**PROPOSAL TITLE:** Express Care – Using Patient-initiated On-Demand Care to Improve Patient Access and Satisfaction in Primary Care

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**ABSTRACT** – In October 2023, UCSF Primary Care at Laurel Village launched Express Care, a pioneering initiative designed to transform the accessibility of care for patients with urgent, low-acuity issues. By enabling on-demand video visits with nurse practitioners, this service aims to significantly enhance patient access, minimize the reliance on non-urgent messages, optimize advanced practice provider (APP) utilization, and improve overall patient satisfaction. The pilot specifically targeted conditions suited for virtual care, ensuring efficient patient management without compromising care continuity.

The initial outcomes of Express Care have been promising, demonstrating a tangible reduction in message frequency from patients—from 1.15 to 0.97 messages per appointment—indicating more direct and efficient patient care pathways. Furthermore, patient satisfaction metrics have soared, with Express Care visits receiving higher satisfaction scores across multiple dimensions, and surpassing traditional in-person visit benchmarks.

As UCSF prepares to extend Express Care across all its primary care clinics, a concerted effort is underway to refine APeX/MyChart technical infrastructure, alongside the creation of patient-centric tools designed to facilitate easy access and utilization of the service. The development of comprehensive data dashboards is anticipated to enable deeper insights into the program's effectiveness, guiding continuous improvement. This expansion and refinement effort represent a critical phase in fully realizing the potential of Express Care, aiming to establish a new standard in accessible, efficient, and patient-centered healthcare delivery.

**TEAM** -

* Adrian Tomes – PGY5 Clinical Informatics Fellow, Family Medicine Staff physician, Project lead
* Nina Soares – Administrative Director, Lakeshore Family Medicine/ Primary Care Laurel Village
* Chad Bingo – Lead ApEX/Ambulatory analyst
* Christina Morato – Senior Analyst Supervisor, Population Health
* Kimberly Cheng – Analyst, Population Health
* Ali Maiorano – Patient Experience lead
* Christina Louie – Nurse Practitioner, Express Care Super User

**PROBLEM** – Primary care patients have four options for seeking care for urgent, acute appointments: scheduling an appointment, sending a message to their PCP, speaking with care team member to be triaged, or seeking care with an outside entity. The ability to schedule an appointment same day is highly variable across the clinics, ranging from same day to several weeks based on availability (see Figure 1).

Acute concerns that are sent via message require multiple staff to review the message, and result in delays of one to three days, and if billed, results a much lower eVisit reimbursement rate (see Table 1). Triage calls are often completed same day, but rarely billed, and if so, at a lower rate of reimbursement. For patients that require more urgent attention than can be satisfied, they are referred to external urgent cares and the primary care practice loses any opportunity to satisfy patient needs and capture revenue. Simultaneously, APP productivity across primary care, and the health system as a whole, is not sufficient – with less than 25% of APPs on track to meet productivity targets (2900 wRVUs/1.0FTE).

Express Care is a module that became available in Epic in 2018 and has had some limited adoption at other large health systems. Express Care provides a fifth option for patients: to initiate a billable, on-demand visit with a provider, which in turn creates instantaneous access, increased APP utilization, and diverts potential inbasket messages and triage phone calls into revenue generating visits.

Express Care holds enormous potential, both within primary care and also in specialty services. However, scaling up utilization to a system-wide level requires addressing gaps for patients with Limited English Proficiency (LEP), and those that have upstream determinants of health for which this type of mode of care may be out of reach. Initial utilization data for Express Care during the pilot phase skewed heavily towards English-speakers (Figure 2) and patients that identify as White are overrepresented compared to all patients (Figure 3). In order for all patients to have the opportunity to utilize this service, it is essential that the infrastructure, resources, and tools are built now with an equity framework in mind.

**TARGET** - By June 2025, expand Express Care to all primary care patients, regardless of language preference, to improve patient access and satisfaction, improve APP utilization, and decrease inbasket workload. This will be achieved through improved data analysis and Epic infrastructure, and patient centered resources that are LEP friendly.

Expected benefits based off of pilot outcomes are: improved patient experience, improved revenue capture of previously underbilled or non-billed medical care, and improvement in inbasket volume.

**GAPS** - Many of the barriers to full expansion of this service are related to a lack of infrastructure and Apex build. A fishbone exercise was used to identify gaps as seen in Figure 4.

**INTERVENTION** – Our proposed intervention, Express Care, is a pilot program designed to enhance access to care for established UCSF primary care patients who have visited any UCSF primary care clinic within the past three years. This entirely virtual practice, facilitated through the Express Care module enabled within ApEX/MyChart, aims to improve patient and provider satisfaction by streamlining the care delivery process for low-acuity, urgent issues. The initial intervention will be piloted at a single site, assessing patient satisfaction and provider ease of use as key outcomes.

