decision trees, and scheduling templates to create consistency, to standardize the monitoring of scheduling functions to ensure the scheduling procedures are followed, and to increase accountability for the patient scheduling to better accommodate and meet patient demands for clinical services. Management has implemented strategies to try to improve its support and response to patient access demands including taking efforts to coordinate with departments to increase recruitment of providers in key specialty areas where the patient demands for healthcare services is much greater than the number of available providers.

Included in the table below is a summary of the observations along with the respective disposition of these observations within the UT Southwestern internal audit risk definition and classification process. See Appendix C for Risk Rating Classifications and Definitions.

Priority (0)	High (0)	Medium (3)	Low (1)	Total (4)
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Key observations are listed below.

- **#1 Implement Scheduling Template, Decision Tree, and Provider Preferences Oversight & Governance** – There are currently no dedicated system resource(s) that assist the clinics with translating the clinics’ operational needs and developing / maintaining scheduling templates, decision trees, and provider preferences. The Access Center has implemented a temporary solution by allocating an analyst to assist select clinics with updating their decision trees. This solution is not sustainable long-term.

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- **#2 Monitor Referral Management Workflow Redesign** – Referrals were inconsistently routing to clinic work queues without clear understanding of ownership by all parties, instead of the Referral Management work queue, increasing the risk of the appointments not being scheduled. A work queue design project was conducted to address the work queue routing logic prior to fieldwork.
- **#3 Develop Scheduling Registration Error Monitoring & Reporting** – Registration is not leveraging existing monitoring reports developed by scheduling to track and trend registration errors when a patient is scheduled with insurance and does not currently have a monitoring report for patients erroneously scheduled as self-pay. This leads to re-work, potential patient dissatisfaction, and limits the department's ability to conduct on-going education and training.
- **#4 Increase Accountability for Ensuring Decentralized Clinic Referrals Are Addressed Timely** – There is a lack of monitoring and accountability to ensure that referrals received by clinics are reviewed and appointments are scheduled timely and in a consistent manner. This could lead to patients not being scheduled for clinic appointments, referral leakage, and patient dissatisfaction.

We would like to take the opportunity to thank the individuals included in this audit for the courtesies extended to us and for their cooperation during our review.

Sincerely,

Valla F. Wilson, Vice President and Chief Audit Executive, Office of Internal Audit Services

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## Executive Summary

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## Detailed Observation and Action Plans Matrix

Observation	Recommendation	Management Response
<p><b>Risk Rating: Medium ●</b></p> <p><b>1. Implement Scheduling Template, Decision Tree, and Provider Preferences Oversight &amp; Governance</b></p> <p>There are currently no dedicated system resource(s) that assist the clinics with translating the clinics' operational needs and developing / maintaining scheduling templates, decision trees, and provider preferences. There is a patient access strategy pillar to implement a governance structure; however, there is a lack of resources and a leader to help the clinics with the ongoing maintenance of the scheduling tools. The Access Center has implemented a temporary solution by allocating an analyst to assist select clinics with updating their decision trees. This solution is not sustainable long-term and does not provide adequate coverage for all of the clinics needing assistance.</p> <p>Lack of scheduling governance and maintenance leads to manual processes, human errors, and deviating from established processes. These issues lead to inefficiencies requiring appointments to be re-scheduled and potential patient and/or physician dissatisfaction. Schedulers rely on external resources (e.g., matrices, tip-sheets, etc.) to reference the protocols that should be integrated into the scheduling decision tree workflow.</p>	<ol style="list-style-type: none"> <li>1. Perform trending and root cause analysis on the decision tree bypass report.</li> <li>2. Determine a plan for review and analysis of scheduling templates and decisions needs based on risk factors such as those with higher scheduling errors and other measures.</li> <li>3. Establish a physician clinical leader within ambulatory services to develop a sustainable approach to manage the prioritization, development and maintenance of the clinic decision trees, scheduling template, and provider preferences.</li> <li>4. Ensure that clinic leaders have access to the decision tree bypass PowerBI report and establish accountability for centralize clinics leaders to review this report on a defined cadence.</li> <li>5. Identify accountability for decentralized clinic leaders to utilize the decision tree bypass PowerBI report.</li> </ol>	<p><b><u>Management Action Plans:</u></b></p> <ol style="list-style-type: none"> <li>1. We will continue to use the quarterly meetings with clinic leadership to discuss decision tree maintenance and governance. This will include trends and root causes identified for schedulers bypassing the decision tree. – Completed.</li> <li>2. We will evaluate integrating a physician clinical leader within centralized ambulatory services to work with clinic stakeholders to change champion the oversight and governance of scheduling template, decision tree, and provider preferences. – Target Date: 12/31/22</li> <li>3. We will develop a prioritization plan to streamline the review of scheduling template, decision tree, and provider preferences needs based on clinics with higher scheduling errors and other measures, utilizing the physician clinical leader to champion these efforts. In addition, we will audit a specific number of scheduled appointments to determine the root cause of scheduling errors. – Target Date: 12/31/22</li> <li>4. We will ensure that clinic leaders reporting to centralized ambulatory services are held accountable to utilizing the decision tree bypass PowerBI report regularly and implementing changes to mitigate root causes of decision tree bypasses. – Target Date: 12/31/22</li> </ol>



## Detailed Observation and Action Plans Matrix

Observation	Recommendation	Management Response
		<p>5. We will determine appropriate reporting and escalation for those decentralized clinics that have ongoing performance issues. – Target Date: 12/31/22</p> <p><b>Action Plan Owner(s):</b></p> <p>Toni Eby, Associate VP, Ambulatory Services (All)</p> <p>Kory Termine, Director, Ambulatory Business Services (1)</p> <p>Karen Copeland, Manager, Scheduling Capacity (1)</p>

## Detailed Observation and Action Plans Matrix

Observation	Recommendation	Management Response
<p><b>Risk Rating: Medium</b> ●</p> <p><b>2. Monitor Referral Management Workflow Redesign</b></p> <p>Referrals were inconsistently routing to clinic work queues without clear understanding of ownership by all parties, instead of the Referral Management work queue, increasing the risk of the appointments not being scheduled. A work queue design project was conducted to address the work queue routing logic prior to fieldwork.</p> <p>Due to these workflow errors, a work queue redesign project was completed in March 2022 to appropriately route referral requests based on the clinic specialty.</p> <p>Testing of nine (9) appointments scheduled by the centralized Referral Management scheduling team identified that 3 of 9 (~33%) appointments scheduled by Referral Management did not have patient contact within five (5) business days of the referral. Referral management leadership determined that these three (3) referrals did not appropriately route to the Referral Management work queue until after the process and work queue redesign.</p>	<ol style="list-style-type: none"> <li>Continue to evaluate and configure the Referral Management work queues post redesign project to ensure that only referrals scheduled by Referral Management fall into the work queue, and referrals scheduled by other teams are routed to another appropriate work queue.</li> </ol>	<p><b><u>Management Action Plans:</u></b></p> <ol style="list-style-type: none"> <li>We will continue to review the Epic work queue logic for the Referral Management referral work queues on a defined cadence to ensure that all referrals that need to be reviewed by the team are falling into the appropriate work queues. – Target Date: 9/30/22</li> </ol> <p><b><u>Action Plan Owner(s):</u></b></p> <p>Michael Townsend, Director, Referral Management</p>