The target population for this intervention includes all UCSF established primary care patients, ensuring a broad and inclusive approach. Our expansion plan over the next 12 months aims to extend Express Care to all remaining UCSF Primary Care clinic locations, including DGIM, China Basin, San Mateo, Geriatrics, and Women's Health, with the specific timing of each rollout dependent on staffing availability. This plan also includes utilizing existing APP staff from Primary Care clinics to increase utilization efficiently.

Addressing ongoing needs and barriers is crucial for the success of Express Care. Developing a backup system to optimize staffing and accommodate surges in volume, as well as unexpected provider absences, is a priority. Additionally, we plan to develop a Tableau dashboard for monitoring metrics, including equity gaps, with a specific focus on ensuring that the target metrics for Limited English Proficiency (LEP) and minority populations match the distribution set by existing standard telehealth visits in primary care. Improving instructional tools for LEP patients to support increased utilization, such as developing a website and instructional videos in the most common languages, is also part of our plan. However, a limitation remains as MyChart is currently only available in English and Spanish.

Potential adverse outcomes of this intervention include the possibility of patients relying too heavily on Express Care for issues outside the listed reasons for visit, which may increase discontinuity of care with their primary care provider (PCP). To mitigate this risk, clear guidelines and communication strategies will be developed to ensure patients understand the appropriate use of Express Care and maintain continuity of care with their PCP.

**PROPOSED EHR MODIFICATIONS**

*Clinical Problems to Solve with APeX -* Our project aims to address several clinical problems through the implementation of Express Care. Firstly, we seek to improve patient access to care for time-sensitive, low-acuity concerns. The current system often results in delays that can exacerbate health issues or lead to patient dissatisfaction due to extensive routing required and lack of timely care. Secondly, we aim to reduce the volume of new in-basket messages that providers (APP, MD, DO) must manage, which can be time-consuming and detract from patient care. Thirdly, by offering near-immediate access to medical services for time-sensitive concerns, we intend to significantly improve patient satisfaction. Lastly, we plan to enhance APP utilization by shifting the focus from addressing medical concerns via messaging or telephone encounters to increasing the volume of standard billable visits.

*Current APeX Tools and Desired Modifications -* To achieve our objectives, we have enabled the Express Care module within ApEX and MyChart on October 11, 2023, which was available within UCSF's existing EPIC license but not previously built out. Currently, this module facilitates patient access to Express Care via MyChart, targeting patients who have had an encounter within the past three years in specific departments including Lakeshore Family Medicine, UCSF Primary Care Laurel Village, and Laurel Village Pediatric Primary Care.

Our desired modifications to the current APeX tools include the elimination of non-essential screens on MyChart to improve patient navigation and the simplification of instructions to maximize patient understanding of the steps involved. Additionally, we aim to create a direct link within the Reason for Visit selection page to route patients directly to scheduling if their concern is not appropriate for Express Care, as a means to reduce potential for further inbasket messaging.

*New APeX Tools/Workflows Needed -* To further enhance our project's effectiveness, we believe several new APeX tools and workflows may be necessary. If approved for a centralized cost-center, we need to consider a standard results/in-basket management protocol for off-shift providers (precedence for this set by UCSF urgent care sites). This would ensure efficient management of patient results. If additional departments are interested in utilizing Express Care, resourcing for the build of additional generic provider pools is necessary to create separate staffing pools. In this setting, an analyst on-demand would need to be established for unexpected scheduling changes to close select templates to avoid closure of the entire tool.

Another potential future enhancement includes the integration with the symptom checker module to improve efficiency further, by allowing patients to provide additional HPI elements prior to start of the visit, so the provider may have this information available to facilitate care more rapidly. This would be a large build requirement, and would need to be evaluated for its potential to fill other existing gaps in the enterprise, and would only be justifiable if provider efficiency was identified as a gap requiring improvement. Otherwise, this runs the risk of creating an increased barrier to patient enrollment and a possible dissatisfier.

**RETURN ON INVESTMENT (ROI)** – The proposal to widely expand Express Care yields significant return on investment in three main forms: cost savings, revenue generation, and patient experience. Express Care, as a service model, is extremely efficient because it ameliorates the need for scheduling support, clinical nursing support, and physical space compared to traditional models of care. Therefore, cost savings are significant, and estimated to be up to $289,262.06 in the first year of expansion, and increasing to $369,270.72 in the second year of expansion.

Revenue generation for this new service is predicted to be strong, as indicated by the pilot period. Almost all visits have been billed as 99213, yielding a Medicare Reimbursement rate of $109.75 per visit, for a total revenue generation of $725,090.43 in year one, and increasing to $925,647.36 in the second year of expansion.

These cost savings and revenue generation estimates (Table 2) are likely conservative to the actual value provided by this service modality, given that creating a billable outlet for these visits also increases downstream capacity in primary care clinics for higher acuity visits and greater patient volumes.

Finally, there is a qualitative return on investment by satisfying the patient expectations and needs. The pilot demonstrated strong satisfaction for patient experience, and likelihood to recommend – further increasing the desirability and convenience of this type of service (Table 3).