## Detailed Observation and Action Plans Matrix

Observation	Recommendation	Management Response
<p><b>Risk Rating: Medium ●</b></p> <p><b>3. Develop Scheduling Registration Error Monitoring &amp; Reporting</b></p> <p>The Registration function does not have a mechanism to track and trend registration errors when a patient is scheduled. This leads to re-work, potential patient dissatisfaction, and limits the department's ability to conduct on-going education and training.</p> <p>Registration verifies coverage two weeks prior to the scheduled appointment. If the incorrect insurance was added at the time of scheduling, this can lead to patient dissatisfaction and the patient choosing to receive care elsewhere if they are not in-network. This can also lead to patient access denials. Coordination of Benefits was the third highest denial category from March 2021 – February 2022 totaling \$44.6M in initial denials.</p> <p>As of June 2022, approximately 5% of scheduled appointments were in a registration work queue for review with incomplete or missing demographic / coverage information. Additionally, approximately 3% of scheduled appointments in the registration work queue were self-pay, and registration leadership estimates that approximately half of these appointments (3,020) were erroneously scheduled as self-pay.</p>	<ol style="list-style-type: none"> <li>1. Evaluate the registration error bypass rate report to identify centralized or decentralized teams that are consistently bypassing registration errors when scheduling appointments. Work with the leaders of the scheduling team(s) to discuss the scheduling workflow to ensure that schedulers are appropriately registering patients.</li> <li>2. Develop tracking and trending mechanisms and establish escalation pathways to communicate self-pay scheduling errors. Request a report to be created for both patients converted from self-pay to insurance by Registration and when the scheduler does not select 'self-pay.'</li> <li>3. Evaluate delineating true self-pay patients versus patients that have insurance but cannot provide the information at time of scheduling within Epic.</li> </ol>	<p><b><u>Management Action Plans:</u></b></p> <ol style="list-style-type: none"> <li>1. We will request access to the registration error bypass rate report to analyze the scheduling team(s) that are consistently bypassing the registration errors within Epic. Once team(s) are identified, work with the scheduling leaders to ensure that the schedulers understand the workflow to appropriately register patients when scheduling appointments. – Target Date: 10/31/22</li> <li>2. We will submit tickets to Information Resources to create the following reports: – Target Date: 10/31/22             <ol style="list-style-type: none"> <li>A. Self-pay patients that were converted to insured by Registration.</li> <li>B. Self-pay patients that were not appropriately selected as self-pay by the scheduler. In addition, we will audit a specific number of scheduled appointments to determine the root cause of scheduling errors.</li> <li>C. Scheduled appointments where coverage was not verified within Epic, including the specific department of the scheduler.</li> </ol> </li> </ol>

## Detailed Observation and Action Plans Matrix

Observation	Recommendation	Management Response
		<p>D. Request that the registration error bypass rate include the department that the team member is on, including the specific clinic department.</p> <p>3. We will evaluate configuring Epic to delineate true self-pay patients from patients that have insurance but cannot provide the information at time of scheduling. – Target Date: 1/31/23</p> <p><b><u>Action Plan Owner(s):</u></b></p> <p>Stephanie Mims, Director, Patient Financial and Access Services (1, 2)</p> <p>Ruxandra Brashear, Manager, Patient Financial and Access Services (1, 2)</p> <p>Kory Termine, Director, Ambulatory Business Services (3)</p> <p>Jennifer Ward, Director, Access Center (3)</p> <p>Michael Townsend, Director, Referral Management (3)</p>

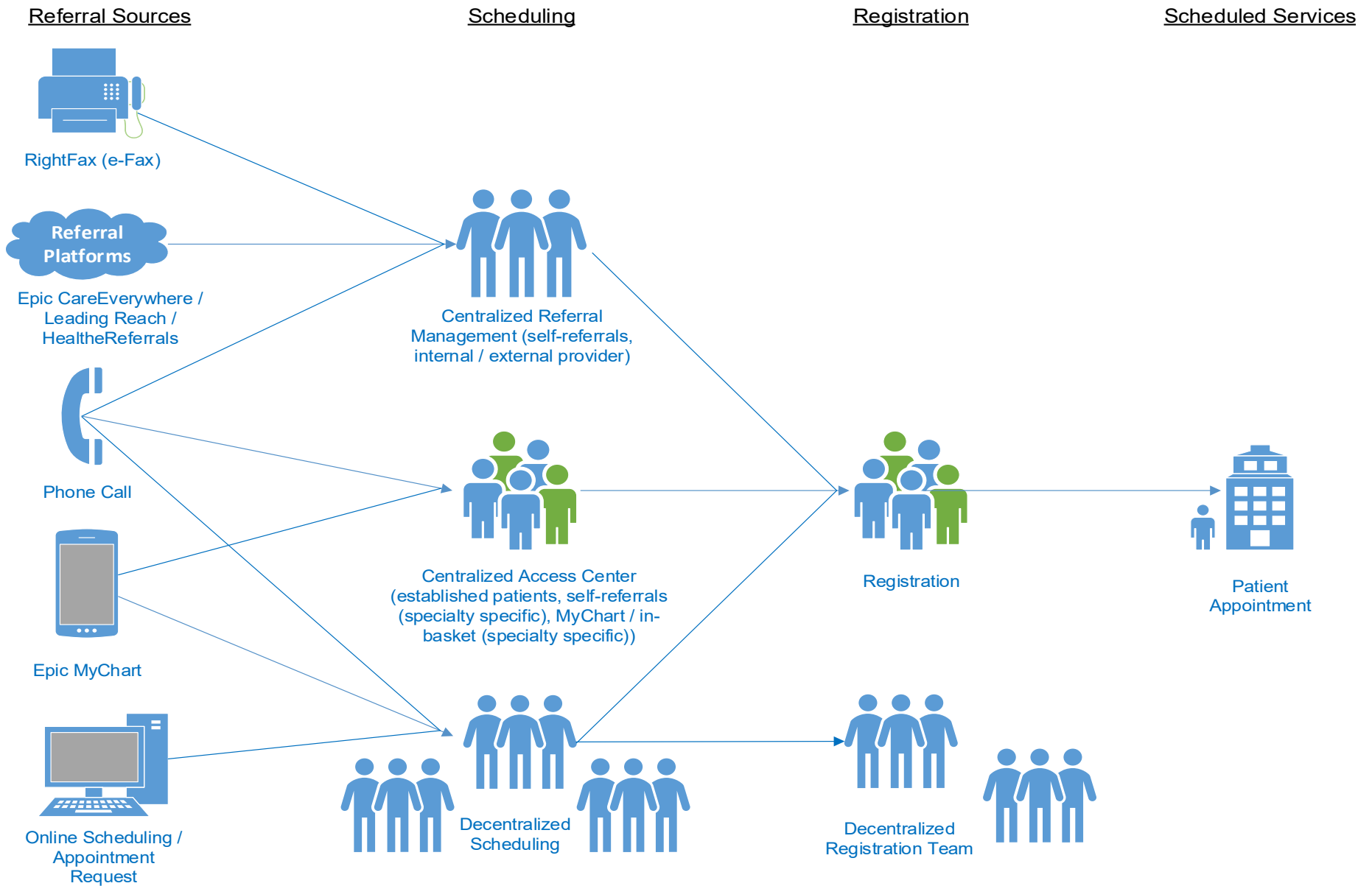
## Detailed Observation and Action Plans Matrix

Observation	Recommendation	Management Response
<p><b>Risk Rating: Low</b> ●</p> <p><b>4. Increase Accountability for Ensuring Decentralized Clinic Referrals Are Addressed Timely</b></p> <p>There is a lack of monitoring and accountability to ensure that referrals received by clinics are reviewed and appointments are scheduled timely and in a consistent manner. This could lead to patients not being scheduled for clinic appointments referral leakage, and patient dissatisfaction.</p> <p>Clinics do not consistently use referral metrics to monitor and determine if referrals are scheduled timely based on target timeframes set by ambulatory leadership (see Appendix B). If Referral Management does not schedule referrals, it is the responsibility of the clinic.</p>	<ol style="list-style-type: none"> <li>1. Continue to meet with clinics that own referral work queues, ensure that they consistently utilize the referral metrics that are produced.</li> <li>2. Perform a cost-benefit analysis of transitioning decentralized referrals to centralized Referral Management.</li> </ol>	<p><b><u>Management Action Plans:</u></b></p> <ol style="list-style-type: none"> <li>1. We will ensure that all clinics have access to and understand how to use the PowerBI report that displays referral metrics by clinic. – Target Date: 10/31/22</li> <li>2. We will continue to work on stabilizing Referral Management metrics and perform a cost-benefit analysis of transitioning out-of-scope clinic referrals to Referral Management. This will involve two phases listed below. – Target Date: 1/31/23               <ol style="list-style-type: none"> <li>A. Phase one: We will have conversations with key stakeholders to show a years’ worth of sustained improvement and provide decentralized clinics more incentive to transition. Centralized and decentralized management will determine what decentralized departments will transition to Referral Management.</li> <li>B. Phase two: We will develop an action plan with key milestones and target dates to transition decentralized referrals to Referral Management based on stakeholder input from phase one.</li> </ol> </li> </ol>