**SUSTAINABILITY –** The financial resources from Caring Wisely would support infrastructure to scale the service. Once scaled, Express Care is a financially sustainable service that generates revenue while minimizing the expense typically associated with providing care. Administrative support for operational planning (budgeting, resource allocation, staffing support) would continue through its existing project leadership, although depending on the scale of Express Visits, could eventually become its own self-sustaining cost center with dedicated leaders.

**BUDGET -** The focus of our budget is to develop infrastructure to support the wide utilization of Express Care through: creation of patient-facing resources, Tableau dashboard development, training resources for staff and creation of standard work, improvements to the MyChart user interface, and team building activities.

1. Patient Facing Resources. Estimate - $10,000. Patient facing resources include a website, with both videos and instructions available for mobile and computer access, as well as PDF instructions. All of these resources should be available in multiple languages (see https://videovisit.ucsf.edu/ ). Plans also include marking resources to familiarize patients with the tool, as well as flyers available in primary care clinics to advertise the service.
2. Tableau Dashboard. Estimate - $10,000. The Tableau Dashboard will have Express Care data to evaluate revenue and billing, utilization, demographics of patients that utilize Express Care, and patient experience. These funds will be used to support analyst time to develop and build the dashboards.
3. Training Resources for Staff. Estimate - $5,000. As a new service, Express Care requires training specific to provider workflows that are distinct from conventional workflows. Training materials, including tipsheets, training videos, and resources will need to be created. Additionally, further development of standard work for managing templates, staffing coordination, and
4. MyChart User Interface. Estimate - $20,000. MyChart has a limited number of icons that are available, and development of a custom library of icons will help make the tool more accessible to LEP patients.
5. Team Development Initiatives. Estimate - $5000. For the use of trainings for professional development, recognition for team participation, and purchase of any supplies or equipment that may be needed.

**Appendix**



Figure 1. Third Next Available Access (TNAA) at UCSF Primary Care at Laurel Village in days, showing that patients may not have urgent access for several days to weeks.

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| --- | --- | --- | --- |
| **Visit** | **Billing Code** | **wRVU** | **Medicare Reimbursement** |
| Digital E/M 5-10 minutes | 99421 | 0.25 | $17.56 |
| Digital E/M 11-20 | 99422 | 0.5 | $34.19 |
| Telephone E/M 5-10 | 99441 | 0.7 | $69.34 |
| Telephone E/M 11-20 | 99442 | 1.3 | $109.42 |
| Video Telehealth | 99213 | 1.3 | $109.75 |

Table 1: wRVU distribution with associated Medicare reimbursement with corresponding level of service (LOS). Visits that are being diverted to Express Care typically are either not billed, or billed as eVisits (digital E/M). Video Telehealth, which is typically billed for Express Care is significantly higher.

Figure 2: Race/Ethnicity patient distribution of patients utilizing Express Care during the pilot phase. This distribution is not aligned with demographics at the pilot practices – White-identifying patients are over-represented, as they comprise 37.5% of patients in the pilot clinics.

Figure 3: Language patient distribution of patients utilizing Express Care during the pilot phase. Patients are almost exclusively English-speaking, showing a disparity for patients with Limited English Proficiency (LEP).



Figure 4. Fishbone analysis for gaps to expansion of Express Care. Many of the gaps identified are associated with technological gaps and materials for patients and staff resources.

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| **ROI Type** | **Savings / Revenue FY 25** | **Savings / Revenue FY 26** | **Notes** |
| Space Recharge | $31,132.80 | $39,744 | Assumes 2 FTE to start, plus a mid year add of 1.0 FTE with a 30% reduction for ramping in FY 25; Assumes 3.0 FTE in FY 26;Space recharge is calculated at $66.24 per square foot, with exam rooms on average 100 square feet; Typically each APP gets two exam rooms per clinic session. |
| Staffing Savings | $289,262.06 | $369,270.72 | Traditional clinics assume 1:1 nursing staffing and 1:2 administrative staffing;Express Care model assumes no nursing staffing, and 1:4 administrative staffing. |
| Revenue Generation | $725,090.432 | $925,647.36 | Assumes 100% visits billed at 99213, with Medicare reimbursement rate. Assumes APPs see 64 billable visits per week, for 44 weeks. |
| **TOTAL** | **$1,045,485.30** | **$1,334,662.08** |  |

Table 2. Return on Investment (ROI) for proposal for cost savings (recharge and staff expense), and revenue generation for Express Care.

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| --- | --- | --- | --- |
| **Patient Experience Measure** | **In Person Score** | **Video Visit Score** | **Express Care Score** |
| Staff Worked Together to Care for you | 91.4 | 92.5 | 94.34 |
| Likelihood of Recommending | 91.8 | 93.8  | 94.58 |
| Care Provider Overall | 92.5 | 93.9 | 95.11 |

Table 3. Patient Experience scores by visits completed in person, telehealth, and Express Care. Traditional visit options for in person and video visit have lower overall scores compared to the Express Care scores during the pilot phase.