## Detailed Observation and Action Plans Matrix

Observation	Recommendation	Management Response
		<p><b><u>Action Plan Owner(s):</u></b>            Toni Eby, Associate VP, Ambulatory Services (2)            Michael Townsend, Director, Referral Management (All)</p>

# Appendix A – Process Flow



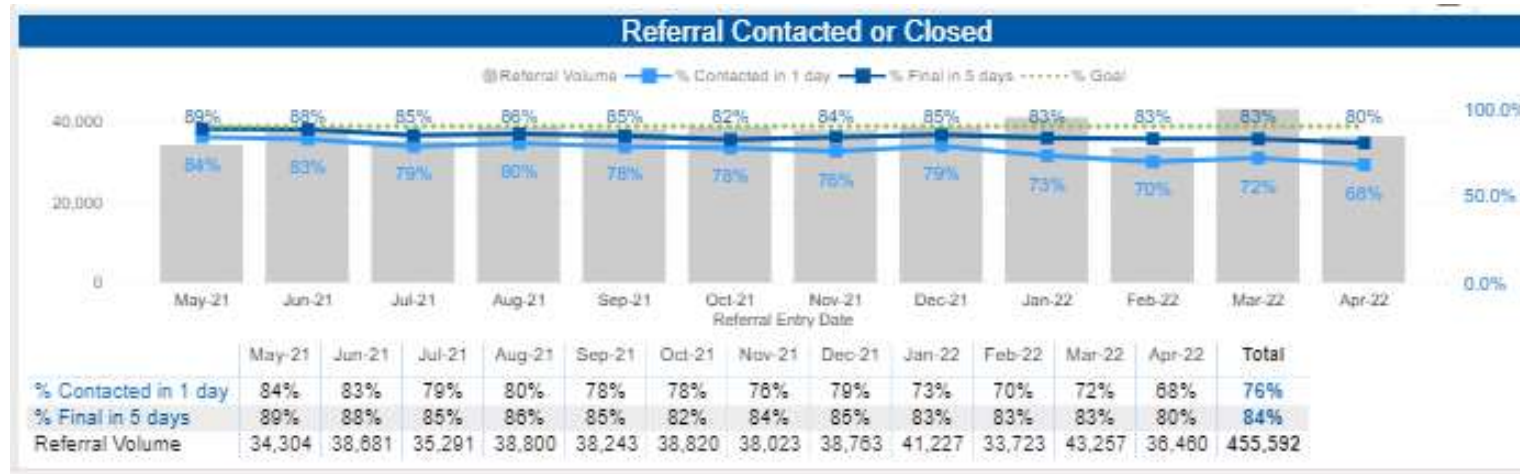
## Appendix B – Referral Metrics – Centralized vs. Decentralized

### Centralized Referral Management Team – Referral Metrics\*

\*Centralized Access Center does not track referral metrics as referrals are completed same day or transferred to the decentralized scheduling departments (clinics)



### Decentralized Scheduling Departments – Referral Metrics





## Appendix C – Risk Classifications and Definitions

As you review each observation within the Detailed Observations and Action Plans Matrix of this report, please note that we have included a color-coded depiction as to the perceived degree of risk represented by each of the observations identified during our review. The following chart is intended to provide information with respect to the applicable definitions and terms utilized as part of our risk ranking process:

<b>Risk Definition - The degree of risk that exists based upon the identified deficiency combined with the subsequent priority of action to be undertaken by management.</b>	<b>Degree of Risk and Priority of Action</b>	
	<b>Priority</b>	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.
	<b>High</b>	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.
	<b>Medium</b>	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.
	<b>Low</b>	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 presented on the above pages of this report. 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.